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Senate Hearings

Before the Committee on Appropriations

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96*th* CONGRESS, SECOND SESSION

PART 4—(Pages 1–1137)
CONGRESSIONAL WITNESSES
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DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1981

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS UNITED STATES SENATE

NINETY-SIXTH CONGRESS

SECOND SESSION

PART 4 (Pages 1–1137)

CONGRESSIONAL WITNESSES
PUBLIC WITNESSES

Printed for the use of the Committee on Appropriations



U.S. GOVERNMENT PRINTING OFFICE
64-129 O WASHINGTON : 1980

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402

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DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1981

MONDAY, MARCH 10, 1980

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

The subcommittee met at 2:08 p.m., in room S–128, the Capitol, Hon. Ernest F. Hollings presiding.

PUBLIC WITNESSES

STATEMENT OF JAY CUTLER, PRESIDENT, COALITION FOR HEALTH FUNDING

ACCOMPANIED BY:
AL GONZALEZ, MEMBER, BOARD OF DIRECTORS
RICHARD VODRA, MEMBER, BOARD OF DIRECTORS
JON WEINTRAUB, NATIONAL ASSOCIATION OF COUNTIES

BUDGET REQUEST

Senator HOLLINGS. The subcommittee will please come to order.

This afternoon we will begin our public witness testimony. There are six groups, all on health programs. Each group has been given a total of 15 minutes, because there are so many, and I would ask that you please stick with that time schedule.

The first group that we want to welcome is the Coalition for Health Funding, and the National Association of Counties.

If you would introduce yourself for the record, it will be a big help.

Mr. CUTLER. I am Jay Cutler, president of the Coalition for Health Funding. With me are Al Gonzalez on my far right, and Dick Vodra, who are both members of the board of directors for the Coalition.

Mr. WEINTRAUB. I am Jon Weintraub with National Association of Counties Organization, and there is only one of me.

COALITION FOR HEALTH FUNDING

Senator HOLLINGS. Good; go right ahead, Mr. Cutler.

Mr. CUTLER. Senator, we appreciate the opportunity to speak on behalf of over 60 nonprofit organizations concerned with America's health care, and which constitute the membership of the Coalition.

For the past decade, the Coalition has presented to the Congress an alternative to the President's funding recommendations for controllable health programs. Our recommendations represent what private-sector health program experts and analysts determine are reasonable and responsible funding recommendations, and this is achieved after a series of minibudget hearings similar to your appropriations process.

The integrity of the process is perhaps best evidenced by the fact that the difference between our recommendation today and the statement we submit for the record is $1.25 billion less than the appropriation recommendation first presented to the Coalition, and we debated, analyzed, and critiqued each controllable health program.

We are deeply concerned that symbolism and rhetoric regarding a balanced budget, which our economic experts tell us have little to do with fighting the American people's enemy, inflation, will result in playing politics with America's health care.

We are not prepared to retreat to simplistic solutions such as an across-the-board percentage budget cut in our appropriations recommendations for the controllable Federal health programs. Rather, we suggest a careful examination and review of each and every one of the health programs, and that any decision you make regarding any controllable health program for its appropriations be made on merit.

As you review and examine the President's and our health program funding proposal, I respectfully suggest that the American people's health care cannot afford arbitrary cutbacks—for example, in biomedical and behavioral research, or cutbacks in the training and education of the Nation's health professions.

I am going to ask that Mr. Vodra now comment in more detail on the research portion of our proposal.

RESEARCH FUNDING

Mr. VODRA. Senator Hollings, this subcommittee in the next few days will hear from a number of individual groups about specific research programs in NIH and ADAMHA. Our Coalition would like to provide an overview of the entire health research program.

This subcommittee has traditionally been a strong supporter of health research. Indeed, over the last 30 years, Congress has approved more money for NIH than was in the President's budget every year but one. We hope that this practice continues for fiscal year 1981.

The benefits that the American people have received from health research have amply justified this congressional support. We frequently hear about polio which happened a generation ago. I would like to provide a few examples of NIH achievements over just the last 10 years taken from two of the Institutes.

Mortality from heart disease has dropped by a third in 10 years. Compared to the rates observed in 1968, 200,000 fewer deaths will occur this year than would have been expected. These reductions are due to such factors as effective hypertension treatment for new drugs, noninvasive diagnostic techniques that are safer, cheaper, and more informative to the doctor than old methods, and better understanding of risk factors to heart disease.

Death from respiratory distress syndrome, the disease that took John Kennedy's last child, have dropped by more than two-thirds in 10 years, because this disease is now detectable and treatable.

Blood substitutes are being developed and used experimentally. Gout is now almost completely controllable. Hospital admissions for duodenal ulcer decreased by 43 percent since 1970. Mortality from peptic ulcer declined by 31 percent because of new drugs available through research.

These advances and dozens more that could be discussed are the results of patient, careful research that has improved our understanding of human health and disease. Those of us in the health field that get a chance to talk to scientists and read the journals are confident that the 1980's and 1990's can be every bit as exciting as the 1960's and 1970's have been for advancing our Nation's health, if Congress continues to support NIH and ADAMHA.

That is the bottom line, Mr. Chairman. Only with continued funding will scientists be able to follow up new leads. Only with more funding will new scientists be trained in research translated into care through centers and clinical trials. Only with continued funding will the Nation's health continue to improve.

A 10-percent cut for NIH such as has been discussed in the press would cripple our research program and hold back advances for many years to come. The budget recommendations of the Coalition for Health Funding totaling $3.9 billion for NIH—about $300 million over the President's current budget estimate—represent a careful attempt to ask for what is needed, but only what is needed for health research.

We have not, even with the Coalition's recommendations, the percentage of our health dollar going to research would continue to decline. We have already presented a barebones budget. We hope you will give our request favorable consideration.

BUDGET RECOMMENDATIONS

Mr. GONZALEZ. I will be brief. In the face of a climate which supports a budget-cutting spree, we are recommending a number of modest increases in health care services. We believe this is a reasonable course for the health care community to follow for the following reasons:

First, decisions on individual discretionary programs should not be made in the context of macroeconomic policies. Not only are the specific health programs we represent small budgets, but they are not the large, cumbersome entitlement programs which contribute to inflation.

It is these programs where innovations are taking place. In the private sector, planning takes place after a market survey of what people want and need; not on inconsistent and little-understood economic policies. It would be wrong to cut these programs for reasons other than on their own merit.

Finally, as you're aware, the Congressional Budget Office, most economists, and even the administration in its private moments agree that a $10 billion reduction in the Federal budget would have a minimal effect on inflation.

The second point I want to make is that it is self-defeating to cut spending for programs which have as their main purpose to save money elsewhere by encouraging alternate provision of health services.

For example, home health services are intended to save money by not keeping people in costly medical institutions, but at home. Community mental health services are a major aid in promoting deinstitutionalization from expensive State-operated facilities.

The National Health Service Corps makes possible cost-effective delivery of health services in unserved and underserved communities through the Community Health Services.

The small genetic education and counseling program is preventive in orientation. The family planning program is an aid in preventing unwanted pregnancies which could otherwise later require public assistance. We need more than budget cuts to control inflation.

Thank you.

Mr. CUTLER. Senator, I ask that our full prepared statement be made a part of the record.

Senator HOLLINGS. It will be included.

Mr. CUTLER. Thank you, sir.

[The statement follows:]

STATEMENT OF JAY CUTLER

Mr. Chairman, I am Jay Cutler, President of the Coalition for Health Funding, and appearing with me today are Al Gonzalez and Dick Vodra, members of our Board of Directors. We appreciate the opportunity to speak on behalf of over sixty non-profit organizations concerned with America's health care which constitute the membership of the Coalition. Each year the Coalition develops alternative funding recommendations for federal health programs after careful analysis of the President's budget and extensive discussions within the Coalition's membership. These recommendations are limited to the so-called "controllable" health programs. By conscious decision the Coalition's activities involve only the funding associated with these programs although individual member organizations take part in the entire legislative process in areas of particular interest to their membership. I would like to submit for the record a list of the organizations which comprise the Coalition and tables which summarize the Coalition's recommendations for funding health programs in the Department of Health, Education and Welfare for FY1981.

The FY1981 budget recommendations of the Coalition for Health Funding, which are presented in the table following this summary, reflect substantial agreement with a number of the requests in the President's FY1981 budget but significant policy differences on a number of others. In general, we agree with the broad policy thrust of the President's budget proposals for the health care services programs of the Public Health Service although, in our judgment, some of the President's estimates in this area fall short of the amounts that would be necessary to achieve significant progress in the coming year - most notably, those relating to health promotion and disease prevention. Our major policy differences, however, center on the proposals in the President's budget for health manpower and biomedical research. These include our especially strong objections to the proposals in that budget for eliminating (1) all funds for capitation grants to schools of medicine and the other health professions, and to institutions training allied health personnel, and for student assistance not directly tied to commitments of service in underserved areas, beginning with a rescission of currently appropriated (FY1980) funds for these purposes, (2) all funds for capitation grants to schools of nursing and public health and for nursing student assistance, beginning in FY1981, and (3) all provisions for competing research training awards from the programs of the National Institutes of Health in FY1981. In addition, the Coalition believes that a number of the estimates in the President's budget for the rehabilitation and handicapped research programs of the new Department of Education and the developmental disability programs of the

Office of Human Development Services, Dept. of Health and Human Services, fall well short of meeting demonstrable needs.

Before explaining the Coalition's position on these and other aspects of the President's FY1981 budget, it is important to put our concerns about the estimates for the Public Health Service in the context of the total health budget for the Department of Health and Human Services, including the "non-controllable" parts of that budget which provide for the entitlement programs of Medicare and Medicaid. In the President's FY1981 budget, these "non-controllable" programs account for 87.7 percent of the total requested budget authority for the health programs of the Department of Health and Human Services. For these programs, the projected budget authority increase alone exceeds the total budget authority requested in the President's FY1981 budget for the "controllable" programs of the Public Health Service. The projected FY1981 budget authority increases for Medicare and Medicaid are 21.7 percent over FY1980, with outlay increases of 11.4 percent, if savings to be achieved through proposed legislation are realized, and 13.7 percent, if they are not. In contrast, the President's FY1981 budget requests an increase of only 4.5 percent in budget authority for the Public Health Service programs, which, incidentally, is well below the estimate in the President's budget for the further inflation of costs of close to 9 percent.

The Coalition, of course, recognizes the imperatives of the Medicare and Medicaid budgets. We simply want to emphasize our conviction that the enormous and expanding funding requirements of these "non-controllable" programs should not be permitted to obscure the essential funding requirements of the individual Public Health Service programs. Nor should their non-controllable character force "trade-off" cuts in the controllable programs of the Public Health Service. The latter should be considered on their own individual merits. Obviously, it would make no sense to pour increasingly huge sums into financing the health care system and not at the same time give appropriate priorities to the programs which are essential for supporting and improving that system.

The Coalition is cognizant of the restraints imposed on budget increases for social programs by the needs for controlling inflation and providing adequate measures for national security. However, we must point out that our recommendations would increase the total health budget of the Department of Health and Human Services by only about 1.5 percent. We consider this to be quite reasonable when full account is taken of the importance of the Public Health Service programs to the whole health care system.

As we have said, these programs should be judged on their individual merits. Our views on these merits are summarized below.

Explanation of the Coalition's Position

I. Health Care Services

The Coalition is gratified with many aspects of the President's FY1981 budget that deal with the delivery of health services--particularly the increases it proposes for

* expanding primary health care services for the underserved, including major increases for the National Health Service Corps, the community health centers and Indian health services,

* developing and improving the health care delivery system including increases for family medicine and primary care residency programs and for health maintenance organizations,

* strengthening community mental health services and community services for dealing with alcohol abuse and alcoholism, and

* providing some increased emphasis on health promotion and disease prevention, including start-up funds for a new program of formula grants to states for preventive health services and increases in funds for health education and the fluoridation of water supplies for communities and rural school systems.

However, the Coalition is proposing increases over the President's budget for some health care services programs. These are discussed by agency below.

Health Services Administration (HSA). The Coalition recommends only a very modest increase of 4.1 percent over the President's budget for the programs of the HSA--i.e., an increase from $2,116 million to $2,202 million. This increase is primarily for home health services, control of hypertension, maternal and child health services, family planning, genetic services, and migrant health centers.

The President's budget proposes to eliminate the funding in FY1981 of home health service grants, for which $5 million are appropriated in the current year. The Coalition requests the Congress to move in the opposite direction and increase the amount for these grants to $10 million in FY1981. The President's budget does propose increased benefits for home health services under Medicare and Medicaid. However, the Coalition believes that the expansion of the grants program is necessary to put more of these services in place in the community. There are more than 630 counties which have no home health services and countless more in which such services are inadequate.

The President's budget would hold the funding of the hypertension program at the FY1980 level of $20 million. The Coalition recommends that it be increased to $29 million. This program, which funds state programs to educate the public about the risk factors involved in high blood pressure and identify, refer for treatment and follow-up hypertense individuals, has been, according to reports of both the

House and Senate Committees on Appropriations, a remarkable success; it has played an important role in reducing, over the past five years, the death rates from heart attacks associated with high blood pressure and from stroke by 15 and 20 percent, respectively. In the Coalition's judgement, a further expansion of this program is fully warranted by its record of achievement and should be a significant part of the overall effort to place increased emphasis on disease prevention.

The President's budget would increase the amounts for maternal and child health programs from $380 million to $394 million in FY1981, or by less than 4 percent. The Coalition would increase the FY1981 amount to $403 million, or by approximately 6 percent and just short of the currently authorized amount of approximately $407 million. This would, at least, come closer to meeting the anticipated rise in costs and, thus, enable the program to continue in FY1981 at a level of effort approaching that of FY1980.

The President's budget would increase funds for family planning from $165 million in FY1980 to approximately $177 million, or by 7.3 percent. The Coalition recommends that this amount be increased to $210 million. Despite the rapid expansion of the family planning program over the last decade, almost 3.5 million low- and marginal-income adults and an additional 2 million sexually active teenagers are still unable to obtain family planning services. A government-supported study shows that these services save $1.80 in health services and welfare costs for every $1.00 spent on the family planning services. We think the record of this program and the broad spectrum of unmet needs for its services fully justify the Coalition's recommendations.

The President's budget would hold funding of grants for genetic education and counseling at the current level of approximately $15 million. The Coalition recommends that it be increased to $21 million. This program is designed to acquaint the public of child-bearing age, and provide counseling services, about risks for genetic disease and methods for detecting the presence of diseases before birth. It has provided grants to over 30 state health departments or universities for promoting the coordination of genetic services in those states. A large number of states remain unserved, however, and many potential providers have not been brought into the system. Expansion of this new and important type of preventive health service is necessary to make greater progress toward achieving nationwide coverage, to reduce the physical and psychological suffering resulting from genetically determined disease.

The President's budget would increase funds for migrant health services from $39.7 million in FY1980 to $44.7 million, or by about 12.6 percent. The Coalition recommends an increase to $53 million. The President's budget proposes to increase Medicaid eligibility for migrants by removal of the "intent to reside" criteria from

the regulations. However, to make health services available to a greater number of migrants, the Coalition believes that the program to support migrant health centers should be expanded to a point just below the authorized amount of $55 million.

Center for Disease Control (CDC). The President's budget shows an increase in funds for the Public Health Service's principal arm for health promotion and disease prevention from approximately $366 million in FY1980 to $391 million in FY1981, or an increase of less than 7 percent. Moreover, when the funds for the construction of the Appalachian Laboratory for Occupational Safety and Health are excluded, the increases in the President's budget for CDC's program operations amount to less than 2 percent. The Coalition recommendations would increase the CDC total amount to approximately $464 million, $73 million more than the estimates in the President's budget.

The President's budget for CDC calls for a cut in the health incentive grants program from $68 million to $52 million and proposes a modest start for a new program of formula grants for prevention centering on the leading causes of health and disability ($10 million). Taken together, the total of the amounts requested in the President's budget for the new formula grants and the on-going health-incentive and other health-promotion grants would be slightly below the FY1980 level. The explanation for the cut-back in the health incentive grants suggests that the greater targeting of the new formula grant will result in more efficient use of federal funds. This may be so, but the Coalition sees no justification for cutting back grant funds in areas which the Administration has declared to be an area of high priority. To the contrary, the Coalition recommends that the amount for health incentive grants be raised from the President's estimate of $52 million to $95 million--slightly more than the amount appropriated in FY1980 for the predecessor program of grants to the states for comprehensive health services and little more than half of the authorized amount of $170 billion for that program. In addition, it recommends doubling the amount in the President's budget for the new formula program to $20 million.

The President's budget proposes only a very small increase for the operation of the occupational safety and health program--from $79 million to $82.7 million, or an increase of about 4.7 percent. Merely to keep pace with the projected inflation of costs, the amount for this program would need to be increased above the President's budget estimate of $82.7 million to at least $86 million. The Coalition believes that the accumulating evidence on the growing hazards to health and safety at the workplace warrant at least some expansion of program effort and recommends the amount of $100 million for FY1981.

Services programs of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). The President's budget proposes increases in community and state mental

health programs from $302.8 million to $352.8 (by means of a $50 million supplemental) in FY1980 and to $379.9 million in FY1981. The Coalition recommends that the FY1981 amount be raised to $451.6 million. The President's budget assumes the enactment of the Administration's proposed mental health systems act in the current fiscal year.

The Coalition recommendations include amounts for new initiatives included in the President's budget for linking community mental health centers with the general health care system and for expanding state programs for supporting mental health services. However, we do not include the funding of the new authorities in the Administration's proposed legislation, pending the outcome of Congressional deliberations on it.

The Coalition's major differences with the President's budget on mental health services relate to its proposal for limiting the funding of community mental health centers to continuation grants. It would provide no funds whatever for other aspects of the communities health centers program, for which the sum of $61.2 million was appropriated in the current fiscal year. These include funds for the planning and initial operations of new centers, maintaining consultation and education services in centers that have completed their 8 years of federal operational support and are unable to obtain alternative funding for these services, and providing aid for centers in financial distress. The Coalition recommends $89 million for these purposes in FY1981 on the assumption that pending legislation to increase the authorized amounts for them will be enacted.

The President's budget would increase the amounts for community programs for alcohol abuse and alcoholism from $122.5 million to $137.5 million (by a $15 million supplemental request) in FY1980 and to $159.3 million in FY1981. The Coalition endorses the Administration's policy position on these programs but recommends a moderately increased amount for FY1981--$175 million.

Health planning and resource development programs of the Health Resources Administration (HRA). The President's budget requests an increase from $167.4 million in FY1980 to $180.4 million in FY1981 for the health planning and resource development programs of the Health Resources Administration. The Coalition recommends that this amount be increased to a total of $231.4 million. Although the Coalition's recommendations include slightly more for grants to health systems agencies than does the President's budget, they principally involve recommended increases over the President's budget for federal grants to assist in closing excess hospital beds or converting parts of hospital facilities to other health uses (from $9.7 million to $30 million), for project grants to support outpatient medical facilities (from zero to $15 million) and for providing funds to health systems agencies for area-wide health services development (from zero to $10 million). We don't see how significant

results can be realized with federal support of only $9.7 million for conversion or closing excess hospital facilities and think it is about time to take action to implement those parts of the national health planning legislation which authorize funding for the development of out-patient medical facilities as an alternative to expensive in-patient hospital care and for strengthening the health system agencies and their planning efforts by providing them with funds to take some initiative in promoting the development of needed services in their areas.

II. Biomedical research

National Institutes of Health (NIH). The President's budget would increase the amounts for the NIH programs from $3,429 million in FY1980 to $3,582 million in FY1981, an increase of about 4.4 percent. The Coalition's recommendations would increase this amount to $3,917 million in FY1981, an increase of about 14.2 percent.

The President's budget states that the estimates it contains would stabilize the number of NIH's new and competing research projects at 5,000 in FY1981. It is obvious, however, that, with an increase of only about half the projected rate of inflation, the President's budget would actually reduce the level of NIH's total program effort in FY1981. Moreover, the rates of increase it would provide the individual institutes range from virtually zero for the National Cancer Institute to 11.6 percent for the National Institute of Environmental Health Sciences (which includes funds for staffing and equipping a new facility) and 7.1 percent and 7 percent for the National Institute on Aging and the National Institute of Arthritis, Metabolism and Digestive Diseases. These allocations, of course, recognize varying priorities, but the fact must be faced that some of the Institutes will experience sharper reductions in their level of program effort than others, as a consequence of rising costs.

The totals in the President's budget also reflect actual dollar reductions for research training from $177.7 in FY1980 to $163.5 million in FY1981, or a reduction of 8 percent. The actual program levels would, of course, be reduced even further by rising costs. In fact, the President's budget requests no funds for new and competing training awards to be made by any of the NIH Institutes. Such an action would have a profound effect on the development of the next generation of scientists. It comes at a time when concern is rising throughout the country about the precipitous decline in the number of young physicians entering clinical research.

The Coalition takes the position that the nation should continue to support strong programs in biomedical research and that their funding should take account of increasing costs and provide some added increases for areas of especially high priority and for taking advantage of new scientific opportunities which will undoubtedly develop. In addition, we advocate increases in research training to provide for new and competing awards, in order to insure the future vitality of the

nation's research effort. The Coalition believes that a 14.2 percent increase in the total budget for NIH in FY1981 will be necessary to serve these objectives.

Research and training programs of ADAMHA. The President's budget would increase the amounts for the research programs of the National Institues of Mental Health, Drug Abuse, and Alcohol Abuse and Alcoholism from $213.6 million in FY1980 to $238.6 million in FY1981, but reduce the amounts for the research and clinical training from $106.2 million in FY1980 to $103.8 million. The Coalition recommends that the FY1981 total for research be raised from $238.6 million to $267 million and that the FY1981 amounts for the training programs be raised from $103.8 million to $147.3 million.

The Coalition is pleased to see the increases totalling $25 million (approximately an 11.6 percent increase) in the President's budget for research in the problems of mental disease, drug abuse, and alcoholism, but believes that the scope of the problems involved warrants a bigger increase--approximately $53.4 million over the FY1980 amounts. It is emphatically opposed to the direction taken in the President's budget on the training programs--i.e. holding the NIMH training programs at the FY1980 level and slightly reducing those of the other two Institutes. Over the years, these programs have suffered cuts in funding and have been further eroded by increasing costs. For example, since FY1970, NIMH funds for the training of clinical manpower have fallen by 20 percent in dollar amounts and by 62 percent in real dollar value. Without any increase over the FY1980 appropriations, 900 fewer students will be trained in FY1981 than in FY1980. And yet with the continuing expansion of mental health services, the need for skilled personnel to provide those services continues to grow. The FY1980 Senate Appropriations Committee report indicated that the committee "continues to be concerned about shortages of training psychiatrists, psychologists, psychiatric social workers and psychiatric nurses." The Coalition urges that the past policy direction on these programs be reversed and that substantial increases be provided for them in the appropriations process for FY1981.

III. Health Manpower

The President's budget would reduce the amounts for Health manpower programs from an FY1980 appropriated level of $478.8 to $331.1 million in FY1981. The Coalition recommends an increase for these programs to $628 million in FY1981.

The President's budget proposes (1) the termination of capitation grants to all health professions schools and schools of allied health and of the health profession student loan programs by means of an FY1980 rescission request of $108.8 million, (2) the elimination of capitation aid for schools of public health in FY1981, and (3) a major reduction in the support of nursing education programs in FY1981

(from $106.3 million to $28.6 million). The basic arguments advanced for these measures are that current trends indicate that the total supply of health professionals and nurses will be adequate or will be surplus to the needs, especially in the case of physicians, and that the primary objectives of health manpower policy should now be directed to problems of mal-distribution and over-specialization.

The Coalition recognizes that problems of mal-distribution and over-specialization need to be addressed and fully supports increases for programs directed at these problems. However, the Administration's justification for eliminating capitation aid represents a grossly over-simplified assessment of the problems of medical and other health professions schools. It completely ignores the damage the elimination of such aid, including its abrupt termination in the current fiscal year, would do to a group of institutions which are vital to the maintenance and strengthening of the nation's health care system--not only for the training of skilled manpower but also for the conduct of biomedical research and the delivery of health services. It also ignores the degree to which the elimination of this aid would compromise the ability of these institutions to increase the opportunities for the disadvantaged to enter careers in the health profession.

Federal capitation aid is no longer tied to requirements for increased enrollment. However, it has provided small but valuable, flexible sums of money which are being used for easing many of the unusually severe financial strains which have been placed on health professions institutions, primarily by rising energy and other costs. A withdrawal of this aid would simply have to lead to further increases of already very high tuition rates, making it even more difficult for sons and daughters of lower- and middle-income families to enter the health professions.

The elimination of the health professions student loan program would further exacerbate this problem. The Coalition fully supports major increases in student aid tied to a year of service in the National Health Service Corps, as proposed in the President's budget, and, in fact, recommends a slightly larger amount than the President's budget does for this purpose. But some loan aid ought to be available to students in need who would either repay it or serve in the Corps.

Whatever view is taken of the Administration's supply-demand model for physicians and of its effects on the health care system, it is not transferrable to the demand-supply situation of these other professions. In the case of nursing, for example, shortages of nurses in hospitals and nursing homes are reported all over the country. In the recently passed legislation for extending nurse training programs for the current year, the Congress requested the Department of Health and Human Services to seek a contract with the Department of Health and the Institute of Medicine, National Academy of Sciences to undertake a study of the problems of nursing education

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and training and of the supply and distribution of nurses. The Administration's 1981 budget, in effect, prejudges the nature of these problems and their solution without waiting for results of a study of them from an objective source.

The question of the direction national policy should take on health manpower programs is now pending before Congress, with the termination of existing legislation at the end of this fiscal year. The Coalition takes the position that, pending the outcome of Congress' deliberations on this major issue, no action should be taken to disrupt or terminate existing capitation and student assistance programs for the health professions schools and schools of nursing assistance programs.

The Coalition does, however, propose some increases over the President's budget for programs on which the future direction of national policy seems clearly established. These include additional increases for exceptional-need scholarship aid to the disadvantaged, for supporting family medicine and primary care residencies, and for training nurse anesthetists. In addition, we recommend the rejection of the proposals in the President's budget for: cutting assistance for training physician assistants below the FY1980 level; and eliminating all federal funding in FY1981 for training dental extenders and supporting nurse research grants and fellowships. In the latter case, we recommend some program expansion beyond the FY1980 level. Also, we are persuaded that Congress will approve continuance of student assistance programs in nursing and recommend that they be expanded somewhat over the FY1980 appropriation levels.

IV. Rehabilitation and developmental disability programs

Rehabilitation services and handicapped research, Department of Education. The President's FY1981 budget requests a small increase over FY1980 appropriated amounts for rehabilitation services and handicapped research--from $931.1 million to $963.6 million. The Coalition for Health Funding recommends that the FY1981 amount be increased to $1,040.9 million.

The federal program for rehabilitation services, has, through state rehabilitation agencies, served many millions of disabled individuals and placed 4.6 million persons in jobs over the 57 years of its existence. In FY1979, the state-federal program provided services to over 1,125,000 handicapped persons. However, the number served and the number rehabilitated declined slightly from the numbers of the previous year. This is attributed to the continuing increase in the costs of goods and health services, as well as to the increased number of severely handicapped persons who require priority service.

In the current fiscal year, the program of grants to states for basic vocational rehabilitation services will be operating with the same amount of funds as last year--$817.5 million (as compared with an authorized ceiling of $880 million).

The President's budget proposes only a 4.5 percent increase to $854.3 million. In view of projected increase in costs, the program's record of success, and estimates that there are 6 million additional handicapped persons who could benefit from the program, the Coalition recommends that the Congress appropriate the full amount authorized for FY1981 or $945 million.

The 1978 amendments to the Rehabilitation Act authorized a new program for providing comprehensive services to handicapped individuals "whose disabilities are so severe that they do not presently have the potential for employment but may benefit from...rehabilitation services which will enable them to live and function independently." The authorized funding ceilings for this program are $150 million in the current year and $200 million in FY1981. However, the funding level for this year is only $15 million, and the President's budget proposes only $18 million for FY1981. In order to make substantial progress toward establishing and operating a nationwide program, including a netowrk of independent living centers and a program of independent living centers for older blind persons, the Coalition recommends that Congress appropriate $100 million, or half of the authorized amount, for this program.

The Coalition agrees with the estimate of $28.9 million in the President's budget for rehabilitation service project grants. However, we consider the proposed cut in that budget of the rehabilitation training program--from $28.5 million in FY1980 to $25.5 million in FY1981--to be unwarranted. At a minimum, programs for the training of rehabilitation counselors, physical therapists, speech therapists, nurses and social workers should be continued at existing levels with an allowance for inflation. Added funds are needed for overcoming shortages of personnel for rehabilitation services in the fields of prosthetics and orthotics and of medicine. Under the circumstances, the Coalition recommends $35 million for rehabilitation training in FY1981.

The President's budget proposes an increase for the National Institute for Handicapped Research for $31.5 million in FY1980 to $37 million in FY1981. The new focus of research under legislation passed in 1978 is upon technology development which was not authorized or undertaken in the past and upon rehabilitation research related to populations which do not necessarily have a vocational objective in life--handicapped children and handicapped elderly. The Coalition is recommending an increase of $3 million for this Institute over the estimate in the President's budget to expand current research and training centers, or an FY1981 total of $40 million for the Institute.

Developmental disability programs, Office of Human Development Services, Department of Health and Human Services. The President's budget proposes that funding for these programs be maintained at the current fiscal year level of $62.4

million. The Coalition recommends that it be increased to $80.8 million. This includes an increase from $50.7 million to $64.8 million for grants to states in order to extend services to new categories of individuals with chronic disabilities added by recently enacted legislation and allow the states to develop programs which will enable them adequately to discharge their responsibility for the four priority functions prescribed in that legislation--namely, case management, child development services, alternative community living arrangement services, and non-vocational social-development service. This increase would also extend protection and advocacy services to handicapped individuals on a statewide basis--the original intent of the legislation.

In addition, the Coalition's recommendations include increases from $4.8 million to $7 million for service project grants and from $7 million to $9 million for support of university-affiliated facilities. The increase for service project grants would be used to fund a few model projects to avoid start-up costs in each of the 50 states to implement various features of the new legislation. The increase for university-affiliated facilities would extend their community outreach programs, expand their services to presently underserved geographic areas and strengthen their support of state agencies in the development of manpower and training plans.

March 1980

Dear Friend:

Each year since 1970, representatives of national health interests have combined their efforts to keep informed of developments in Federal health budgets, to prepare an alternative to the President's budget, and to inform the Congress, the press, and the public of alternate funding to the President's proposal. Representing over 60 organizations, the Coalition monitors the development of the Federal budget, the Congressional budget process, appropriations process, and the overall status of health financing. The Coalition annually publishes this analysis of the President's health budget, including carefully developed alternative recommendations.

The stated goals of the Coalition for Health Funding are: (1) to identify inadequacies in existing and proposed levels of support for all Federal health programs; (2) to establish priorities for increased funding of the various health programs; (3) to communicate the need for adequate funding for specific health programs to the public, the press, the Administration and the Congress; (4) to prepare and present documentation of the funding needs of the Federal programs involved, stressing the potential accomplishments if appropriate funding were available; (5) to seek Congressional support for specific appropriation levels; and (6) to seek expenditure of all appropriated funds.

The Coalition's funding recommendations are carefully developed over a three-month evaluation period. Coalition members develop preliminary funding levels in their areas of interest, which are presented and justified to a panel of Board members. The Board then considers each program individually, evaluates previous funding levels and the suggested increases and their

purposes, and then approves a tentative budget. The tentative budget is distributed to members, who are given an opportunity to appeal the Board's decision. After the President's budget is released, the Board considers all appeals and formulates a final budget which is then approved by the membership.

The Coalition limits its activities to the Congressional Budget and Appropriations process for controllable health programs. The Coalition attempts to provide assistance to the Administration, the Congress, and the public by distributing its analysis of the health funding process. The CHF takes no partisan political positions, nor does it attempt to influence authorizing legislation.

This collective proposal of the Coalition members contains our line by line proposals for the health budget, narrative justifications for the recommended funding levels, and names of our members, listed below each narrative, who can provide further information.

If the Coalition leadership or its members can provide you with any further information, please do not hesitate to call upon us.

Sincerely,

Jay B. Cutler
President

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COALITION FOR HEALTH FUNDING MEMBERSHIP

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American Congress of Rehabilitation Medicine
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American Nurses' Association
American Optometric Association
American Pediatric Society
American Personnel and Guidance Association
American Psychiatric Association
American Psychological Association
American Public Health Association
American Social Health Association
American Society of Allied Health Professions
American Speech-Language-Hearing Association
Arthritis Foundation
Association of American Medical Colleges
Association of American Veterinary Medical Colleges
Association of Independent Research Institutes
Association of New York Neighborhood Health Centers
Association of Physician Assistant Programs
Association of Schools & 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
Council of State Administrators of Vocational Rehabilitation
Council on Social Work Education
Cystic Fibrosis Foundation
Endocrine Society
Friends of Eye Research, Rehabilitation and Treatment
Group Health Association of America
Human Growth Foundation
March of Dimes Birth Defects Foundation
Medical Library Association
Memorial Sloan-Kettering Cancer Center
National Association of Community Health Centers
National Association of Counties
National Association of Social Workers
National Committee Against Mental Illness
National Council of Community Mental Health Centers
National Council on Alcoholism
National Health Education Committee
National League for Nursing
National Mental Health Association
National Retired Teachers' Association/American Association of Retired Persons
National Student Nurses' Association
New York State Committee for the Treatment of High Blood Pressure
Planned Parenthood Federation of America
Research Foundation of State University of New York
Society for Investigative Dermatology
Society for Neuroscience
United Auto Workers

EXPLANATION OF JUSTIFICATION STATEMENTS

APPROPRIATION: Money appropriated by Congress to fund programs in FY1979 and FY1980. Aggregate totals are used, derived from appropriations bills and continuing resolutions.

AUTHORIZATION: Upper limits for appropriations established by Congressional legislative committees. Where "Open" appears, authorizing legislation calls for "...such sums as necessary" to meet the statutory purpose set forth in a law. The word "Expired" appears for those authorizations which expire before the beginning of FY1981.

PRESIDENT'S REQUEST: These budget authority levels are those submitted to the Congress in January 1980 by President Carter in his FY1981 Budget.

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 FY1980, 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 asterisks (**) and may have to be adjusted at a later date.

JUSTIFICATION MATERIAL: Each statement begins with a program description and then proceeds to explain and justify the recommended increase for each program over the FY1980 level.

CONTACT: These Coalition members are those who had input into the recommended funding level and its justification. Since the justification statements are so brief, all members are available and willing to provide more information and data on request.

($ in thousands)

	FY1979 APPROPRIATION	FY1980 AUTHORIZATION	FY1980* APPROPRIATION	FY1981 AUTHORIZATION	FY1981 PRESIDENT'S BUDGET	FY1981 CHP RECOMMENDATION
Section 1. Recommendations to I-HEW Subcommittee						
I. HEALTH SERVICES ADMINISTRATION						
A. Community Health Services						
1. Community health centers - p.12	258,500	405,000	320,000	472,000	374,402	384,000
2. Research and demonstration centers	10,564		14,009		9,064	9,064
3. Home health services - p.20	6,000	10,100	6,000	21,000	0	10,000
4. Hypertension - p.13	11,000	24,500	20,000	29,000	20,000	29,000
5. Maternal and child health - p.14						
a. Grants to states	345,500	399,864	345,500	399,864	360,500	366,000
b. Research and training	32,177		31,843		31,043	33,000
c. Sudden infant death syndrome - p.16	2,802	4,000	2,802	7,000	2,802	4,000
Subtotal - Maternal and child health	380,479	403,864	380,145	406,864	394,345	403,000
6. Genetic services - p.19	10,567	21,500	14,567	26,000	14,945	21,000
7. Family planning - p.17	135,000	234,406	165,090	269,526	176,875	210,000
8. Migrant health - p.18	34,500	48,500	39,700	55,000	44,700	53,000
9. National health service corps - p.21	61,986	82,000	70,000	EXPIRED	133,832	133,832**
10. Private practice grants (NHSC)	1,000	SSAN	500	SSAN		1,000
11. Black lung clinics	7,500	10,000	7,500	10,000	7,500	7,500
12. Program support	30,046	OPEN	32,600	OPEN	42,492	42,492
B. Health Care Services and Systems						
1. Patient care and special health services						
a. Hospitals and clinics	172,016	OPEN	166,434	OPEN	165,031	165,031
b. Federal employee health	686	OPEN	728	OPEN	792	792
c. Payments to Hawaii	1,600	OPEN	1,800	OPEN	1,800	1,800
Subtotal - Patient care and special health services	174,302		168,962		167,623	167,623
2. Emergency medical services - p.22	42,625	46,000	42,625	58,000	26,500	26,500
3. Program support	7,547	OPEN	8,988	OPEN	10,078	10,078
Subtotal - Health Care Services & Systems	244,474		220,575		204,201	204,201
C. Buildings and Facilities	---	OPEN	3,000	OPEN	6,969	6,969
D. Program Management	7,026	OPEN	7,416	OPEN	7,955	7,955
II. CENTER FOR DISEASE CONTROL						
A. Disease Control						
1. Basic preventive health programs - p.24						
a. Prevention formula grants	New Program	20,000	---	60,000	10,000	20,000
b. Health incentive grants for Comp. Pub. Svcs. (Comp hlth grants to states)	90,000	150,000	68,000	170,000	52,000	95,000
c. Health education	1,112	14,000	4,500	15,000	16,541	16,541
Subtotal - Basic preventive health	91,112		72,500		78,541	131,541
2. Disease prevention program - p.25 & 26						
a. Venereal diseases	32,000	51,500	40,000	59,000	47,749	47,749
b. Immunization	35,000	39,500	24,532	45,000	30,491	30,491
c. Fluoridation	2,037		6,785		9,584	12,000
Subtotal - Disease prevention program	69,037		71,317		87,824	90,240
3. Control of chronic conditions - p.26						
a. Chronic diseases	15,365		16,499		19,528	19,528
b. Environmental hazards	27,883		30,022		31,028	31,028
Subtotal - Control of chronic conditions	43,268		48,521		50,554	50,554
B. Occupational Safety & Health	63,470	OPEN	79,552	OPEN	82,705	100,000
C. Epidemic Services	26,606		28,054		30,147	30,147
D. Technology Development & Application	25,737		26,777		27,336	27,336
E. Buildings & Facilities	1,912	OPEN	11,436	OPEN	29,951	29,951
F. Program Management	3,604	OPEN	3,703	OPEN	3,978	3,978
III. NATIONAL INSTITUTES OF HEALTH						
A. Cancer - p.31 (Research training)	936,677 (20,129)	1,030,000	1,000,000 (27,114)	EXPIRED	1,007,800 (22,657)	1,060,000** (30,096)
B. Heart, Lung, and Blood - p.34 (Research training)	506,364 (21,792)	560,000	527,544 (33,268)	EXPIRED	546,399 (31,029)	610,000** (36,928)
C. Dental Research - p.38 (Research training)	65,211 (3,293)	OPEN	68,318 (4,198)	OPEN	70,451 (3,765)	80,000 (4,660)
D. Arthritis, Metabolism, Digestive Diseases - p.40 (Research training)	302,767 (14,896)	OPEN	341,246 (22,077)	OPEN	365,711 (15,192)	395,000 (23,382)

($ in thousands)

	FY1979 APPROPRIATION	FY1980 AUTHORIZATION	FY1980* APPROPRIATION	FY1981 AUTHORIZATION	FY1981 PRESIDENT'S BUDGET	FY1981 CHF RECOMMENDATION
E. Neurological, Communicative Disorders and Stroke - p.43 (Research training)	212,365 (7,365)	OPEN	242,000 (8,912)	OPEN	249,807 (7,095)	260,000 (9,002)
F. Allergy and Infectious Diseases - p.46 (Research training)	191,328 (9,130)	OPEN	215,402 (9,868)	OPEN	228,412 (8,341)	250,000 (10,953)
G. General Medical Sciences - p.49 (Research training)	277,628 (46,570)	OPEN	312,478 (47,422)	OPEN	331,639 (54,379)	362,500 (59,595)
H. Child Health and Human Development - p.51 (Research training)	197,630 (10,238)	OPEN	208,981 (9,820)	OPEN	217,531 (8,175)	240,000 (10,900)
I. Aging - p.54 (Research training)	56,911 (2,385)	OPEN	70,000 (2,782)	OPEN	75,317 (2,172)	90,000 (3,088)
J. Eye - p.57 (Research training)	105,192 (4,643)	OPEN	113,000 (5,043)	OPEN	116,562 (3,301)	130,000 (5,320)
K. Environmental Health Sciences - p.59 (Research training)	78,260 (4,568)	OPEN	83,912 (6,568)	OPEN	97,269 (6,714)	98,600 (7,453)
L. Research Resources - p.61 (Research training)	154,164 (515)	OPEN	169,199 (656)	OPEN	184,439 (707)	200,000 (777)
M. Fogarty Center - p.64	8,989	OPEN	8,989	OPEN	9,181	9,500
N. National Library of Medicine - p.65	41,431	OPEN	44,000	OPEN	44,730	53,000
O. Office of the Director - p.66	20,427	OPEN	21,062	OPEN	22,549	23,000
P. Buildings and Facilities - p.67	30,950	OPEN	3,250	OPEN	11,750	15,000
IV. ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION						
A. National Institute of Mental Health						
1. Research - p.68	130,807	OPEN	145,250	OPEN	162,964	185,000
2. Training - p.69	90,400	OPEN	90,354	OPEN	90,354	129,500
a. Clinical training	(74,263)		(71,663)		(71,663)	(98,500)
b. Research training	(16,137)		(18,691)		(18,691)	(31,000)
3. Community Programs						
a. Linkage to CHCs - p.72	---	405,000	---	463,000	10,584 1/	11,500
b. Community mental health centers - p.72						
1) Continuations of operations	250,100	Indefinite	234,000	Indefinite	277,600	277,600
2) New operations	30,500	35,000	35,000	42,000 2/	---	42,000
3) Consultation and education	12,400	20,000 3/	12,400	19,000 3/	---	19,000
4) Planning (new only)	---	1,000	---	1,000 2/	---	1,000
5) Conversion (new only)	1,800	25,000	1,800	--- 2/	---	2,000
6) Distress	12,000	25,000 3/	12,000	25,000 3/	---	25,000
Subtotal - CMHCs	306,800		295,200		288,184 4/	378,100
4. State programs - p.74	7,600	Indefinite	7,600	Indefinite	45,600	40,500
5. Formula grants to states - p.76						
a. Mental health planning	13,500	20,000	---	25,000	12,117	25,000
6. Program support						
a. Management and information	31,200	OPEN	35,000	OPEN	38,113	42,200
B. National Institute on Drug Abuse - p.77						
1. Research	42,930	OPEN	46,000	OPEN	50,420	55,000
2. Training						
a. Clinical training	9,379	OPEN	7,978	OPEN	6,942	8,500
b. Research training	621		702		702	1,500
Subtotal - Training	10,000	OPEN	8,680	OPEN	7,644	10,000
3. Community programs						
a. Project grants and contracts	161,000	169,000	161,000	185,000	161,000	161,000
b. Grants to states	40,000	45,000	40,000	45,000	35,902	35,902
4. Program support	18,178	OPEN	18,570	OPEN	19,448	19,448
C. National Institute on Alcohol Abuse and Alcoholism - p.79						
1. Research						
a. Grants	16,197	28,000	16,317	28,000	17,918	20,000
b. Research centers	6,000	8,000	6,000	9,000	7,250	8,000
Subtotal - Research	22,197		22,317		25,168	28,000
2. Training						
a. Clinical training	5,052	OPEN	6,005	OPEN	4,521	8,500
b. Research training	2,148	OPEN	1,195	OPEN	1,300	3,500
Subtotal - Training	7,200		7,200		5,821	12,000
3. Community programs						
a. Project grants and contracts	78,706	102,500	78,706	115,000	108,308	115,000
b. Grants to states	56,800	60,000	56,800	65,000	50,961	60,000
4. Program support	10,202	OPEN	10,515	OPEN	10,957	11,000

($ in thousands)

	FY1979 APPROPRIATION	FY1980 AUTHORIZATION	FY1980* APPROPRIATION	FY1981 AUTHORIZATION	FY1981 PRESIDENT'S BUDGET	FY1981 CHF RECOMMENDATION
5. Natl. Comm. on Alcoholism & Alcohol Related Problems	---	1,000	---	1,000	---	1,000
D. Buildings and Facilities	---	OPEN	792	OPEN	5,425	5,425
E. Program Management	8,112	OPEN	10,413	OPEN	11,019	11,019
F. St. Elizabeth's Hospital	79,252	OPEN	85,119	OPEN	97,706	97,706
V. HEALTH RESOURCES ADMINISTRATION						
A. Health Planning and Resource Development - p.82						
1. Health planning - p.82						
a. HSA grants	107,000	150,000	124,700	165,000	124,717	130,000
b. States' grants	29,500	35,000	32,000	40,000	34,500	35,000
c. Conversion/Closure grants	---	30,000		50,000	9,747	30,000
d. Planning methods/centers	6,500	6,000	1,000	6,000	1,700	1,700
e. Modernization and life safety codes (Sec. 1613 & 1625(a))--Project Grant Construction	39,940	40,000		50,000	---	---
f. Resource development	---	OPEN		OPEN	---	---
g. Project grants--Outpatient Med. Facilities	---	---		15,000	---	15,000
h. Area health services development	---	---		20,000	---	10,000
i. Rate regulation grants		6,000	---	6,000	---	---
j. Program support	11,882		9,689		9,703	9,703
B. Health Manpower - p.84						
1. Health professions, capitation grants (institutional assistance) - p.84						
a. Medicine, osteopathy, and dentistry	96,700	196,700	69,748	EXPIRED	---	70,000**
b. MDD, bonus phase-out	---	---	---	EXPIRED	---	- **
c. Veterinary, optometry, pharmacy and podiatry (includes bonus phase-out)	14,400	33,725	11,520	EXPIRED	---	11,600**
d. Startup assistance	5,000	5,000 3/	2,700	EXPIRED	---	1,000**
e. Financial distress	5,000	10,000 3/	5,000	EXPIRED	9,200	9,200**
2. Health teaching facilities						
a. Construction grants	---	40,000	1,000	EXPIRED	---	10,000**
b. Interest subsidies	3,000	4,300	4,300	EXPIRED	4,300	4,300**
3. Health facilities financing						
a. Conversion/closure	---	---	---			
4. Health professions, student assistance - p.86						
a. Health professions student loans	10,000	28,000	16,500	SSAN	---	28,000
b. Loan repayments	1,500	SSAN	1,500	SSAN	11,700	11,700
c. National Health Service Corps scholarships	75,000	200,000	85,500	SUMS NECESSARY FOR PRIOR RECIP.	93,500	95,000
d. Health professions scholarships	Program Discontinued ----------					
e. Exceptional need scholarships	7,000	18,000	10,000	EXPIRED	10,000	18,000**
f. Shortage area scholarships	---	---	---	EXPIRED		---**
5. Health professions, special educational assistance - p.87						
a. Family medicine/general dentistry residencies	45,000	50,000	40,500	EXPIRED	46,000	55,000**
b. Family medicine departments	---	20,000	9,500	EXPIRED	15,000	15,000**
c. Primary care residencies & training (General pediatrics/Internal medicine)	17,500	25,000	19,500	EXPIRED	22,235	25,000**
d. Interdisciplinary training (Primary care - special projects)	7,141	10,000 3/	8,500	EXPIRED	---	12,500**
e. Physician Assistants	9,100	35,000 3/	9,100	EXPIRED	7,500	9,100**
f. Area health education centers	20,000	40,000	21,000	EXPIRED	21,000	21,000**
g. Disadvantaged assistance	19,000	21,000	19,568	EXPIRED	22,392	22,392**
1) Health professions	(18,000)	(20,000)				(21,000)
2) Allied health	(1,000)	(1,000)				(1,392)
h. Foreign medical transfers	1,000	4,000	---	EXPIRED	---	---**
i. Emergency medical training	3,000	EXPIRED	---	EXPIRED	---	---**
j. National Advisory Committee on Graduate Medical Education	1,000	SSAN	500	SSAN	500	1,000
k. Supply and distribution reports	2,700	SSAN	2,700	SSAN	2,700	5,000
l. Project grants - MDD	Program Discontinued ----------					
m. Project grants - VDPP	Program Discontinued ----------					
n. Manpower initiatives	Program Discontinued ----------					
6. Dental health education - p.89						
a. TEAM grants (Dental extenders)	2,000 2,000	4/	2,000 2,000	EXPIRED	2,000 ---	2,000** 2,000
b. Educational development	---	SSAN	---	SSAN		
Subtotal - Dental health education	4,000		4,000		2,000	4,000

($ in thousands)

	FY1979 APPROPRIATION	FY1980 AUTHORIZATION	FY1980* APPROPRIATION	FY1981 AUTHORIZATION	FY1981 PRESIDENT'S BUDGET	FY1981 CHI RECOMMENDATION
7. Nursing, institutional assistance - p.97						
a. Capitation	24,000	24,000	24,000	EXPIRED	---	24,000**
b. Advanced nursing training	12,000	13,500	12,000	EXPIRED	---	13,000**
c. Nurse practitioner training	13,000	15,000	13,000	EXPIRED	17,000	18,000**
d. Special projects	15,000	17,000	15,000	EXPIRED	9,600	17,000**
e. Financial distress	---	---	---	EXPIRED		---**
8. Nursing facilities - p.96						
a. Construction grants	3,500	2,000	---	EXPIRED	---	---**
b. Interest subsidies	---	1,000	---	EXPIRED	---	---**
9. Nursing, student assistance - p.96						
a. Loans	13,500	13,500	13,500	EXPIRED	---	22,500**
b. Scholarships	9,000	FORMULA	9,000	EXPIRED	---	11,000**
c. Traineeships	13,000	15,000	13,000	EXPIRED	---	16,000**
d. Loan repayment	750	---	750	EXPIRED	1,000	---**
10. Nurse anesthetists - p.97	-------	2,000	---	EXPIRED	1,000	2,000**
11. Nursing research projects - p.98						
a. Fellowships (Research training)	1,000	SSAN	1,000	SSAN	---	3,000
b. Projects	5,000	OPEN	5,000	OPEN	---	7,000
12. Allied health - 95	13,000	31,500	10,000	EXPIRED	---	16,000**
13. Public health and health administration - p.90						
a. Capitation	5,900	11,060	6,500	EXPIRED	---	9,000**
b. Public health traineeships	7,000	10,000	7,000	EXPIRED	7,000	10,000**
c. Special projects - public health and health administration	5,000	6,000	5,000	EXPIRED	5,000	7,000**
d. Health administration program support (grants and training)	3,000	3,750	3,000	EXPIRED	3,700	3,700**
e. Health administration traineeships	2,000	2,500	2,000	EXPIRED	2,500	2,500**
14. D.C. medical and dental	Program Discontinued ----------					
15. Program support (BHM)						
a. HRA overhead, regional offices						
b. Div. of Associated Health Professions						
c. Div. of Dentistry						
d. Div. of Medicine						
e. Div. of Nursing						
f. Other programmatic activities						
g. Support activities						
Subtotal - Program support (BHM)	19,908	OPEN	15,916	OPEN	17,434	17,434
C. Program Management (HRA)	17,350	OPEN	17,691	OPEN	18,293	18,293
D. Sales Insufficiencies	2,412	SSAN	2,000	SSAN	---	SSAN
E. Medical Facilities Guarantee and Loan Fund	42,000	SSAN	45,000	SSAN	---	SSAN
VI. OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH						
A. Health Research, Statistics and Technology						
1. Health services research - p.100	33,418	40,000	29,772	45,000	34,617	34,617
2. Health statistics - p.99	30,916	65,000	44,987	70,000	41,575	55,000
3. Health care technology - p.103	---	25,000	3,250	33,000	7,822	7,822
4. Program management	321	---	709	---	732	732
B. Health Maintenance Organizations - p.101						
1. Grants and contracts	25,217	65,000	50,119	68,000	58,900	58,900
2. Program management	7,764	OPEN	8,261	OPEN	10,393	10,393
Subtotal - HMOs	32,981		58,380		69,293	69,293
C. Health Initiatives						
1. Adolescent health - p.102	1,000	65,000	17,500	75,000	17,574	20,000
2. Smoking and health	---	OPEN	12,329	OPEN	13,042	13,042
3. Health promotion - p.103	1,790	OPEN	1,672	OPEN	5,278	5,278
4. Physical fitness and sports	801	OPEN	899	OPEN	942	942
5. International health - p.103	652	OPEN	700	OPEN	790	1,400
6. Special health initiatives	400	OPEN	---	---	---	---
D. Public Health Service Management	21,297	OPEN	21,777	OPEN	23,166	23,166
E. Scientific activities overseas	11,367	SSAN	6,520	SSAN	---	---
F. Retirement & Medical Benefits For Commissioned Officers	65,083	OPEN	76,925	OPEN	91,958	91,958

($ in thousands)

	FY1979 APPROPRIATION	FY1980 AUTHORIZATION	FY1980* APPROPRIATION	FY1981 AUTHORIZATION	FY1981 PRESIDENT'S BUDGET	FY1981 CHF RECOMMENDATION
VII. OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE SERVICES (Department of Education - Selections)						
A. Rehabilitation Services - p.104						
1. Basic state grants - p.104	817,484	880,000	817,484	945,000	854,259	945,000 1/
2. Innovation and expansion	18,000	50,000	11,775	55,000	---	---
3. Service projects and construction - p.105	26,728	SSAN	26,860	SSAN	28,860	28,860
a. Training services and facilities improvement grants	(4,900)	SSAN	---	SSAN		
b. Construction	---	SSAN	---	SSAN		
c. Service projects	(21,828)	SSAN	(26,860)	SSAN	(28,860)	(28,860)
4. Training - p.105	30,500	40,000	28,500	45,000	25,500	35,000
5. Independent living - p.105	2,000	150,000	15,000	200,000	18,000	100,000
B. National Institute for Handicapped Research-p.108	31,500	75,000	31,500	90,000	37,000	40,000
VIII. OFFICE OF HUMAN DEVELOPMENT SERVICES (Department of Health and Human Services - Selections)						
A. Developmental Disabilities - p.106						
1. State grants	33,058	65,500	43,181	75,000	43,181	49,779
2. Protection & advocacy	3,000	12,000	7,500	15,000	7,500	15,000
3. Special projects	18,567	22,000	4,756	26,000	4,756	7,000
4. University affiliated facilities	6,500	14,000	7,000	16,000	7,000	9,000
Section 2. Recommendations to Agriculture Subcommittee						
IX. FOOD AND DRUG ADMINISTRATION - p.10						
A. Salaries and Expenses						
1. Food	85,708	OPEN	90,169	OPEN	96,307	97,700
2. Drugs and devices	135,559	OPEN	144,406	OPEN	154,962	160,600
3. Radiological products	20,489	OPEN	22,001	OPEN	23,273	25,800
4. National Center Toxic Research	13,974	OPEN	14,489	OPEN	15,168	15,900
5. Program management	39,344	OPEN	41,711	OPEN	42,899	43,300
B. Buildings and Facilities	10,459	OPEN	4,372	OPEN	29,663	37,300
Section 3. Recommendations to Interior Subcommittee						
X. INDIAN HEALTH SERVICE - p.23						
A. Indian Health Services	477,041	OPEN	538,874	OPEN	601,619	601,619
B. Indian Health Facilities	76,960	OPEN	74,302	OPEN	76,670	76,670

FOOTNOTES

* The regular appropriations for these accounts for 1980 have not been enacted at the time this Budget was prepared. The 1980 amount shown are based on a continuing resolution (P.L. 96-123) in effect through 9/30/80 which authorizes the amounts agreed upon in the House-Conference on FY1981 bill. For those activities that were deferred from regular appropriation consideration because of the lack of authorizing legislation at the time, P.L. 96-123 provides funding at the current rate.

1/ Assumes enactment of Mental Health Systems Act as proposed by Administration.

2/ Assumes enactment of Senate Bill 1177, or, alternatively, a one-year exentsion of CMHC Act.

3/ Assumes enactment of pending legislation to increase authorizations.

4/ The President's 1981 budget includes an additional $33,671 for the proposed Mental Health Systems Act in FY1981.

5/ These are covered by total authorization of $25,000,000.

6/ Also encompasses Item 62, team grants.

7/ Actual sum to be determined by matching state grants.

National Association of Counties

STATEMENT OF JON WEINTRAUB, ON BEHALF OF THE NATIONAL ASSOCIATION OF COUNTIES

Mr. Weintraub. My name is Jon Weintraub. I'm a legislative coordinator with the National Association of Counties. We are here today to discuss the full range of the Labor-HEW budget. But before we do that, I wanted to point out that our executive committee met in an emergency meeting just last week to respond to the President's request on where to cut the budget. And as a result of that meeting, the exec-

utive committee decided that we can best accept an across-the-board percentage cut in the budget for all programs, exempting defense.

We believe that this is the best approach for the administration and the Congress to take, given the time constraints in this Congress and in this political year—while we caution that a balanced budget has become the symbol to those making decisions in the financial community, and that we will probably have to go through the process of balancing the budget just to see what it will achieve and will not achieve.

In short, we feel that most of the general public will feel the pinch in some way, large or small, as the result of this activity; and we caution that a year from now, if inflation is still running 10 percent or more after the budget is balanced, what will the pubic think?

The public could well be very bitter as a result of all the fuss that has been stirred up over the balanced budget and expect more than that policy can achieve.

YOUTH AND CETA BUDGET

With regard to the Comprehensive Training and Employment Act, and in light of my earlier statements recommending an across-the-board cut to all programs including CETA, we caution against a severe cut in the public service jobs area when the administration and CBO is predicting unemployment rates of 7.4 percent or higher.

We would support for the future, forward-funding for titles II–B and C, IV, and VII of CETA. And with that in mind, we would request that the committee in its report require the Secretary of Labor to report to the Congress by February 1 on the advantages of forward funding.

With regard to consortia bonuses, they've shrunk to 2.2 percent this year. What we would like to suggest is, either report language or specific language in your appropriations bill to set aside such sums as necessary to provide a 10-percent consortium bonus.

With regard to the President's youth program, we are concerned that a consolidation of one set of acronyms and substitution of a whole new set is not really new, creative programing. What we have requested to the authorizing committees, both House and Senate, is that they extend the existing bill, and take the time necessary to develop a decent youth bill.

SOCIAL SERVICES

With regard to alternate social services, we caution that the budget includes a number of new initiatives that are offset by cost-saving measures; that within this budget, the HSS budget outlay projects an increase of $26 million for 1981 over fiscal 1980; and that it must be stressed that that increase is mainly due to higher costs of income and medical benefits for the elderly, blind, and disabled.

We also flag for the committee the welfare reform items in the budget are contingent on Senate passage of the cash bill, which has passed the House, H.R. 4904.

With regard to title 20, we are reluctantly willing to accept the $400 million cut from our previously stated $3.1 billion funding level, and support the conferees' position of $2.7 billion.

We are supportive of the emergency low-income energy assistance program. We are interested in maintaining adequate funding for the Indochinese refugees, which the House and Senate just concluded a conference on—the Refugee Act of 1979, S. 643.

We are also supportive of the President's budget request for programs under the Older Americans Act. With regard to health funding, because of counties' heavy responsibilities, and again in light of our earlier statement of accepting across-the-board percentage cuts for all programs, we strongly urge this subcommittee to do all it can within its power not to make further cutbacks in programs which directly impact service delivery.

In the area of several specific programs, if I can highlight quickly; under section 1610(a) of the Public Service Act, which insures funding for public hospital facilities, we would urge that at a minimum half of the current authorized level, or $25 million, be appropriated.

With regard to section 1642, which provides for conversion and discontinuance of hospital facilities, again we would urge at least half of that authorization be provided, $25 million.

For section 314(d), which is for immunization and sanitation programs and venereal disease control, we request that the current $68 million level be retained.

I would be happy to answer any questions, sir.

[The statement follows:]

STATEMENT OF JON WEINTRAUB

MR. CHAIRMAN, MEMBERS OF THE SUBCOMMITTEE, MY NAME IS JON WEINTRAUB. I AM ASSOCIATE DIRECTOR AND LEGISLATIVE COORDINATOR OF THE NATIONAL ASSOCIATION OF COUNTIES. I SERVE AS STAFF LIAISON TO THE NATIONAL ASSOCIATION OF COUNTIES' EMPLOYMENT STEERING COMMITTEE WHICH IS RESPONSIBLE FOR DEVELOPING NACO'S POLICY ON ALL EMPLOYMENT AND TRAINING RELATED PROGRAMS, INCLUDING THE JOBS ASPECTS OF WELFARE REFORM.

LET ME BEGIN BY EXPRESSING TO THE SUBCOMMITTEE OUR TOTAL UNDERSTANDING OF THE IMPORTANCE THESE HEARINGS HAVE IN OUR ORGANIZATION'S ABILITY TO REFLECT OUR CONCERN OVER THE FEDERAL BUDGET AND THE PROGRAMS IN WHICH WE HAVE SIGNIFICANT INTEREST.

NACO HAS DONE AN ANALYSIS OF THE ADMINISTRATION BUDGET AND BASICALLY BELIEVES THAT IT IS A RESPONSIVE BUDGET. THOUGH IT HOLDS THE LINE ON MOST DOMESTIC PROGRAMS IT DOES, TO A DEGREE, REPRESENT AN UNDERSTANDING BY THE ADMINISTRATION OF THE EFFECT INFLATION IS HAVING ON LOCAL BUDGETS.

OUR ANNUAL LEGISLATIVE CONFERENCE ENDED LAST WEEK. DURING THAT CONFERENCE, NACO'S PRESIDENT MET WITH SENIOR WHITE HOUSE STAFF, AT THEIR REQUEST, TO RESPOND TO PRESIDENT CARTER'S REQUEST ON WHERE TO CUT THE BUDGET. IN PREPARATION FOR THAT MEETING, NACO HELD AN EMERGENCY MEETING OF ITS EXECUTIVE COMMITTEE. NACO PROPOSED A SIMPLE, ACROSS THE BOARD PERCENTAGE CUT OF ALL PROGRAMS IN THE BUDGET, EXEMPTING DEFENSE. WE BELIEVE THAT THIS IS THE BEST APPROACH FOR THE ADMINISTRATION AND CONGRESS TO TAKE GIVEN THE TIME CONSTRAINTS ON THE 96TH CONRESS IN THIS POLITICAL YEAR.

WE OPPOSE BOTH THE CONSTITUTIONAL AMENDMENT TO BALANCE THE BUDGET AS WELL AS THOSE BUDGET INITIATIVES WHICH SET SPENDING LIMITS AS A PERCENTAGE OF THE GNP.

A BALANCED BUDGET HAS BECOME A SYMBOL IN THE MINDS OF MANY PEOPLE, PARTICULARLY THOSE MAKING DECISIONS IN FINANCIAL MARKETS, NOT JUST OF THE GOVERNMENT'S ABILITY TO CONTROL INFLATION BUT THE ECONOMY AS WELL. WE WILL PROBABLY HAVE TO GO THROUGH THE PROCESS TO SEE WHAT IT WILL ACHIEVE AND WON'T ACHIEVE.

MOST ECONOMISTS BELIEVE A FULL-FLEDGED RECESSION IS THE ONLY WAY TO UNDERCUT INFLATION IN 1980. BALANCING THE BUDGET FOR 1981, WOULD DEMONSTRATE CONGRESSIONAL INTENT TO KEEP TIGHTENING FISCAL POLICY UNTIL THAT, AND THE SKY-HIGH INTEREST RATES BEING GENERATED BY FEDERAL RESERVE MONETARY-POLICIES, COMBINE TO PRODUCE A RECESSION.

AT SOME POINT, THERE WILL BE A RECESSION. FEW ECONOMISTS BELIEVE THE NATION HAS ENTERED SOME STRANGE NEW ECONOMIC WORLD IN WHICH DECLINING

FAMILY INCOMES AND SOARING INTEREST RATES HAVE NO DEPRESSING EFFECT WHATEVER ON THE WILLINGNESS AND ABILITY OF CONSUMERS AND BUSINESS TO SPEND MONEY. IN SHORT, MOST OF THE PUBLIC WILL FEEL THE PINCH IN SOME WAY LARGE OR SMALL. A YEAR FROM NOW IF INFLATION INDEED IS STILL RUNNING 10 PERCENT OR MORE AND THE BUDGET IS BALANCED, WHAT WILL THE PUBLIC THINK? THE PUBLIC COULD WELL BE BITTER BY THEN BECAUSE ALL THE FUSS OVER BALANCING THE BUDGET HAS PROBABLY BEGUN TO RAISE EXPECTATIONS ABOUT A DROP IN INFLATION FAR ABOVE WHAT THIS POLICY CAN DELIVER.

CETA

DESPITE THE ADMINISTRATION'S PROJECTION OF AN UNEMPLOYMENT RATE HOVERING AT 7.4% THROUGH FISCAL '82, THE PRESIDENT'S BUDGET REQUEST FOR PROGRAMS UNDER THE COMPREHENSIVE EMPLOYMENT AND TRAINING ACT (CETA) SHOWS NO NEW INCREASES EXCEPT FOR THE YOUTH INITIATIVE AND COMPENSATION FOR MINIMUM WAGE.

WE SUPPORT THE PRESIDENT'S REQUEST TO MAINTAIN THE NUMBER OF PUBLIC SERVICE JOBS AT THEIR CURRENT LEVEL OF 450,000. WITH A PREDICTED UNEMPLOYMENT RATE OF 7.4%, WE CAUTION THE MEMBERS OF THE SENATE APPROPRIATIONS COMMITTEE AGAINST ANY CUTS IN PUBLIC SERVICE JOBS. NACO HAS ALWAYS SUPPORTED TRAINING FOR JOBS IN THE PRIVATE SECTOR IN PREFERENCE FOR SOLE RELIANCE ON PUBLIC SERVICE JOBS. HOWEVER, AS THE UNEMPLOYMENT RATE RISES AND HITS INTOLERABLE LEVELS IN COUNTIES ACROSS THE COUNTRY, WE NEED TO BE ABLE TO RELY ON A RESERVOIR OF PUBLIC SERVICE JOBS FOR INDIVIDUALS WHEN FEW, IF ANY, NEW JOBS EXIST IN THE PRIVATE SECTOR.

NACO SUPPORTS FORWARD FUNDING FOR TITLES II B AND C, IV, AND VII OF THE COMPREHENSIVE EMPLOYMENT AND TRAINING ACT (CETA). THE CETA AMENDMENTS OF 1978 (PL 95-524) FOCUSED ON BETTER MANAGEMENT OF THE DELIVERY SYSTEM. CURRENTLY, THE FUNDING OF CETA, WHICH HAS BEEN MARKED BY CONTINUING RESOLUTIONS THE LAST THREE YEARS (PL 95-205, 95-482, AND 96-86), HAS MADE PRUDENT PLANNING AND EFFECTIVE MANAGEMENT DIFFICULT. THE CETA SYSTEM HAS GONE THROUGH A SERIES OF JOLTS, AN UNFORTUNATE PATTERN WHICH NEEDS TO BE REVISED.

FORWARD FUNDING WOULD ALLOW CETA:

- TO PLAN AND DELIVER SERVICES MORE EFFECTIVELY WITH THE EDUCATION COMMUNITY. CURRENTLY CETA AND LOCAL SCHOOL BOARD PLANNING IS OUT-OF-PHASE;
- TO AVOID FRICTION AMONG DIFFERENT LEVELS OF GOVERNMENT WITH DIFFERENT FISCAL YEARS;
- TO COORDINATE MORE EFFECTIVELY WITH OTHER FEDERAL JOB CREATION PROGRAMS WITH LONGER RANGE IMPLEMENTATION PERIODS, SUCH AS ECONOMIC DEVELOPMENT AND COMMUNITY DEVELOPMENT;
- TO RETAIN EFFECTIVE STAFF AT THE PRIME SPONSOR LEVEL;

- o To improve selection of enrollees;
- o To improve the employability development of and placement of clients;
- o To create more meaningful on-the-job training and work experience opportunities;
- o To develop year-long contracts in the middle of a fiscal year to better provide trained personnel for local businesses; and
- o To create a level of certainty within the CETA system.

We propose that this committee in its report accompanying the Labor-HEW appropriations bill require the Secretary of Labor to report to the Congress by February 1, 1981, on the advantages for forward funding of Titles II B, and C, IV, and VII.

The 1980 CETA consortia bonuses have been released and provide a 2.2 percent bonus this year. NACo feels this is disastrous to the future of consortia. An analysis of the prior spending for consortia follows:

	% Bonus	$
FY 1977	10%	$40.8 million[1]
FY 1978	10%	$39.3 million[1]
FY 1979	7.3%	$30 million[2]
FY 1980	2.2%	$ 9 million[2]

Notes:

1. Results from a specific 5 percent set-aside in P.L. 93-203, section 103 (b)
2. Without a specific set-aside in P.L. 95-524, section 202(f)(2)(c)

Only $9 million was available this year for three reasons: (1) the law (P.L. 95-524) gives a lower priority to consortia bonuses; (2) $40 million had to be used for the 90 percent hold harmless in FY 1980 because of the formula change rather than $5 million in FY 1979, thus obligating more Title II B, C funds; and (3) DOL rates consortia as a low "political" priority when making decisions on how to use the approximately $30 million left in discretionary funds from Title VI and whatever is left in Title III.

Title II B, C money ($2.054 billion) for Fiscal 1980 is being spent as follows:

$1745.9 million	formula
40.2 million	90% hold harmless

25.0 MILLION	CPS ADJUSTMENT[3]
20.7 MILLION	STATE COUNCILS
124.3 MILLION	VOCATIONAL EDUCATION
82.9 MILLION	STATE SERVICES
30.3 MILLION	1% LINKAGES[4]
90.0 MILLION	CONSORTIA BONUSES

NOTES:

3. NOT FUNDED AFTER FISCAL 1980

4. $6 MILLION IS II B, C AND $24 MILLION IS II D DISCRETIONARY

THUS, AFTER THE STATE SERVICES ACCOUNT IS FUNDED, $2.039 BILLION OF THE $2.054 BILLION IS UTILIZED LEAVING ONLY $15 MILLION FOR THE ONE PERCENT LINKAGES AND CONSORTIA BONUSES. $6 MILLION OF THE REMAINING II B, C FUNDS WAS USED FOR LINKAGES WITH $24 MILLION FROM II D, LEAVING ONLY $9 MILLION FOR CONSORTIA BONUSES.

WE URGE MEMBERS OF THIS SUBCOMMITTEE TO AMEND CETA TITLE II B AND C IN THE LABOR-HEW APPROPRIATIONS BILL TO PRIORITIZE FUNDING FOR CONSORTIA BONUSES. WE SUGGEST THAT AN AMENDMENT BE ADDED TO INSURE THAT "SUCH SUMS AS NECESSARY BE SET ASIDE TO PROVIDE A 10% CONSORTIUM BONUS" FOR CONSORTIA IN TITLE II B AND C.

TURNING TO THE ADMINISTRATION'S PROPOSAL TO MODIFY AND EXTEND THE TITLE IV PROGRAMS, THE NATIONAL ASSOCIATION OF COUNTIES SUPPORTS ANY EFFORT TO CONSOLIDATE ANY SIMPLIFY THE ENORMOUSLY COMPLEX REQUIREMENTS CREATED UNDER THE YOUTH EMPLOYMENT AND DEMONSTRATION PROJECTS ACT OF 1977. EXCHANGING AN OLD SET OF ACRONYMS FOR A NEW SET OF ACRONYMS IS NOT CONSOLIDATION. WE'RE CONCERNED THAT THE DIVISION OF FUNDS PROPOSED BY THE ADMINISTRATION DOES NOT ACCOMPLISH ITS OWN GOALS OF CONSOLIDATION AND SIMPLIFICATION. FIRST, THE DISTRIBUTION OF FUNDS IS A CONCERN. WE SERIOUSLY QUESTION THE ADMINISTRATION'S PROPOSAL TO SPLIT THE FUNDS EQUALLY BETWEEN THE TWO TITLES. AT A MEETING ON MARCH 2, 1980, NACo's EMPLOYMENT STEERING COMMITTEE PASSED A MOTION IN SUPPORT OF ALL TITLE I AND II FUNDS GOING BY FORMULA TO CETA PRIME SPONSORS WHICH WOULD HAVE RESPONSIBILITY FOR DECIDING WHICH EDUCATION PROGRAMS WORK IN THEIR COMMUNITY AND WHICH SHOULD BE FUNDED. IN THE NAME OF GRANT REFORM, NACo's EMPLOYMENT STEERING COMMITTEE FELT STRONGLY THAT ONE AGENCY NEEDS TO BE IN CHARGE AT THE LOCAL LEVEL AND IT SHOULD BE CETA. THEIR THOUGHT WAS THAT WE NEED MORE THAN INTERAGENCY "COOPERATION" AT THE FEDERAL LEVEL TO ACHIEVE A STRONG DELIVERY SYSTEM FOR YOUTH AT THE LOCAL LEVEL. DISADVANTAGED YOUTH DO NOT RECEIVE THE BEST LEVEL OF SERVICES WHEN TO FEDERAL AGENCIES ACHIEVE A VAGUE STAND-OFF AS THEY DO IN THIS BILL. WITHIN TITLE I, ENTIRELY TOO MUCH MONEY IS OUTSIDE

THE BASIC FORMULA GRANT. AS YOU KNOW, ONLY THREE-FOURTHS OF THE 59 PERCENT ASSIGNED TO CETA PRIME SPONSORS WOULD BE DISTRIBUTED BASED ON THE YETP FORMULA. THAT IS $497.8 MILLION DOLLARS COMPARED TO $693 MILLION CURRENTLY AVAILABLE UNDER YETP, A $200 MILLION DOLLAR REDUCTION. SINCE YCCIP AND YIEPP ARE TO BE ELIMINATED, THE PROPOSED FUNDING LEVEL INSURES THAT PRIME SPONSORS MUST ENGAGE IN A DESPERATE EFFORT TO OBTAIN INCENTIVE FUNDS SIMPLY IN ORDER TO AVOID A ONE-THIRD DISRUPTION IN THEIR CURRENT PROGRAMS. THE DISRUPTION GOES FURTHER BECAUSE THERE IS A MATCHING REQUIREMENT ON EVERY INCENTIVE DOLLAR OBTAINED BY PRIME SPONSORS. THUS, THE POOL OF FUNDS AVAILABLE FOR LOCALLY DETERMINED PROGRAM NEEDS CAN BE EXPECTED TO BE GREATLY REDUCED. SIMPLY STATED, THERE ARE TOO MANY MINI-POTS AND MINI-SPLITS OF FUNDS IN THIS BILL.

THE CETA SYSTEM HAS HAD MORE THAN ITS FAIR SHARE OF SHOCK WAVES. LET'S ALLOW THE AUTHORIZING COMMITTEE TO TAKE THE TIME NECESSARY TO DRAFT AN EXCELLENT YOUTH BILL. IN THE MEANWHILE, LET'S EXTEND YEDPA WITH THE NECESSARY AMENDMENTS TO THE EXISTING CETA LAW ON THE AVERAGE AND MAXIMUM WAGE AND ON FLEXIBILITY FOR THE SECRETARY IN DETERMINING PRIME SPONSORS LIABILITY.

WELFARE AND SOCIAL SERVICES

NACO SUPPORTS THE BUDGET TARGETS THAT THE ADMINISTRATION HAS SET FOR WELFARE AND SOCIAL SERVICES PROGRAMS. THE BUDGET INCLUDES SOME NEW INITIATIVES THAT ARE OFFSET BY SEVERAL COST SAVING MEASURES. IT MUST BE NOTED THAT $4 BILLION OF ANTICIPATED SAVINGS ARE DEPENDENT UPON PASSAGE OF PENDING LEGISLATION. DESPITE THE OFFSETS AND LIMITED SPENDING INITIATIVES IN THIS BUDGET, THE ANTICIPATED HSS BUDGET OUTLAY FOR FISCAL '81 IS $26 BILLION HIGHER THAN FISCAL '80. IT MUST BE STRESSED THAT THE INCREASE IS MAINLY DUE TO HIGHER COSTS OF INCOME AND MEDICAL BENEFITS FOR THE ELDERLY, BLIND, DISABLED AND POOR. AS SECRETARY PATRICIA HARRIS CITED, SUPPLEMENTAL SECURITY INCOME BENEFITS AND THE RISING COST OF HEALTH CARE ARE THE MAJOR FACTORS. OUT OF THE DEPARTMENT'S ESTIMATED TOTAL, $219.3 BILLION OUTLAYS FOR FISCAL YEAR '81, 94% GOES TO BASIC INCOME SUPPORT AND MEDICAL CARE FOR THE POOR. THE RISING NUMBER OF ELDERLY AND DISABLED ACCOUNT FOR 1.6 MILLION NEW BENEFICIARIES OVER 1980.

WELFARE REFORM ITEMS IN THE BUDGET ARE DEPENDENT UPON SENATE PASSAGE OF THE HOUSE PASSED ADMINISTRATION BILL, H.R. 4904. ALTHOUGH MOST OF THE REFORMS WILL BE EFFECTIVE IN 1982, THE NATIONAL MAXIMUM PAYMENT OF 65% OF POVERTY LEVEL AND THE HIGHER FEDERAL MATCHING WOULD BE IMPLEMENTED IN FISCAL '81. NACO STRONGLY SUPPORTS THE $850 MILLION SET-ASIDE FOR THESE PURPOSES WHICH INCLUDE FISCAL RELIEF. INCLUDED IN H.R. 4904 ARE SAVINGS OF APPROXIMATELY $200 MILLION WHICH COULD BE

IMPLEMENTED AS EARLY AS JULY, 1980 IF THE BILL IS ENACTED. THESE SAVINGS WOULD BE IN THE AFDC CALCULATION FOR EARNINGS AND WORK EXPENSES.

NACo HAS SUPPORTED A $3.1 BILLION FUNDING LEVEL FOR TITLE XX SOCIAL SERVICES. THE ADMINISTRATION SUPPORTS THE CURRENT LEVEL OF $2.9 BILLION FOR THE TITLE XX PROGRAM. HOWEVER, THE RECENTLY CONCLUDED HOUSE-SENATE CONFERENCE COMMITTEE ON H.R. 3434 HAS SET THE TITLE XX LEVEL AT $2.7 BILLION. RELUCTANTLY, NACo WILL SUPPORT THE $2.7 BILLION FUNDING LEVEL FOR TITLE XX, ACCEPTING A $400 MILLION CUT FROM OUR ORIGINAL POSITION. WE REMIND THE SUBCOMMITTEE THAT IF $2.5 BILLION IN 1972 WAS A VALID MEASURE OF FEDERAL SUPPORT OF SOCIAL SERVICES, INFLATION HAS ERODED THAT LEVEL OF SUPPORT TO $1.3 BILLION.

THE RECENTLY CONCLUDED HOUSE-SENATE CONFERENCE ON THE REFUGEE ACT OF 1979 (H.R. 2816), CONTINUES FULL FEDERAL FUNDING FOR REFUGEES UNTIL OCTOBER, 1982. THIS REPRESENTS AN ADDITIONAL $40 MILLION TO THE CURRENT BUDGET.

NACo STRONGLY ENDORSES THIS YEAR'S EMERGENCY LOW INCOME ENERGY ASSISTANCE PROGRAM. HOWEVER, WE FERVENTLY HOPE THAT A JOINT FEDERAL STATE-LOCAL APPROACH AS ENVISIONED IN S. 1724, MAY HELP TO MAKE NEXT YEARS'S PROGRAM MORE EFFICIENT IN MEETING NEEDS IN THE FUTURE.

NACo STRONGLY SUPPORTS THE PRESIDENT'S REQUEST FOR PROGRAMS FUNDED UNDER THE OLDER AMERICANS ACT. ALTHOUGH THERE ARE SOME INCREASES OVER FY '80, THESE EXTRA-FUNDS MUST BE SEEN AS SIMPLY THE DOLLARS REQUIRED TO (A) MEET REQUIREMENTS MANDATED BY THE 1978 AMENDMENTS TO TITLE III (B) AND 9B) KEEP THE HIGHLY EFFECTIVE TITLE III (C) HOT MEAL PROGRAM OPERATING AT CURRENT LEVELS. TO REDUCE TITLE III (B) ALLOCATIONS WOULD SIMPLY FORCE LOCAL COMMUNITIES OUT OF COMPLIANCE WITH THE LAW. TO REDUCE FUNDING UNTER TITLE III (C) WOULD FORCE CUTBACKS OF HOT MEALS FOR THE ELDERLY BELOW EXISTING LEVELS. LIKEWISE, THE SMALL DOLLAR INCREASE IN TITLE V WILL NOT ADD ONE EXTRA JOB TO CURRENT PAYROLLS. AND, FINALLY THE TITLE IV RESEARCH BUDGET IS ALREADY ABOUT $1.5 MILLION BELOW FY '80 LEVELS. FURTHER CUTS COULD ONLY SERIOUSLY THREATEN THE ABILITY OF THE ADMINISTRATION ON AGING TO DEVELOP ANY INNOVATIONS TO BETTER SERVE OUR ELDERLY CITIZENS.

HEALTH

IN THE AREA OF HEALTH, OUR CONCERNS ARE EQUALLY ACUTE. AS YOU KNOW, MR. CHAIRMAN, COUNTIES HAVE FAR-RANGING RESPONSIBILITIES FOR THE FINANCING AND DELIVERY OF HEALTH CARE SERVICES. THEY PAY FOR A MAJOR PROPORTION OF CARE FOR THOSE WHO ARE CURRENTLY TARGETED BY NATIONAL HEALTH INSURANCE PROPOSALS, INCLUDING SOME TWENTY-TWO MILLION AMERICANS MOST OF WHOM ARE POOR AND LOW-INCOME WHO ARE CURRENTLY WITHOUT MEDICAID,

MEDICARE OR OTHER INSURANCE PROTECTION, AND ANOTHER FIVE MILLION UNDOCUMENTED ALIENS. IN ADDITION, IN SOME TEN STATES, COUNTIES CONTRIBUTE TO THE COST OF MEDICAID. NATIONWIDE, COUNTIES ALSO PAY THE DIFFERENCE BETWEEN MEDICAID RATES OF REIMBURSEMENT AND THE REAL COSTS OF DELIVERING CARE. THESE SERVICES ARE ALL FINANCED BY LOCAL TAXES - CHIEFLY THE LOCAL PROPERTY TAX.

MR. CHAIRMAN, BECAUSE OF THESE HEAVY RESPONSIBILITIES - AND THE SEVERE FINANCIAL CONSTRAINTS UNDER WHICH WE OPERATE - WE STRONGLY URGE THIS SUBCOMMITTEE TO DO ALL IN ITS POWER NOT TO MAKE FURTHER CUTBACK IN PROGRAMS WHICH IMPACT ON DIRECT DELIVERY OF SERVICES.

IN ITS ORIGINAL BUDGET REQUEST, THE ADMINISTRATION CAREFULLY TARGETED LIMITED RESOURCES TO THE UNDERSERVED, TO PRIMARY CARE, AND TO HEALTH PROMOTION ACTIVITIES, AND OTHER COST-SAVING MEASURES AND WE COMMEND THE ADMINISTRATION FOR THAT APPROACH. IT WAS BASED ON A RECOGNITION OF THE VERY REAL NEEDS FOR HEALTH SERVICES WHICH ARE STILL UNMET, AND THE NEED TO BEGIN THE TASK OF RESTRUCTURING OUR EXISTING HEALTH CARE SYSTEM. AS A NATION, WE LITERALLY CANNOT AFFORD TO DO LESS. AS WE ALL KNOW, THE COSTS OF HEALTH CARE HAVE ESCALATED EVEN FASTER THAN THE OVERALL RATE OF INFLATION. THE LOCAL TAX BASE SIMPLY CANNOT KEEP PACE. THE GAP BETWEEN OUR COMMITMENTS AND TRADITIONAL RESPONSIBILITIES AND OUR ABILITY TO FULFILL THEM IS WIDENING, AND WE ARE CONCERNED ABOUT THE LONG-LASTING CONSEQUENCES OF THIS SITUATION, SHOULD IT CONTINUE.

WE ALSO STRONGLY URGE THE ADOPTION OF SOME SMALL INCREASES IN SEVERAL PROGRAM AREAS WHERE IT IS CLEAR THAT CURRENT BUDGET-CUTTING EFFORTS WILL ONLY RESULT IN FAR HIGHER LONG-RANGE COSTS. THESE AREAS ARE AS FOLLOWS:

SECTION 1610(A) OF THE PUBLIC HEALTH SERVICE ACT. UNDER THIS SECTION, $50 MILLION IS AUTHORIZED TO ENSURE THAT PUBLIC HOSPITAL FACILITIES ARE MAINTAINED TO MEET BASIC LIFE SAFETY AND FIRE CODE STANDARDS, IN OTHER WORDS, MINIMUM STANDARDS FOR ACCREDITATION. THERE IS AMPLE EVIDENCE THAT THE CURRENT NEED FOR SUCH FUNDING FAR EXCEEDS THE AUTHORIZED LEVEL, YET NO FUNDS HAVE BEEN REQUESTED BY THE ADMINISTRATION. THE LONGER FUNDING FOR THIS PURPOSE IS POSTPONED, THE GREATER THE NEEDS WILL BECOME. EVEN NOW, FUNDING IS TOO LATE, WHERE SOME FACILITIES ARE SO ANTIQUATED AS TO BE BEYOND THE COST OF RENOVATION. WE WOULD URGE, AS A MINIMUM, GIVEN CURRENT BUDGETARY CONSTRAINTS, THAT HALF OF THE AUTHORIZED LEVEL - OR $25 MILLION - BE APPROPRIATED IN FISCAL 1981.

SECTION 1642 OF THE PUBLIC HEALTH SERVICE ACT. UNDER THIS SECTION, $50 MILLION IS AUTHORIZED IN FISCAL 1981 TO PROVIDE RESOURCES FOR THE CONVERSION AND DISCONTINUANCE OF HOSPITAL FACILITIES. CURRENTLY,

JUST $10 MILLION IS INCLUDED IN THE PRESIDENT'S BUDGET FOR CLO AND CONVERSION. THESE FUNDS ARE DESIGNATED TO HELP REDUCE THE NU OF EXCESS ACUTE CARE BEDS AND TO CONVERT THEM FOR THE PROVISION OF LESS COSTLY MODES OF HEALTH CARE DELIVERY SUCH AS LONG TERM CARE AND PRIMARY CARE, IN KEEPING WITH THE DECISIONS OF LOCAL HEALTH PLANNING AGENCIES. IN TESTIMONY BEFORE THE HOUSE WAYS AND MEANS HEALTH SUBCOMMITTEE, UNDER SECRETARY OF HEALTH NATHAN STARK NOTED THAT "CLOSURE AND CONVERSION OF EXCESS HOSPITAL CAPACITY IS A FUNDAMENTAL COMPONENT OF THE ADMINISTRATION'S STRATEGY FOR CONTAINING HOSPITAL COSTS". CLEARLY, THAT STRATEGY REQUIRES ADDITIONAL SUPPORT TO PRODUCE THE DESIRED RESULTS, AND WE WOULD URGE FUNDING OF AT LEAST, $25 MILLION, WHICH IS HALF THE AUTHORIZED LEVEL.

SECTION 314(D) OF THE PUBLIC SERVICE HEALTH SERVICE ACT. THIS SECTION PROVIDES FOR THE MOST ESSENTIAL OF PUBLIC HEALTH SERVICES, INCLUDING IMMUNIZATION AND SANITATION PROGRAMS, VENEREAL DISEASE CONTROL, ETC. LAST YEAR, THE PRESIDENT RECOMMENDED FUNDING BE SLASHED TO $52 MILLION FROM A LEVEL OF $76.5 MILLION. CONGRESS EASED THE CUT, INSTEAD APPROPRIATING $68 MILLION. EVEN SO, THE LOWER LEVEL OF FUNDING MEANT CUTBACKS IN SERVICE DELIVERY. THIS YEAR, THE PRESIDENT IS AGAIN RECOMMENDING A $52 MILLION APPROPRIATION - REPRESENTING A NEARLY 25% DECREASE IN FUNDING, DISCOUNTING THE IMPACT OF INFLATION. WE DO NOT SEE ANY JUSTIFICATION FOR THIS VERY SERIOUS EROSION OF SUPPORT FOR SOME OF THE MOST BASIC HEALTH SERVICES, AND REQUEST THAT THE CURRENT $68 MILLION LEVEL BE RETAINED.

WE APPRECIATE THIS OPPORTUNITY TO TESTIFY BEFORE YOUR SUBCOMMITTEE AND LOOK FORWARD TO ANSWERING ANY QUESTIONS YOU MIGHT HAVE.

PERCENTAGE CUT OF BUDGET

Senator HOLLINGS. What percentage across the board would you suggest?

Mr. WEINTRAUB. Well, the figure that has been tossed around is that approximately a 2-percent across-the-board cut would be sufficient. Now when the executive committee of the board of directors took a look at that, they did not have the resources of the Administration in terms of what figure they wanted to end up with.

Obviously, whatever percentage you pick leaves you with a certain result. My understanding is that Mr. Eizenstat on the President's staff is trying to push movement in that direction but is losing.

Senator HOLLINGS. Very good. We are $139 million over the President's budget request, and you ask for $300 million more, I think. Isn't that right, Mr. Cutler?

Mr. CUTLER. That is correct.

Senator HOLLINGS. The economist might say that the $10 billion will not save us from inflation—incidentally, they have not been right about anything they have ever said. [Laughter.]

But I do know that at interest rates of 16 percent—and that is what the Government is having to pay to borrow money now—that is $1.6 billion. Wouldn't it be delightful if I had just $1.6 billion to put into health services by paying the bill this year and not going $10 billion over? Or more specifically, that I didn't have to put out $79 billion just in interest payments on the national debt. That is $79 billion worth of hospitals, health research, everything else you and I could think of, just in interest going down the drain. So we are going to have to cut back somewhere. But we appreciate your appearances here today.

Mr. WEINTRAUB. Mr. Chairman, if I could comment on the other side of that: Whatever economic policy we come up with, on the down side, for every increased percent in the unemployment rate, you're talking about a $22 to $25 billion loss in revenues due to unemployment insurance, food stamps, and other obligated expenditures that automatically kick in as a result of that.

Senator HOLLINGS. Yes; and I have seen some of the automatic kick-ins.

Mr. WEINTRAUB. Thank you.

Mr. CUTLER. Thank you, Senator.

Senator HOLLINGS. Thank you.

Our next group is interested in the many programs in the Health Services Administration. We have the Mid-Atlantic Emergency Medical Services Council, the National Association of Community Health Centers, the National Family Planning and Reproductive Health Association, and Planned Parenthood.

PROGRAMS OF HEALTH SERVICES ADMINISTRATION

STATEMENTS OF:

R. ADAMS COWLEY, M.D., FOR THE MID-ATLANTIC EMERGENCY MEDICAL SERVICES COUNCIL, INC.

JANICE M. ROBINSON, R.N., NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS

DOROTHY MANN, NATIONAL FAMILY PLANNING AND REPRODUCTIVE HEALTH ASSOCIATION

KIT SMITH, PLANNED PARENTHOOD

EMS SYSTEM DEVELOPMENT

Senator HOLLINGS. We will start right here.

Dr. COWLEY. Mr. Chairman, members of the committee, I am Dr. R. Adams Cowley, director of the Maryland Institute for Emergency Medical Services Systems, and director of the Emergency Medical System in Maryland. I am also president of the Mid-Atlantic Emergency Medical Service Council, the purpose of which is to foster complete compatible emergency service systems throughout the regions which encompass the States of Maryland, Delaware, Pennsylvania, West Virginia, and the city of Washington.

I appreciate this opportunity to appear before you to discuss the Federal appropriations for the development of an EMS system throughout the country. We come to you knowing that the Congress and the President 3 months ago, with passage and signing into law the extension of the assistance for Emergency Medical Service Systems Act, renewed their commitment to the completion of a nationwide system for emergency medical services.

I am also aware of the fact that the national economy now dictates that all programs funded with Federal dollars must be viewed with a critical eye. The President and the Congress must look carefully at all programs—from those that deliver care to the individual to those who built waterways and highways, and make a judgment where the placement of Federal dollars will produce the most beneficial result.

In order for there to be no misunderstanding, let me state to you what an EMS system is, and what its components are. It is a five-phased operation: Rescue and immediate aid; communications via communications network with a medical command center; transportation to some care area which is adequate for that patient and which involve those components necessary for survival in the medical center; and finally, rehabilitation.

So many people believe that emergency medicine is just a program of building hospitals, buying fancy ambulances and other hardware to haul the patient to the nearest hospital. EMS systems should now spend very little in this area. They must concentrate their dollars on better management of existing facilities, and on upgrading facilities and manpower capabilities wherever necessary.

In arriving at your decision on proper funding for these systems, I would like you to keep three points in mind: First of all, they save lives; they also save money; and they bring the best medical care to all the individuals in the United States on whatever level is needed.

EMS saves lives. They're young lives. Emergency-related death is the biggest killer between the ages of 1 and 39, and it's third overall, and yet minimal amounts of money are spent in this area compared with other health entities.

Second, it will save money for the taxpayers. I have testified before, and do so again now, the U.S. Government cannot afford not to fund this kind of a system. Today we have no system and we are paying dearly for this opportunity.

Let me cite some statistics to illustrate what I mean. In 1978, there were 104,000 accidental deaths in the United States. There were 10 million disabling injuries, and 51 of these were deaths by automobiles. Those injured in their early lives may have to live with a disability for more than 30 years. It is entirely because the young person's disease is different from cancer or stroke which attack many of we older people—we don't live long after it happens. These young people have years and years of life, with their disability ahead, which we as taxpayers have to pay for.

This cost in this country today with no system is $67 billion a year—we could run a Vietnam war, I believe, on that. In Maryland, we have demonstrated that with a total system of care we have cut down in

severe accidents the mortality rate from 70 down to 20 percent. Because the system provides immediate care to the victim and takes him through rehabilitation, we are returning victims to productive lives. They are not dependent on the taxpayer's subsidy. They are not a drain on society; but become productive, useful citizens.

Senator HOLLINGS. Dr. Cowley, pardon me, but you have already gone over 5 minutes, and we have three other witnesses to hear in the 15-minute period. The rest of your entire statement will be included in the record. Do you want to summarize it further?

Dr. COWLEY. Yes; I would simply like to tell you that I think that a national EMS system is also critical for the defense of this country. I think that the Department of Defense should be involved in civilian systems so that there can be intertraining between these groups. In the case of war, in the case of a major disaster, we need both systems working together.

Senator HOLLINGS. Very good.

[The statement follows:]

STATEMENT OF R. ADAMS COWLEY, M.D.

Mr. Chairman, members of the Committee, I am Dr. R. Adams Cowley, director of the Maryland Institute for Emergency Medical Services Systems, and the director of Emergency Medical Services in Maryland. I am also president of the Mid-Atlantic Emergency Medical Services Council, the purpose of which is to foster complete, compatible, Emergency Medical Services systems throughout the region which emcompasses the states of Maryland, Delaware, Pennsylvania, West Virginia, Virginia, and the city of Washington, D.C.. I appreciate the opportunity to appear before you today to discuss the federal appropriations for the development of EMS systems throughout the country.

I come to you today knowing that Congress and the President have as recently as three months ago, with the passage and signing into law of the Extension of Assistance for Emergency Medical Services Systems Act , renewed their commitment to the completion of a nationwide system for emergency medical services.

I am also aware of the fact that the national economy now dictates that all programs funded with federal dollars must be viewed with a critical eye. The President and the Congress must look carefully at all programs, from those that deliver care to the individual, to those that build waterways and highways, and make a judgment on where the placement of federal dollars will produce the most beneficial results.

In order for there to be no misunderstanding, let me state for you what an EMS system is and what its components are. A system is an arrangement of personnel, facilities and equipment for the effective and coordinated delivery of health care services in an appropriate geographical area under emergency conditions. It is a five phase operation: rescue and immediate aid; communication, via a communication network, with a medical command center; transportation to a

definitive care center; provision of all those components necessary for survival in a medical center; and finally, rehabilitation. So many people believe EMS is just a program of building hospitals and buying fancy ambulances and other hardware to haul the patient to the nearest hospital. EMS systems should spend very little on hardward. They must concentrate their dollars on better management of existing facilities and on upgrading facilities and manpower capabilities wherever necessary.

In arriving at your decision on proper funding for these systems, I would like you to keep three points in mind:

- They save lives
- They save money
- They bring the best medical care to all individuals in the system at whatever level it is needed.

First, and foremost, EMS systems save lives - with immediacy. They deal with life and death, and the adequacy of the system the victim is in can determine which of those two alternatives - life or death - will be the victim's fate. There is no other program funded which produces such immediate consequences. No other health program deals as critically with life and death consequences as this one does.

Second, EMS systems will save money for the taxpayer. As I have testified before, and do so again now, the United States government cannot afford NOT to fund EMS systems. Today we do not have systems and we are paying for this dearly. Let me cite some statistics to illustrate what I mean.

In 1978 there were 104,500 accidental deaths in the United States. There were 10,200,000 disabling injuries, 51,500 deaths in vehicles. Those injured in their early lives may have to live with disability for more than 30 years and may require some sort of public subsidy - paid for by the taxpayer. Many of these will require extensive hospital

care at great expense to the taxpayer. In 1978 the cost of these accidents was a staggering 68.7 billion dollars. Of this amount 19.3 billion dollars was in lost wages. The amount of lost dollars in productivity soars.

A war must be waged against this gruesome story. I am convinced the winning of that war can only come through full development of EMS systesm. I have seen proof of this in Maryland. There, due to a state-wide system being in place the mortality rate from accidents is down from 70% to 20%. Morbidity rates have been decreased dramatically. Because of the system which provides immediate care to the victim and takes him through rehabilitation, we are returning victims to productive lives. They are not dependent on the taxpayers subsidy, they are not a drain on society, but are productive useful citizens. We have shown that the dreadful statistics I just mentioned need not be.

EMS systems therefore are an investment with measurable returns in the productive lives and dollars saved. The question is, are a relatively few dollars spent now to build a national network of systems, or do we continue to pay billions of dollars and lose countless years of productive services of victims due to a lack of proper EMS systems and the care they produce? This country can spend $58,000,000 in FY 1981, the amount the legislation authorizes, and continue working towards the development of systems or continue to pay $62,000,000,000+ in 1981 because we have no systems. $58,000,000 is less than .1% of the proposed FY 1981 budget for all health programs and .01% of the entire budget. Yet the amount spend due to neglect by no systems equals 10% of the dollar amount proposed for the 1981 budget. The Congress stated emphatically last year that the authorization level in the extension legislation was being lowered to insure that appropriations would equal authorization. That was only three months ago. That must be done now.

EMS systems address not only the critically injured,

but they have a great rippling effect, which leads me to my third point. They are the answer to health delivery at all levels of care; primary, secondary, and beyond. Because they must be highly disciplined in order to insure patient survival from the scene of the accident, during transportation to the proper and most sophisticated facility of care, it produces a categorization of facilities as well as response and medical capabilities. This ultimately identifies all care facilities for their proper use. Emergency rooms are no longer used for every injury or malady from a cut finger to a massive heart attack. Facilities are sorted out and this produces non-duplication, which saves money.

EMS systems involve local and state persons and governments and generate dollars from these sources on an average of 3 dollars from state and local sources for every 1 dollar from federal sources. Not many other federal programs can boast of such a record. Once these systems are established they are 100% supported from state and local funds.

The EMS systems program needs several more years of federal support to get the job done. Never in the history of the program has it been adequately funded or properly staffed. That must be corrected. The systems would be completed now throughout the country had these two problems not existed. I have recently traveled across this wonderful country holding hearings for the Department of Transportation, examining the adequacy of EMS systems and I find that we do not have systems today. We have made a start. I am told by HEW officials that over 134,000,000 persons in this country are covered by basic or advanced life support and that in the Mid-Atlantic region there are over 32,000,000 covered, which is the best record of any federal region. But those figures are rather meaningless to me unless the systems are in place. They do indicate to me a start, and a good one. But without total coverage in this country, a person covered by this

support might well find himself in an area with no system and with a need for one desperately. The job is not complete until the entire country, and every citizen in it, is protected with a system. If the federal appropriations are not forthcoming, the danger is we will have no nationwide system.

It must be noted too that EMS systems are critical to this country's defense. I read that no budget cuts are contemplated for our defense efforts; indeed we can probably expect a budget increase here. All defense plans that I am aware of - and I am aware of many - require medical response capability. This will be impossible without EMS systems in place.

The same holds true for all disaster preparedness and response capability. Last year, when the Three Mile Incident occurred, it was the Maryland system that Pennsylvania and all concerned looked to for emergency medical assistance and evacuation response. A solid EMS system provided the answer to their immediate problems.

I am painfully aware that the EMS story has not been properly set forth. Many people do not know what is meant when we speak of an EMS system. Better information is needed. I have recently called for the formation of a national EMS Association that will address this deficiency. I expect it to be in place by the end of this coming summer and in the future you will have better material.

This morning I had a very pleasant drive from Baltimore to Washington. I passed many cars - people going to work. Maybe I passed some of you here. Chances are some of those people did not have a nutritious breakfast - maybe no breakfast at all. They will not die because of that. Chances are some will need counseling, more education, or want a wider, better paved road to drive on - but they will not die from these needs. There is also a good likelihood that one of these persons will be in a serious accident; car or work,

before this day ends, and from that they may die or be critically injured. If the accident is in Maryland, the chance of survival, if the victim is alive, and a return to normalcy is greater than in any other state because the Maryland EMS system is in place. Maryland is the only state in the Union where that can be said. That need not be.

* * *

This testimony has taken about 10 minutes to deliver. During this time 2 people have died in this country from accidental death and 200 were critically injured. During this time over $500,000 has been spent on people who have been in accidents who did not die. During the next hour and every hour throughout the year, 1160 disabling injuries will occur and 1.3 million dollars will be spent addressing injuries. There will be 12 accident related deaths. A clean kill presents no problems - the surviving victim is the problem and the challenge. The statistics I have cited throughout this testimony will only continue to grow. There will be over 500,000 disabilities in this country this year and over 63 billion dollars spent and until there are systems throughout the nation there can be no management and correction of this problem.

The budget level is critical to the solution of this problem. I know this Committee, the Congress and the President have many problems with budget issues. But few, I suggest, involve life and death situations with such enormous financial costs and hours of pain and suffering, if left unaddressed. The job of developing systems has only begun in this country, and unless completed will never be adequate. Total completion can only be done with proper funding. I can think of no greater priority than full appropriations for this program.

Thank you.

National Association of Community Health Centers

Ms. Robinson. Mr. Chairman, my name is Janice Robinson and I am the executive director of the National Association of Community Health Centers, formerly the director of the William F. Ryan Health Center in New York City.

I am here today as a representative of our organization which represents over 800 health centers serving in excess of 5 million medically underserved people in America. While such a figure is in and of itself impressive, I must point out that there are approximately 49 million medically underserved people for whom shortage of health services, and for some a complete lack of health services, is a fact of day-to-day living.

The right to quality health care touches all populations. Problems in meeting health needs in small rural communities is no less pressing than those in large, depressed inner cities. In presenting our recommendations, it is our intent that the voices of millions of Americans for whom decent health care is not a reality be heard.

First I would like to thank you and members of the subcommittee for your support of community, rural, and migrant health centers. Our programs have worked hard and clearly proven their effectiveness and can be termed successful by any standard. An objective review of this program's 15-year history will bear it out. In these times of budgetary constraints, community, rural, and migrant health centers are clearly wise investments.

Studies have shown that since the establishment of the community health center programs 15 years ago, community health center users experienced between 25 and 50 percent fewer hospital admissions and shorter average length of stay than comparable noncommunity health center populations.

Community health centers have improved access to care. They have provided greater emphasis on prevention, and contributed to improved health status among their target populations. The quality of care rendered in community health centers is equal to, and in some cases is superior to, other established providers of health care.

Recent DHEW data from 1974 to 1979 shows community health centers have demonstrated marked improvement by their administrative efficiency. They have reduced administrative costs by 12 percent, and third-party collections have increased by 123 percent.

While health centers have demonstrated that they do in fact reduce hospitalization, many evaluations of health center effectiveness fail to take such a factor into consideration. One Government study utilizing 1979 data indicated a programwide savings in excess of $385 million through reduced hospitalization. This is more than the $320 million appropriated for this program in 1980.

The further content of my report has been submitted for the record. Right now I would like to summarize our request for the community health center and migrant health program in the interest of time.

The President has requested $391 million in the budget, but we are requesting $410 million. We have included in our statement the justification for these increases.

Senator HOLLINGS. You're counting those black lung programs? Because we've got a $374 million request at present; the current budget is $320 million; that's a $54 million increase. But your figures include black lung claims?

Ms. ROBINSON. Yes, they do. They do include black lung.

And finally, for the migrant health center program, the administration has requested $44.7 million, and we are requesting an increase to $53 million. Again, the documentation for it and the justification for such increases we have included in our statement for the record.

Senator HOLLINGS. Very good. Frankly, it's one of the best programs I know of.

[The statement follows:]

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STATEMENT OF JANICE M. ROBINSON

MY NAME IS JANICE M. ROBINSON, EXEUCTIVE DIRECTOR OF THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS AND FORMERLY EXECUTIVE DIRECTOR OF THE WILLIAM F. RYAN HEALTH CENTER IN NEW YORK. I AM HERE TODAY AS A REPRESENTATIVE OF OUR ORGANIZATION WHICH REPRESENTS OVER 800 HEALTH CENTERS SERVING IN EXCESS OF FIVE MILLION MEDICALLY UNDERSERVED AMERICANS. WHILE SUCH A FIGURE IS, IN AND OF ITSELF, IMPRESSIVE, I MUST POINT OUT THAT THERE ARE APPROXIMATELY 49 MILLION MEDICALLY UNDERSERVED PEOPLE FOR WHOM A SHORTAGE OF HEALTH SERVICE AND FOR SOME, A COMPLETE LACK OF HEALTH SERVICES IS A FACT OF DAY TO DAY LIVING. THE RIGHT FOR QUALITY HEALTH CARE TOUCHES ALL POPULATIONS. PROBLEMS IN MEETING HEALTH NEEDS IN SMALL RURAL COMMUNITIES IS NO LESS PRESSING THAN THOSE IN LARGE DEPRESSED URBAN INNER CITIES. IN PRESENTING OUR RECOMMENDATIONS, IT IS OUR INTENT THAT THE VOICES OF MILLIONS OF AMERICANS FOR WHOM DECENT HEALTH CARE IS NOT A REALITY WILL BE HEARD.

FIRST, I WOULD LIKE TO THANK YOU AND THE MEMBERS OF THE SUBCOMMITTEE FOR YOUR SUPPORT OF COMMUNITY, RURAL, AND MIGRANT HEALTH CENTERS. OUR PROGRAMS HAVE WORKED HARD AND HAVE CLEARLY PROVEN THEIR EFFECTIVENESS AND CAN BE TERMED SUCCESSFUL BY ANY STANDARD. AN OBJECTIVE REVIEW OF THIS PROGRAM'S FIFTEEN YEAR HISTORY WILL BEAR OUT, IN THESE TIMES OF BUDGETARY CONSTRAINTS, THAT COMMUNITY, RURAL, AND MIGRANT HEALTH CENTERS ARE CLEARLY WISE INVESTMENTS.

STUDIES HAVE SHOWN THAT SINCE THE ESTABLISHMENT OF THE COMMUNITY HEALTH CENTER PROGRAM FIFTEEN YEARS AGO, THAT:

- CHC USERS EXPERIENCE FROM 25 TO 50 PERCENT FEWER HOSPITAL ADMISSIONS AND SHORTER AVERAGE LENGTHS OF STAY THAN COMPARABLE NON-CHC POPULATIONS.

- CHCs HAVE IMPROVED ACCESS TO CARE, PROVIDED GREATER EMPHASIS ON PREVENTION AND CONTRIBUTED TO IMPROVED HEALTH STATUS AMONG THEIR TARGET POPULATIONS.

- THE QUALITY OF CARE RENDERED IN CHCs IS EQUAL TO, AND IN SOME CASES, SUPERIOR TO OTHER ESTABLISHED PROVIDERS OF HEALTH CARE.

- RECENT DHEW DATA (1974-79) SHOWS CHCs HAVE DEMONSTRATED MARKED IMPROVEMENT OF THEIR ADMINISTRATIVE EFFICIENCY (REDUCED ADMINISTRATIVE COSTS BY 12%) AND THIRD-PARTY COLLECTIONS (INCREASED BY 123%).

WHILE HEALTH CENTERS HAVE DEMONSTRATED THAT THEY DO IN FACT REDUCE HOSPITALIZATION, MANY EVALUATIONS OF HEALTH CENTER EFFECTIVENESS FAIL TO TAKE SUCH A FACTOR INTO CONSIDERATION. ONE GOVERNMENT STUDY, UTILIZING 1979 DATA, INDICATED A PROGRAMWIDE SAVINGS IN EXCESS OF $385 MILLION THROUGH REDUCED HOSPITALIZATION. THIS IS MORE THAN THE $320 MILLION APPROPRIATED FOR THIS PROGRAM IN 1980.

IN ADDITION, THE AVERAGE MEDICAL COST PER PERSON SERVED IN HEALTH CENTERS (INCLUDING ANCILLARY SERVICES SUCH AS LABORATORY, X-RAYS, AND PHARMACEUTICAL) IS $32 PER ENCOUNTER COMPARED TO THE MEDICAID RECIPIENT AVERAGE OF $55. THIS $23 DIFFERENCE REPRESENTS A REDUCED COST OF 42% PER ENCOUNTER.

THE ANNUAL COST PER PATIENT WHEN ALL SERVICES ARE CONSIDERED, THE CHC USER COST IS $96, $155 FOR THE MEDICAID RECIPIENT AND $172 FOR THE AVERAGE U.S. CITIZEN. THE DIFFERENCE FOR CHC PATIENTS AND THE AVERAGE U.S. CITIZEN REPRESENTS A

DIFFERENCE OF $76 PER PERSON OR A 44% REDUCTION OF COSTS FOR CHC USERS.*

- COMPARISONS OF HEALTH CENTERS AND HOSPITAL OUTPATIENT DEPARTMENTS AND EMERGENCY ROOMS SHOW THAT HEALTH CENTER COSTS ARE 33 TO 50 PERCENT LESS THAN HOSPITAL OPDs/ERs UNITS.

- A HEALTH CENTER IN HARLINGEN, TEXAS, WHICH PROVIDES BIRTHING SERVICES (ON-SITE DELIVERY) INCLUDING COMPLETE PRENATAL AND POST-PARTUM CARE SHOWS A COST OF

  $368 PER PATIENT FOR NORMAL VAGINAL DELIVERY COMPARED TO THE LOCAL HOSPITAL'S COST OF $1,253 FOR COMPARABLE SERVICES. THE HEALTH CENTER SHOWS A 70 PERCENT REDUCTION IN COST PER DELIVERY.

- A RECENT (1980) NACHC STUDY COMPARING PHARMACEUTICAL AVERAGE COSTS FOR CHC/MHC USERS IN SIX STATES AGAINST AVERAGE COSTS FOR STATE MEDICAID USERS IN THE SAME STATES, THE COST PER USER FOR CHC PATIENTS IS $17.00 COMPARED TO THE STATE AVERAGE (DISCOUNTED FOR OVERUTILIZATION BY SSI RECIPIENTS) OF $43.15. THIS REPRESENTS A COST SAVINGS OF 60 PERCENT.

WHILE HEALTH CENTERS HAVE SHOWN THEMSELVES TO BE COST-EFFECTIVE, THEY HAVE ALSO PROVEN THAT SUCH AN ACHIEVEMENT DOES NOT HAVE TO BE AT THE COST OF QUALITY HEALTH CARE.

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*Community Health Centers: Bureau of Community Health Services Common Reporting Requirements, Calendar Year 1978.
Medicaid Recipients: Medicaid State Tables, Fiscal Year 1976, in 1978 dollars.
U.S. Population: National Health Expenditure 1977, in 1978 dollars.

STUDIES HAVE SHOWN THAT HEALTH CENTERS PROVIDE CARE MUCH SUPERIOR TO THE PRIVATE SECTOR BECAUSE THEY ARE ORGANIZED SYSTEMS WHICH PROVIDE COMPREHENSIVE AND CONTINUOUS CARE, STRESS PREVENTION AND PLACE EMPHASIS ON THE PATIENT. FOR EXAMPLE:

- IN COMPARING GROUP PRACTICES, SOLO PRACTITIONERS, HOSPITAL OPDS, AND HEALTH CENTERS, DR. MOREHEAD FOUND THAT HEALTH CENTER PROGRAM PERFORMANCE IS EQUAL TO AND IN SOME INSTANCES, SUPERIOR TO THAT OF OTHER ESTABLISHED PROVIDERS OF HEALTH CARE (USING BASELINE SURVEYS,MEDICAL AUDITS, AND DENTAL AUDITS).

- ANDERSON AND MORGAN FOUND THAT INFANT MORTALITY DROPPED BY AS MUCH AS 50 PERCENT AFTER THE ESTABLISHMENT OF COMPREHENSIVE CARE CENTERS IN RURAL SOUTHERN COUNTIES. NEIGHBORING COUNTIES WITH COMPARABLE POPULATIONS EXPERIENCED NO SUCH DECREASE IN INFANT MORTALITY.

- CHABOT'S STUDY OF DENVER'S HEALTH CENTER NETWORK SHOWS A DECLINE OF ABOUT 25 PERCENT IN INFANT MORTALITY.

- GORDIS' STUDY OF RHEUMATIC FEVER AMONG CHILDREN IN BALTIMORE DOCUMENTED THAT OVER A DECADE, THE INCIDENCE OF THIS DISEASE WAS REDUCED BY 60% IN THOSE AREAS OF THE CITY SERVED BY PRIMARY CARE CENTERS, BUT REMAINED UNCHANGED FOR THE REST OF THE CITY.

MOREOVER, COMMUNITY/MIGRANT HEALTH CENTERS ARE MEASURED AGAINST STRINGENT QUALITY STANDARDS IN AREAS SUCH AS HYPERTENSION SCREENING AND TREATMENT, PAP SMEARS, PRENATAL CARE AND OTHERS. TO OUR KNOWLEDGE, NO OTHER HEALTH CARE PROVIDERS ARE BEING EVALUATED ACCORDING TO SIMILAR STANDARDS.

MR. CHAIRMAN, THE FACT IS THAT COMMUNITY AND MIGRANT HEALTH CENTERS HAVE PROVEN TO BE HIGHLY EFFICIENT AND EFFECTIVE MODELS OF HEALTH CARE DELIVERY. THEY HAVE CONTINUED TO DEMONSTRATE A SERIOUS EFFORT TO HELP CONTAIN HEALTH CARE COSTS; A RECORD UNPARALLEL IN THE HEALTH CARE INDUSTRY. THEY HAVE PROVEN TO BE A SOUND INVESTMENT FOR A COST CONSCIOUS CONGRESS. HOWEVER, IN THE LAST 5 YEARS IN SPITE OF CONTINUED IMPROVEMENTS, OUR PROGRAMS HAVE SUFFERED IN THE FACE OF EVER SPIRALLING INFLATION.

AS THE GOVERNMENT'S PRIME PROGRAM TO PROVIDE ACCESS TO HEALTH CARE TO AMERICA'S MEDICALLY UNDERSERVED AND UNSERVED COMMUNITIES, I HOPE YOU SERIOUSLY CONSIDER OUR REQUEST. WE HAVE TRIED TO CONSIDER WHAT IS NEEDED AND WHAT IS REALISTICALLY AVAILABLE.

SHOULD YOU HAVE ANY QUESTIONS, I WOULD BE PLEASED TO RESPOND.

FY 81

NACHC RECOMMENDATIONS AND

BUDGET JUSTIFICATION

COMMUNITY HEALTH CENTERS (PHS Act Secs. 328,330,340, and Black Lung)

ADMINISTRATION REQUEST - $391 (Jan. 1980)

NACHC'S REQUEST - $410

We support the Administration's Budget Request of $390,966,000 Such a figure would include:

A. Maintain existing services taking into consideration the effect of inflation on health care.

B. Make operational ten (10) hospital-affiliated primary care centers (currently in developmental stage).

C. Allow for grants to states in the planning, establishment and monitoring of statewide programs.

D. Would allow for the expansion of 51 existing centers and the creation of 14 new starts.

In addition, we recommend an additional $19m over the Administration's request which would allow for an additional 216,000 new users.

MIGRANT HEALTH PROGRAMS (PHS Act Sec. 329)

ADMINISTRATION'S BUDGET REQUEST - $44.7m

NACHC'S REQUEST - $53m

We support the Administration's Budget Request of $44.7m Such a figure would include:

A. Providing services to 91,000 migrant and seasonal farmworkers and their families in the existing 112 centers.

B. Allow for 4,000 people to be served by the hospitalization program, 200 more than FY 80.

C. Allow an additional 800 high risk migrant women to be served through 2 new birthing clinics.

In addition, our request would call for an additional $8.3 million which would:

D. Provide $2.1 million for priority health services outlined by the authorizing committees such as pharmacy, home health, and environmental services.

E. Provide $6.2 million for health services to an additional 50,000 migrants and seasonals and services for an additional 4,000 high risk migrant women through 10 birthing clinics.

National Family Planning and Reproductive Health Association

Ms. Mann. Good afternoon, Senator. Thank you for the opportunity to testify on title X of the Public Health Service Act.

My name is Dorothy Mann, and I am the chairperson of the Health Administration of the National Family Planning and Reproductive Health Association, a nationally based membership organization devoted to the improvement and expansion of family planning and reproductive health services.

Our association represents some 700 groups and individuals—family planning councils, freestanding clinics, private physicians, research groups, international programs, and consumers—all concerned with family planning and reproductive health.

Now, I have prepared a written statement which will, I think, be put into the record. So for the rest of my time I would like to talk to you a little bit about why we think the President's request for $177 million for family planning services and $76.8 million for research is insufficient.

First, some information about my program in Philadelphia. I work in a family planning council. That's a nonprofit management organization. The funds that we have—which are the Federal dollars that come into our region—do not support abortion services, either directly or indirectly.

We are an agency that does not provide service but subcontracts with direct providers of care—18, total, that provide care in 55 sites throughout the region in Philadelphia. This network, in this year, will provide

family planning services to 80,000 residents; a third of those being teenagers or women 19 years of age or younger. That's a lot of health care to a lot of people.

However, we calculate that in our community alone, there will be 150,000 women who will not be served who are in need of those services. The limitations are money—even though my program will get $2.4 million of title X funds.

Now the administration is requesting an increase of $8 million in service in fiscal 1981. By the time those funds get to me in Philadelphia that will translate to an increase of $125,000. Now with $125,000—at our average cost of $70 a patient a year—we could provide services to 1,800 new patients. That's if there wasn't any inflation.

So with current inflation, I will be lucky if I can maintain the services to the 80,000 women that I now serve. Chances are, I will have to reduce those services.

TITLE X BUDGET REQUEST

Therefore, the National Family Planning and Reproductive Health Association is requesting $215 million for title X services. That's a $15 million increase from what we currently have. And in a time of budget cutting, that sounds greedy to me. But when it gets down to my program, that will result in an increase in our service load of only 10,000 women, which will still leave 140,000 in my community unserved.

FAMILY PLANNING PROGRAM EFFORTS

Now it is easy to think of our programs as a network of pill-dispensing clinics, but we do a lot more than that, and I would like to leave you with that understanding:

Our program provides primary care to those 80,000 patients. For some women, it's the only contact that they have with the health care system, particularly adolescents. We do outreach programs. I have a program that has a hospital in North Philadelphia that's providing 20 volunteers out in the community to help parents talk to their children about human sexuality.

We have a program in West Philadelphia where we work with black pharmacists to help them use their pharmacies to counsel young black males in West Philadelphia about human reproduction, veneral disease, and things of that sort.

We fund a hot line, which is an information and referral service. We publish books and pamphlets, some of which will be distributed to 60,000 people in the community. It is a complex, comprehensive program providing fertility services, sterilization services, natural family planning, and family planning for the handicapped. We have a training program that trains nurse-practitioners to provide services. We have a research program.

Family planning I think is a low-cost service in relation to most medical care. Our costs are low, and they've been contained. Far from contributing to inflation, I believe as a preventive program title X contributes to an anti-inflationary effort.

I urge you therefore to increase support for our programs, and as providers we will respond with expanded, high-quality preventive services.

Senator HOLLINGS. Very good.

[The statement follows:]

STATEMENT OF DOROTHY MANN

Good afternoon. Thank you for the opportunity to testify on title X of the Public Health Service Act. My name is Dorothy Mann and I am the chairperson, Health Administration Section of the National Family Planning and Reproductive Health Association, Inc., a nationally based membership organization devoted to the improvement and expansion of family planning and reproductive health services. Our association represents some 700 groups, and individuals, family planning councils, and freestanding clinics, private physicians, research groups, international programs, and consumers all concerned with family planning and reproductive health.

As you know, title X of the Public Health Service Act is the primary pregnancy prevention program in the Federal Government. It provides medical and educational family planning services to low-income women and teenagers. More than half of all Federal dollars for family planning services comes from title X. Title X alone currently serves approximately 4 million women (including 1 million teenagers) at some 5,000 family planning sites across the country.

I am here today because the members of the National Family Planning and Reproductive Health Association, Inc. are concerned about the 1981 budget request for title X services and research. The administration has requested $177 million for services under title X. This represents a 7.2-percent increase over 1980 title X funds. Unfortunately, this increase is actually a decrease in real dollars for family planning services because of the current rate of inflation. Such a decrease would require cutbacks in services to women in need. Our members tell us that there is a large demand for increased, not decreased, services. A recent Alan Guttmacher Institute study showed that:

An estimated 2 million sexually active teenagers and 3.5 million poor women are currently unable to obtain family planning services either from clinics or private physicians;

Approximately 1.4 million abortions were performed in 1978, reflecting a high incidence of unwanted pregnancies that could possibly have been avoided had preventive services been more readily available. Title X funds cannot be used to perform abortions; and

Approximately 250,000 babies each year are born with congenital defects, occurring largely to very young and older mothers who have the highest incidence of unintended and unwanted pregnancies.

In view of the remaining unmet need for family planning services the National family Planning and Reproductive Health Association, Inc. recommends a fiscal year 1981 appropriation of $215 million for family planning services. A funding level of $215 million would enable title X to serve an additional 450,000 persons or a total patient population of nearly 4.5 million. This would mean an 11-percent increase in the number of people served by title X.

The President's 1981 budget request for research in human reproduction and population under title X provides for $76.8 million. This represents a $3.1 million increase over 1980 title X research funds, clearly insufficient in terms of the inflationary dollar and the importance of research projects. Research continues to be a vital adjunct to the provision of family planning services. Through research our service providers could offer improved and safer contraceptive methods to their clients. The 1981 budget request means that many projects which have already been approved for funding may have to be cancelled or compromised. Two examples of research programs which may be jeopardized without additional funding are:

Clinical and use effectiveness tests of new barrier methods of contraception for men and women; and

Studies of new oral contraceptives which would be safer for women.

Therefore, the National Family Planning and Reproductive Health Association, Inc. recommends a fiscal year 1981 appropriation of $102 million for research in population and human reproduction.

Mr. Chairman, the 700 group and individual members of the National Family Planning and Reproductive Health Association, Inc., are deeply concerned about current efforts to slow inflation through cuts in Federal spending. We applaud the efforts of this Congress to control an everincreasing inflation rate. However, in your deliberations we urge you not to endanger major Federal programs such as title X which have proven to be extremely cost effective in assisting millions of Americans in planning their families in healthful and reproductive ways.

Again, thank you for giving the National Family Planning and Reproductive Health Association, Inc. the opportunity to speak here today.

PLANNED PARENTHOOD FEDERATION OF AMERICA

Ms. SMITH. I'm Kit Smith.

Senator HOLLINGS. Kit Smith?

Ms. SMITH. That's right.

Senator HOLLINGS. I thought I recognized you.

Ms. SMITH. It's nice to see you, sir.

Senator HOLLINGS. I'm glad to see you. I thought you looked familiar to somebody I knew.

Ms. SMITH. That's right.

Senator HOLLINGS. Welcome.

Ms. SMITH. I'm Kit Smith, president of the Board of Planned Parenthood of Central South Carolina. I am a housewife and a volunteer.

I am here today on behalf of the Planned Parenthood Federation of America, the Nation's oldest and largest voluntary family planning organization. If "family planning" published an advertisement that had a "before" and "after" picture like they do for the weight loss places, I would have to be the "before." My husband and I had three children over 38 months time. I get a lot of ribbing from my friends when I say I'm an advocate for family planning, but I'm one of the lucky ones. I can afford to pay a babysitter in South Carolina so I can come here today and speak to you on behalf of the women of this Nation who are not so lucky.

I would guess that everybody in this room is an advocate for family planning, either consciously or unconsciously. We know and make decisions about planning our families based on the economic impact that that will have on our families, the happiness of our families and the care of our children. But there are 5.5 million women in this Nation that cannot do that. They have no family planning services available to them. And what is more appalling to me, is they don't even know they can plan their families.

COST-EFFECTIVENESS OF FAMILY PLANNING

Family planning is cost effective; it is anti-inflationary. At the Federal level, we see a return of $1.80 every year for every $1 that we spend in a previous year. And an impact study in South Carolina recently showed that over the past decade our State has saved twice as much as it has spent in family planning, and I will submit that impact study for the record.

In addition to being cost effective, family planning prevents abortions. This same study shows that in South Carolina we averted 1,500 abortions over the past decade with family planning money.

The third great thing about family planning—and to me the most important—is that it does improve the quality of life. It impacts on families in ways that no other social services program can. It interrupts the poverty cycle. It prevents child abuse. It sustains the marriage, and it enhances the family.

TITLE X BUDGET REQUEST

The President has requested a woefully inadequate amount of money for family planning in the title X program. He has requested $177 million for the program services. Planned Parenthood would respectfully submit that $225 million would allow us and the nationwide family planning program to expand to serve 500,000 to 700,000 additional women of those 5.5 million that right now have no opportunity to avail themselves of such programs.

The research proposal from the administration is for $77 million. American women are concerned about the effectiveness and the safety of contraceptive health care. Not only would primary research be damaged by such a level of funding, but the secondary research in contraceptive application would be tremendously curtailed.

I really appreciate, Mr. Chairman, the difficulty of the current economic situation. As a taxpayer, I really appreciate congressional efforts, and your personal efforts, at restraint. I feel personally that in this time a lot of the human services are going to have to revert back to volunteer effort, to Americans reaching out to Americans to help them.

I can go to my church and serve soup, and I can visit the elderly, but I cannot provide medical services. I can help the Federal Government in doing that and bring the framework for that, but there's no way that we as American citizens can deliver that service to our fellow Americans.

All of us will lose if the family planning program is reduced. There are no alternatives. I urge you to expand this program for the sake of our society and for the individuals in our society.

Thank you.

[The statement follows:]

STATEMENT OF KIT SMITH

I am Kit Smith, President of the Board of Planned Parenthood of Central South Carolina and I come before you today representing the Planned Parenthood Federation of America. Founded more than 60 years ago by Margaret Sanger, Planned Parenthood is the nation's oldest and largest voluntary family planning organization. In 1980, our 188 affiliates in 43 states and the District of Columbia provided family planning education, counseling and medical services to 1.2 million Americans. On behalf of Planned Parenthood's affiliates, their clients and their supporters around the country, I thank you for giving me the opportunity to be with you here today.

Mr. Chairman, my remarks today concern the need for the federal government to increase funding under Title X of the Public Health Service Act for both family planning services and research efforts in human reproduction and population. In the midst of our nation's current economic crisis, and the recent Administration announcement of likely recisions, we encourage careful scrutiny of the total federal budget in order to identify those programs that have proven their cost-effectiveness as well as their capacity to adequately serve the intended population. At the same time it is necessary to evaluate the magnitude and the urgency of the remaining need for a particular service or government activity. In the past, Congress has acknowledged both the success of the national family planning program and the importance of augmenting it by approving funding levels over and above the President's budget requests. This year, the Administration's budget of $177 million for family planning services and $77 million for the Center for Population Research (CPR) at the National Institute of Child Health and Human Development (NICHD) reflects a reduction in real dollars for both components of Title X. Teenagers and poor adult women currently enrolled in the program might have to be denied services for lack of sufficient clinic funds - certainly contrary to explicitly stated federal health policy to assist disadvantaged women in avoiding unwanted pregnancy. Developments in population research, which benefit all classes of society, would also have to be sharply curtailed, but most damaging are the proposed cutbacks (not even counting inflation) in perhaps the two most vital areas of study at CPR: contraceptive development and contraceptive safety.

In the statement that follows, I will specifically describe some of the major accomplishments of the services and research programs and I will discuss some of the most serious and glaring indicators of remaining need. It is essential that Congress not allow our efforts in this critical preventive health

program to regress. Rather, we strongly urge you to recommend increases in real dollars for Title X to enable this truly anti-inflationary program to continue the momentum begun less than a decade ago to expand availability of voluntary family planning services to all those in need, and to promote research in contraceptive development, safety and effectiveness for the benefit of all men and women of reproductive age.

FAMILY PLANNING SERVICES

Much has been accomplished...

As you know, the Title X program has been in operation for less than a decade. In that brief time, remarkable strides have been made in voluntary, individual fertility regulation among low-income American women and teenagers through the rapid expansion and wide acceptance of specialized family planning clinics. By 1979 the program was serving 4.4 million American women at about 5,000 clinic sites in 2,300 counties. Family planning providers included state and local health departments (serving 41 percent of the entire national caseload), Planned Parenthood affiliates (serving 27 percent), hospital-based programs (serving 13 percent) and other community action agencies (serving 19 percent). In addition to birth control methods (including "natural" family planning methods), family planning patients receive a wide array of preventive gynecological services, including counseling and screening for cancer and venereal diseases. For many low-income women, the family planning clinic is an initial entry point into our national health care system, and with one-third of the entire patient caseload now under age 20, family planning clinics have been the country's single largest provider of health services to teenagers.

In 1976, NICHD sponsored a study which documented that between FY 1970 and FY 1975 - in six years alone - an estimated 1.4 million unwanted births were averted as a direct result of the federally-subsidized family planning program. In addition to the direct health and social benefits of family planning to individuals and families, this study also documented that each dollar invested in family planning by the government in one year yielded a government saving of $1.80 the very next year in unneeded health and welfare costs and that the long range cost/benefit ratio is obviously enormous. This scientifically documented short term cost/benefit ratio is believed to be unmatched in any other federal health program and should be an important factor in a year of tight budgets.

Mr. Chairman, the average yearly cost per family planning patient, including not only contraception but also related preventive health services,

will be less than $82 in FY 1981. In 1972, the average per-patient per-year cost was $66 and that figure remained constant through 1976 despite 36 percent cumulative inflation in the rest of the economy (and 43 percent cumulative inflation in the cost of medical care*). Family planning providers, with HEW's help, obviously became increasingly efficient in delivering services. Maintaining an average per-patient cost that is only about 20 percent above the cost of nine years ago is a remarkable accomplishment for any program - public or private - in the health sector or any other sector of our economy. Clearly, it demonstrates the strong and successful commitment on the part of family planning providers and administrators to finding extremely cost-effective methods of delivering high quality care.

...but substantial need for services remains.

Despite the program's achievements since 1970, evidence of the large amount of work to be done is not hard to find. It is estimated that 2 million sexually active teenagers and 3.5 million poor women are currently unable to obtain family planning services either from clinics or private physicians. There are many symptoms of the problems associated with a lack of preventive family planning service for these women or with inadequate services for others. In 1978, for example, 1.4 million American women, 1/3 of them teenagers, sought and received abortions; each year about 300,000 married women have unwanted births, a disproportionate number being poor and women over age 35; one out of every seven births - 447,000 in 1975 - occurs out of wedlock; approximately 250,000 babies each year are born with congenital defects, occuring mainly to very young and older mothers who have the highest incidence of unintended and unwanted pregnancies. These are but a few indicators of the job before us - the problems being not only large in magnitude but vital in the sense that each woman's life, and that of her family, is changed forever in the event of an unplanned or unwanted pregnancy and birth.

Federal support for family planning services is desperately needed; Title X is the best vehicle

Indeed, while it is true that family planning services are provided to some extent under Titles V (Maternal and Child Health), XIX (Medicaid) and XX (Social Services) of the Social Security Act, it is also true that in FY 1980 about 50 percent of all family planning funding comes from Title X.

*not including hospital costs

Moreover, there is a direct positive association between increased Title X funding and the growth of the entire organized family planning system. That is to say, between 1970 and 1973, when Title X appropriations increased substantially, the number of patients served by the entire organized family planning program increased by an average of 40 percent each year. Between 1973 and 1977, however, when Title X funds were essentially frozen, the average annual rate of increase dropped precipitously to nine percent.

The trend since 1973 has been a shift in federal policy toward support of the state-administered Medicaid and social services programs. The amount reportedly expended for family planning under these programs is misleading since the Health Care Financing Administration (HCFA) estimate for Title XIX for FY 1979 of $58 million includes reimbursements for abortions and sterilizations and the Social Security Administration (SSA) estimate for the same year for Title XX of $71 million includes counseling, outreach and other social - not medical - services. To add to the confusion, both HFCA's and the SSA's estimates conflict with the figure that the Health Services Administration reported to this committee of $78 million that was spent on family planning services under Titles XIX and XX combined. Funding family planning under Title X is truly the only guarantee that the money will actually go toward preventive, medical services. This issue aside, from a substantive perspective, the state-administered programs vary widely in scope and coverage from state to state, while federally administered Title X assures more uniformity in service delivery as well as greater accountability.

Finally, support through Title X is the only way many women can afford family planning services at all. For adults, those who are "not poor enough" or otherwise ineligible for Medicaid or Title XX but whose incomes are close to the poverty level depend on the subsidization of Title X clinics so that fees can be significantly lowered or waived entirely. Teenagers face a variety of barriers in obtaining family planning services; the existence of a clinic in close proximity to their home where they can receive confidential services at a minimal cost could make all the difference.

In accordance with the above analysis, Mr. Chairman, on behalf of Planned Parenthood Federation of America I strongly urge you to fund services under Title X to allow for real growth - to continue serving "near poor" women who cannot pay for services themselves but do not qualify for reimbursement from the other government sources of family planning money, to reduce the need for abortion, to enable more teenagers to be reached and served. Planned Parenthood supports an appropriation of $225 million which would allow approxi-

mately 500,000-700,000 additional patients to enter the program. While we appreciate the concern to limit government spending and are aware of the Administration's search to reduce its FY 1981 request by up to $20 billion overall, I would conclude, Mr. Chairman, by stressing that because of its cost-saving method of operation and the short- and long-term health and social benefits of voluntary family planning, this country cannot afford not to support program growth.

RESEARCH IN HUMAN REPRODUCTION/POPULATION

Mr. Chairman, when the Title X legislation was drafted, it was recognized that efforts to expand family planning service programs must be accompanied by an expansion of our efforts to acquire new basic knowledge in the processes of human reproduction and to apply this knowledge to produce new and usable technologies. It is clear that limitations in our current knowledge of basic reproductive physiology, along with the imperfect state of even our most sophisticated contraceptive technology, impose drastic constraints on the ability of individual couples to avoid unplanned, unwanted pregnancy. It is therefore extremely important to assure that studies in this field of research are well-funded in order to pursue current leads.

Title X is the primary legislative authority for NICHD's Center for Population Research, which conducts the bulk of the national and international research in the field. The Administration's recommended FY 1981 budget of $77 million for grants and contracts represents a cut in CPR's funding policy from its FY 1980 level. Certainly this is inconsistent with the needs and well-founded concerns of millions of Americans over the safety and effectiveness of current contraceptive methods. Moreover, the Administration's proposed budget for CPR shows that while studies in basic reproductive sciences and social and behavioral research will have to be slowed down, the most severe effect will be in the areas of contraceptive development and safety - ironically the two pursuits that have recently shown the most promising advances and where the most urgent need exists for more work. The President has requested cuts, not even counting inflation, for safety and development. Planned Parenthood Federation of American supports, at a minimum, a funding level of $102 million so that projects already approved by CPR and regarded as high priority can receive the funds to get underway.

Exiting advances have been made...

Scientists agree that the most significant breakthrough for new contraceptives in the last decade involves the brain hormone (LHRH) which could supplant

today's birth control pills for women and provide the first such pill for men. This work was initiated by two NICHD-supported scientists who won the Nobel Prize in 1977 for their efforts. Two other examples of achievements under the auspices of CPR relate to new information on contraceptive safety. It has been shown that while women on the pill actually decrease their chances of developing benign breast disease, for women under 50 - especially if they smoke - their chances of heart attack are increased. On the more reassuring side, a study was completed showing little, if any, long-term health risk to men who have had vasectomies. This is ever more relevant since sterilization is rapidly becoming a popular option for thousands of American couples.

...but the President's regressive budget precludes the possibility of major progress.

Work on LHRH, which has received much publicity in the media lately as the most likely lead toward development of the "male pill", has finally reached the clinical trial stage. Officials at CPR have indicated that activities in this project will have to be cancelled or severely compromised under the President's budget proposal. Also cut back will be studies on new barrier methods of contraception; this is particularly disturbing since the trend in recent years clearly shows that American women are precisely favoring use of barrier methods, which pose less health risk than the pill, for example, but are currently not nearly as effective in preventing pregnancy. Studies on the safety and effectiveness of contraception for adolescents, such as the protective efforts of spermicides against venereal disease, will also be curtailed.

Mr. Chairman, in the absence of a real funding increase, we all lose. Even our most sophisticated contraceptive methods - the oral contraceptive and the intrauterine device - are neither entirely effective nor entirely safe. One out of every three married couples fail to prevent an unintended pregnancy within five years of contraceptive use. In addition, there is growing apprehension about the long-range safety of these methods. Yet without them, the number of unwanted pregnancies, and of abortions, would inevitably be greater than they are now. Clearly, the need to develop safer, more effective and more acceptable methods - especially for teenagers and for men - should be a public health effort of the first magnitude. Support for this research is statutorily limited to Title X; we urge you not to sacrifice the health and social well-being of women and their families in the United States, and indeed worldwide, for the sake of an uncertain, short-term solution to curb inflation by slashing spending.

PLANNED PARENTHOOD RECOMMENDATIONS

For family planning services, Mr. Chairman, we urge funding under Title X, documented to be perhaps the most cost-effective government program, of $225 million to enable sure progress towards the goal of providing care for the millions of women still in need. Our recommendation for human reproduction and population research is $102 million which would provide support for the high priority studies already approved by CPR. We realize that the effort to limit spending overall unfortunately results in intense competition for funds among the discretionary programs, which are as a group probably the most effective ones. I can only reiterate that without real increases in both components of the family planning program, however, indeed we will all lose.

Senator HOLLINGS. Thank you, very much. That's just $48 million more?

Ms. SMITH. $48 million more, that's right.

Senator HOLLINGS. And you're going to put that——

Ms. SMITH. We're going to save $200 million next year.

Senator HOLLINGS. I know it, but I mean you're going to put that out now—that you want me to balance the budget and increase the $48 million back home?

Ms. SMITH. I'll give you more than a year to do it. How about that? [Laughter.]

Senator HOLLINGS. That's a very good presentation. We appreciate it.

Ms. SMITH. Thank you, sir.

COMPREHENSIVE HEALTH CENTERS

Senator HOLLINGS. We have the comprehensive health centers. That's where we started them down there—with a group at Jasper, and the first thing we did was start the family planning——

Ms. SMITH. Yes, sir.

Senator HOLLINGS [continuing]. In each one of the 46 counties, and it's saved us a fortune.

Ms. SMITH. That's right. And we will show you savings in our State, too, in this study.

Senator HOLLINGS. Thank you. I didn't know you all were going to present all of this today. I came here for the National Eye Institute and I've gotten everything but it. [Laughter.]

CENTER FOR DISEASE CONTROL

STATEMENTS OF:

DR. KENT PETERSON, DIRECTOR, AMERICAN COLLEGE OF PREVENTIVE MEDICINE

MS. GERTRUDE ENGEL AND DR. DEAN BURK, SAVE THE UNITED STATES MOVEMENT

DR. JOHN YIAMONYIANNIS, THE NATIONAL HEALTH FEDERATION

Senator HOLLINGS. Let's see. Now we've got the Center for Disease Control programs. That's how this staff works. They used to just fix up the record; now they just fix up the Senators. [Laughter.]

Do we have Mr. Michael Buckner from the United Mine Workers?

Ms. ENGEL. He canceled.

Senator HOLLINGS. How about Dr. Kent Peterson of the American College of Preventive Medicine?

Mr. Peterson. Yes, sir.

Senator HOLLINGS. And we have Ms. Engel and——

Ms. ENGEL. And Dr. Yiamonyiannis.

Senator HOLLINGS [continuing]. And Dr. Yiamonyiannis.

Senator HOLLINGS. Who should we proceed first with?

Ms. ENGEL. Well, I will defer to you, Dr. Peterson.

Senator HOLLINGS. Good, Dr. Peterson, go right ahead.

AMERICAN COLLEGE PREVENTIVE MEDICINE

Mr. PETERSON. I am Dr. Kent Peterson. I am the Director of the American College of Preventive Medicine. Mr. Dennis Barbour works for us in our government relations activities.

I am pleased to appear before you to commiserate about this difficult task of holding down expenditures for fiscal 1981, while at the same time attempting to solve some of the basic problems that have led to inflation.

The American College of Preventive Medicine is a medical specialty society comprised of the physicians in this country who specialize in preventive medicine—public health, occupational medicine, clinical preventive medicine, and aerospace. I guess if there are a group of poor physicians in this country, it's those of us who have chosen to improve the public health by dealing with populations rather than one-to-one individual care.

We are very excited these days, Senator, because we see throughout this country an emerging national commitment to health promotion and disease prevention on the part of the public, of this Congress, this administration, and even the medical profession. It is encouraging, because if we are going to break this alarming spiral of health care costs, we have got to go to the root of the problem. That is, the incidence of disease.

This can only be done through prevention. Especially in the light of scarce financial resources, it is important to look at what prevention can do. For example, it is a fact that 50 percent of all heart attacks can be prevented; that 30 percent of all strokes may be prevented; and that 60 percent of all cancer deaths may be preventable.

This means that two-thirds of the deaths in our country are due to causes which have a major preventable component. Now looking at the particular areas that I would like to comment on, I suggest you turn to the last page of my testimony, which has a set of budget figures. I'm going to go down them very carefully.

TARGETED BUDGET REQUESTS

There are four areas: First are the formula grants. These were initiated and authorized in 1978, and directed each of the States to identify the five leading causes of death and disability, and to target in on the major killers and cripplers in each State. It's a targeted strategy and therefore is likely to be a cost-effective one. Last year, no money was appropriated for this new program. This year, the administration is very strongly in favor of disease prevention and has requested $10 million. That amounts, Senator, to about $200,000 a State. We are recommending $20 million, which will give each State about $400,000 to identify the leading causes of death and disability, to develop quantitative goals and step-by-step plans for reducing the preventable deaths where they can be prevented. It's a targeted approach and we commend it to your consideration.

The second area are the health incentive grants known as section 314(d). As you well know, these funds were fixed since 1966 at $90 million. For 13 years they were fixed at $90 million, and last year they were dropped to $68 million. The administration requested $52 million, but the Congress appropriated $68 million. This has led to difficulty in providing flexible programs to attack problems that have come up—problems in the area of environmental health hazards such as the Three Mile Island disaster; communicable diseases such as the growing rate of tuberculosis. And under the new authorization for these incentive grants, the incentive is that there will be a matching higher proportion of State and local funding. So the Federal Government is only paying 3 percent of the funds for this total comprehensive health program. We recommend $95 million. That's $5 million above the $90 million which has been stable now for 14 years.

The third area is the Office of Health Information and Health Promotion, which you see received a meager $1.7 million in the past year. OHIHP, which is relatively new, has played a coordinative and leadership role for health information programs, as well as research. It led in this past year to the publication of "Healthy People," the first Surgeon General's report on health promotion and disease prevention. This was followed shortly thereafter by an actual report attempting to target priorities and to set measurable goals over the next 5 years. In the area of research, OHIHP has now funded a clearinghouse. The clearinghouse is not a duplication of other activities, but it's a clearinghouse of clearinghouses. It's an attempt to avoid the duplication of the wheel. We believe that the Surgeon General's report has sparked new interest in health promotion, and that this kind of coordinated leadership is needed. The $5.3 million requested by the President is something that we are very much in favor of.

The last area is the demonstration projects, also authorized during 1978. It's another new program, and yet it focuses on evaluating the most effective, efficient methods of delivering services. Certainly in an area of management concerns about our allocation of resources, research on finding out the most efficient way of delivering prevention services is important.

In conclusion, impressive evidence is now being compiled about the long-term benefits and the costsavings of disease prevention, and it pours in every month. Disease prevention takes time to work, but a relatively small investment now can render a profitable return in the future.

Thank you.

Senator HOLLINGS. Very good.

[The statement follows:]

STATEMENT OF DR. KENT PETERSON

Mr. Chairman and subcommittee members, my name is Kent Peterson, and I am the Executive Vice President of the American College of Preventive Medicine. I am pleased to appear before you today to express our views regarding fiscal year 1981 funding levels for the Center for Disease Control and related prevention programs.

The American College of Preventive Medicine is a medical specialty society comprised of approximately 2,000 physicians specializing in four preventive areas: public health, occupational medicine, general preventive medicine and aerospace. Our specialty society represents all facets of preventive medicine, including physicians engaged in teaching, practice, and research.

We presently see an emerging national commitment to health promotion and disease prevention on the part of the American public, the Congress, the administration, and even the medical profession. This is encouraging, for if we are ever to brake the alarming spiral of health care costs, it will only be if we check the cause of those costs -- the incidence of disease. This can only be done through prevention.

Especially today, as financial resources are becoming increasingly scarce, it is time for us to re-examine our nearly total reliance on the treatment model of health care. What is more, the economic cost of treating preventable disease is compounded by the human suffering which it entails. In 1976 preventable cancer and cardiovascular diseases were responsible for over three quarters of a million deaths in this country.

FACT: 50% of all HEART ATTACKS CAN BE PREVENTED.

FACT: 30% of all STROKES CAN BE PREVENTED.

FACT: 60% of all CANCERS MAY BE PREVENTED.

Many programs are currently authorized which, if adequately funded, could provide us with valuable information and experience regarding the effectiveness of prevention. Among these are:

FORMULA GRANTS FOR PREVENTIVE MEDICINE HEALTH CARE SERVICES

In late 1978 section 315 of the Public Health Services Act was signed into law. This authorizes a new program of grants to states to reduce, through application of primary and secondary prevention, the five leading causes of mortality and morbidity within each state. States will develop quantitative goals for reducing mortality and morbidity as well as assorted risk factors. Included within this new authority is a requirement that the states develop a health communications component, which is to utilize the mass media to educate the public.

Actual delivery of preventive health care services is the end-point in the implementation of a targeted disease prevention strategy. Although many such services can and have been delivered within the confines of other federal programs, no comprehensive system such as that envisioned in this section has yet been launched. If adequately funded, such a program could provide us with a focused attack on our greatest health care problems.

HEALTH INCENTIVE GRANTS FOR COMPREHENSIVE PUBLIC HEALTH SERVICES

In the past, under Section 314(d) of the Public Health Services Act, states have been awarded grants to provide comprehensive public health services. The states have established a positive record of performance under this program, although federal appropriations under this section have amounted to less than 3 percent of the total public health expenditures of official state agencies. Unfortunately, while grants under Section 314(d) have allowed states flexibility in designing programs to meet local needs, funding has been fixed at a meager $90 million since 1966, and dropped to $68 million in FY 80. New authority enacted in late 1978 provides "a national program of stable generic support for such public health activities as the prevention and control of environmental health hazards, prevention and control of diseases, prevention and control of health problems of particularly vulnerable population groups, and development and regulation of health care facilities and health services delivery system." This program will greatly assist local jurisdictions in carrying

out their responsibilities for enforcement of control over health hazards, such as the environmental hazard posed by the incident at Three Mile Island. Under the new authorization for these Health Incentive Grants, one of the features is that additional Federal funds will be matched with higher proportions of state and local funding.

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH, OFFICE OF HEALTH INFORMATION AND HEALTH PROMOTION

Over the past year the Office of Health Information and Health Promotion has begun to make important strides toward fulfilling its mandate under P.L. 94-317. Its plans for the future are equally encouraging; many of the programs in planning for FY 81 could prove tremendously beneficial.

OHIHP's current authorities allow it to assume a coordinative, leadership role for health information programs as well as research activities within the Department. Over the past two years the OHIHP has provided leadership for a number of task forces in the area of prevention, including the Task Force on Disease Prevention and Health Promotion. This led to the first Surgeon General's Report on Health Promotion and Disease Prevention, released in 1979, which calls for a second revolution in public health in this country.

In the area of research, OHIHP has undertaken a number of projects to identify existing data in the area of prevention. Perhaps the most ambitious and promising of such projects will be the establishment of the National Health Information Clearinghouse, which OHIHP has recently initiated. The primary role of the clearinghouse is to identify existing health information resources and to link them together into a network to facilitate greater access to such information by health planners, practitioners, and consumers.

At the community level, OHIHP has undertaken a number of exciting projects in conjunction with a number of private organizations. One of the most ambitious of these was the series of 8 Regional

Forums on Community Health Promotion held in 1979 jointly with the National Health Council and the National Center for Health Education.

The Surgeon General's report has sparked a new interest in prevention which can provide a framework for a comprehensive national strategy for health promotion and disease prevention. The development of such a strategy will require the leadership of a strong federal office with a coordinative role. A review of past and future activities clearly illustrates that OHIHP has the potential for providing the leadership in the development of such a strategy, but only given the necessary financial resources.

COMPREHENSIVE DEMONSTRATIONS FOR DELIVERING PREVENTIVE HEALTH CARE SERVICES

This program was newly enacted in 1978 as part of P.L. 95-626 "to demonstrate and evaluate optimal methods for organizing and delivering comprehensive preventive services to defined populations." The need for such large-scale demonstration projects was clearly affirmed by NIH's health research principles, carefully developed in conjunction with the scientific community.

The centerpiece of any health promotion and disease prevention program is actual delivery of services to the public. To prepare for such programs, it is essential that we expand upon the limited research which has been conducted relating to the delivery of prevention services. By establishing multidisciplinary centers for health promotion this new authority meets a vital need. The results of these demonstrations will also assist the states in designing programs to deliver preventive health care services under their newly authorized formula grant program.

CONCLUSION

Unfortunately, our national health care priorities have fostered such an undue emphasis on the treatment of disease and have largely ignored the promise which prevention holds.

As we face the 1980's we have an opportunity to begin to right this imbalance. Impressive evidence is now being compiled about the long term benefits (and cost savings) of disease prevention. However, disease prevention takes time to work. A relatively small investment now can render a profitable return in the future.

AMERICAN COLLEGE OF PREVENTIVE MEDICINE

SUMMARY RECOMMENDATIONS

FY 80: PREVENTIVE HEALTH CARE SERVICES

PREVENTION PROGRAMS	(in millions) FY 80 APPROPRIATION	FY 81 REQUEST	FY 81 RECOMMENDATION
Formula Grants for Preventive Health Care Services (S 315, PHSA)	$ 0.0	$10.0	$20.0
Health Incentive Grants for Comprehensive Public Health Services (S 314(d), PHSA)	$68.0	$52.0	$95.0
Office of the Assistant Secretary for Health, Office of Health Information and Health Promotion	$ 1.7	$ 5.3	$ 5.3
Comprehensive Demonstrations for Delivering Preventive Health Care Services (P.L. 95-626, Title IV, S 401)	-	-	$ 8.0
Health Education Programs (CDC)	$13.5	$16.5	$16.5

FLUORIDATION AND THE SAVE THE UNITED STATES MOVEMENT

Ms. ENGEL. Senator, I thought that what we ought to do is yield, with your permission, sir, to Dr. Dean Burk, who is our organization's famous scientist here, and then Dr. Yiamonyiannis, and then I will be last.

Senator HOLLINGS. Thank you. Dr. Burk, we're glad to hear from you, sir.

Dr. BURK. Thank you, Senator Hollings.

PROBLEMS OF FLUORIDATION

I have been a research biochemist, an employee of the U.S. Government, for 47 years, and I've been interested in the problem of

fluoridation for many years. I estimate, together with studies with Dr. Yiamonyiannis, that a very high proportion of the cancer deaths in this country—someplace between one-quarter and one-tenth, and one-tenth and one-fourtieth—can be ascribed to the fluoridation of public drinking waters.

I have some of the evidence given here, and Dr. Yiamonyiannis will probably have more evidence. Here is an opportunity where I think this committee could save money and act in the direction of the prevention of poor health.

There is no question in my mind that every bit of water not fluoridated represents people that will not die. The facts of the matter have been gathered all over the world. And this is what is important to this committee to weigh up, there are some alleged benefits of artificial fluoridation of drinking water with respect to improved teeth, but these, in my opinion, are utterly overwhelmed by the harm induced by drinking fluoridated water—with respect to cancer, as I mentioned, and many other human ills. And I think Dr. Yiamonyiannis will touch much more on those points.

Senator HOLLINGS. Good; Dr. Yiamonyiannis?

Dr. YIAMONYIANNIS. Senator Hollings, it is a pleasure to be here today.

I would like to speak in opposition to the Center for Disease Control's request for $9.5 million to promote fluoridation of public water supplies. Whenever any agency or group supports a measure which will in some way change our drinking water by the addition of a chemical, it is incumbent upon them and the burden of proof should be upon them, to first of all provide evidence of effectiveness and beneficially, as well as safety.

Within this context, it should be important to point out that we have asked three basic questions concerning fluoridation of public water supplies.

STUDIES OF FLUORIDATION

The first one: Can the proponents—that is, the CDC, the U.S. Public Health Service—produce just one laboratory study showing that fluoridation of public water, supplied at 1 part per million, reduces tooth decay? Under laboratory conditions, they cannot and have not been able to do it. The experiment has been tried many times, and they cannot do it.

The second question we put to CDC and Dr. Foege was to ask him and the U.S. Public Health Service for one blind or double-blind experiment showing that fluoridation of public water systems reduces tooth decay among humans. As a matter of fact, they have not been able to provide this study. Now when I talk about the "blind experiment," I'm talking about an experiment where either the subjects treated or those investigating those subjects are unaware of which group is fluoridated and which group has not been fluoridated. This study has also not been provided because it doesn't exist.

Third, we have asked the U.S. Public Health Service for just one study to show that fluoridation of public water supplies is absolutely safe as claimed, and of course they cannot prove—they have not provided that study.

With that understanding, I would like to go a little bit further. While they have not been able to bear the burden of proof, they have fluoridated the water systems of close to 100 million people in this country. I would like to point out that on September 21 and October 12, 1977, the House Subcommittee on Intergovernmental Relations held 2 days of hearings on the fluoridation issue. Specifically discussed was the work of myself and Dr. Dean Burk—formerly of the National Cancer Institute as their chief chemist.

What we were able to find out through the subcommittee was that the National Cancer Institute was surreptitiously trying to cover up the fluoridation cancer link, which was brought out at the hearings. The chairman of the committee pointed out, after these 2 days of hearings and 580 pages of records and documents, that the American people can no longer be assured that fluoridation doesn't cause cancer.

The following year, in 1978, we filed suit in the Pennsylvania court to enjoin fluoridation as a public health hazard. We were able to show by a preponderance of the evidence—again, us bearing the burden of proof where we really shouldn't have to—we were able to show by a preponderance of the evidence that fluoridation created a public health hazard and increased cancer deaths to the amount of 10,000 per year; genetic damage and chronic effects, adverse effects.

The judge pointed out—and I am quoting him:

> The evidence is quite convincing that the addition of sodium fluoride to the water supply at 1 part per million is extremely deleterious to the human body, and a review of the evidence will disclose that there was no convincing evidence to the contrary.

As a matter of fact, late last year Judge Flaherty's decision was confirmed by the Environment Ministry of Quebec, Canada, who reaffirmed his decision.

Now the point is that we have the CDC coming before you asking to promote a program that they cannot even defend in a court of law. We believe that this program should be cut. We believe that if we do have this money bind and we have an inflation bind, that we have an easy way for you to save about $10 million, just by stopping them from promoting a measure which they cannot even prove safe in a court of law.

FLUORIDATION COST SAVINGS CLAIMS

And I would like to make a couple of other statements. I think when Dr. Foege was here before you in the past, he said for every $1 spent on fluoridation, $50 was saved in dental bills. As a matter of fact, I am very well versed with the literature, as Dr. Foege has pointed out in other communications, and this is absolutely not true. As a matter of fact, a study which we are doing right now which should be published shortly will show that there is no difference in dental costs between fluoridated and nonfluoridated areas.

Basically, I would just finish up by stating that the National Cancer Institute and the Center for Disease Control have knowingly put out fraudulent statements, even after the court case, saying that we have not adjusted for demographic variables such as age, race, and sex, and when these corrections are made the cancer death rate increase disappears.

This was the major part of the court case, and I would like to see an end of this fraudulent promotion of fluoridation of public water supplies with Federal moneys. If the localities want to have it, I think they should decide it. Quite frankly, I would like to see national legislation to prohibit its use in the public water supplies.

You know that in your home State, Senator, there is a move afoot by the EPA to actually remove fluoride naturally occurring in your water supplies, because it is naturally too high. How insane it is to actually have to add it to the public water system.

Thank you.

DENTAL ASSOCIATION EVIDENCE

Senator HOLLINGS. How do you account for the sharp difference you have with the statement on fluoridation from the Dental Association, and the chairman of the Department of the Surgeon General, Public Health Service, Dr. Richmond, who through more than 30 years of research and community experience has demonstrated the benefits and safety of fluoridation? We will put this research in the record, too, with your statements and look at them side by side.

Dr. YIAMONYIANNIS. Senator, the arguments that are put in by the Surgeon General and the American Dental Association are these general, broad arguments. There is no question that if I today were provided with these three studies—I'm not asking for thousands of studies over 30 years; I'm asking for three basic studies, which I have put into the record already—one, a laboratory study; two, a double-blind human epidemiology study; and three, a study showing absolute safety of fluoridation, or any safety that they claim for fluoridation of public water supplies—if they would provide just those three studies, I can assure you that I would no longer oppose fluoridation of public water supplies, and we could save your $10 million and you could fluoridate it overnight.

It is my opposition, in large part, which keeps the major part of this country unfluoridated, and it is based on scientific fact. It is not based on wishful endorsements. This is a scientific issue, Senator. When politics gets involved in science, I think that the scientific facts have to rule.

In the court case, which extended over 21 days, science did rule there. One particular individual, who is an experienced tryer of facts and I think on the board of the Pennsylvania Academy of Sciences, listened to the testimony very carefully, 2,800 pages of it, and ruled that he was compellingly convinced of the adverse effects of fluoridation. I don't think we should go on promoting it.

Senator HOLLINGS. Very good; do you wish to add something?

Ms. ENGEL. Thank you, Senator.

It is indeed an honor to be here today. Today is my birthday.

Senator HOLLINGS. Happy birthday.

Ms. ENGEL. Thank you very much. We are affirming——

Senator HOLLINGS. Fluoride hasn't caught you yet? [Laughter.]

Ms. ENGEL. Not yet, but that's because I eat right and live right. Let there be health, the greatest of all possessions, and let it begin with a cast of thousands which include you and me, to live longer and younger.

I promised myself today that I would not cry. I hope I don't. I brought something that I thought you ought to see. It's an illustration. All the statistics that I have furnished here has been tons more that I could give you, Senator, because I've been around——

Senator HOLLINGS. We will include it all in the record.

Ms. ENGEL. I would like it included in the record.

Senator HOLLINGS. Yes, ma'am.

Ms. ENGEL. The reason I am here today is for 18 years I kept telling my husband, "Don't drink the water that's coming out of this tap." And that was in our home in Michigan before I came to Washington. And he said, "Oh, what's the difference?" I said, "There's a lot of difference." I said, "There is bacteria in the water, and it's going to lead to something very disastrous." Only to get a very serious phone call to rush home, which I did one morning from Washington, to take my husband to a hospital because he had cancer.

Irrespective of the fact that he didn't want to listen to me, thinking I might not be so smart, but yet taking the hint, "don't drink the water," I have boiled water for him. Drink distilled water. Drink juices. Drink milk—I was interviewed in 1974 as to why I felt this way. And I've always said that sometimes individual wisdom supersedes scientific evidence.

Therefore, my husband since has had five operations for cancer. My mother has had it 25 years. We went into 22 hospitals, and 27 doctors took care of her during my youth, and we could not find the answer to the cure of cancer.

RESIDUE IN BOTTLE CAPS

Now I did a test here in Washington, and I hope that no one here drinks the water from Washington. I took a jar, set it aside, and the concave of the bottle turned black, and I thought, "My gosh, is this what we are all drinking here in Washington?"

Then a couple of weeks ago, Senator, I took this cap—and I put it on a jar, and a couple of days ago I looked at it. A few drippings of the water remained in the cap. And when I removed the cap, this is what I saw.

Why are we spending millions of dollars—and I'm asking everybody who is at all intelligent or intellectual, call it whatever you want—why are we spending all this money to poison ourselves? It doesn't make sense. This is what I found in the water.

So every belief that I had, which I was getting in meditation, which I was getting psychically—not that I am a psychic—but I was getting this information, that if there is a universal disease in the whole country, it must be coming from something universal we all do, and we all drink water.

FLUORIDE IN FOOD

So my recommendation was not to drink the water. Now I also furnished in my report the fluoride that is in food. Here is an apple. I paid 70 cents for one apple, and luckily I eat apples, two a day, and the fluoride in the table that I have given you shows 0.35 concentration fluoride per apple. Here is a message that I am delivering on all kinds of

foods—the fish content, the fruit, the vegetables we eat, and everything else that goes with it—you get enough fluoride out of it. If we live right, eat right, we're going to get it out of the food. We don't have to have fluoride in the water to make us any healthier than we already are.

Another thing I have found out—and I have talked to quite a few dentists—they all scream the same message. How are we going to bring our children up? We've got to get rid of the cavities in our teeth.

It begins with the genes. It begins where you were born, about your teeth. At my age today I have all of my own teeth, and it's because I ate right, believed in milk. If they'd put flouride in milk, maybe we'd all get along and we wouldn't have to spend $9 million more to educate the public to tell them that they shouldn't have fluoride in their water, which is ridiculous. Because I am absolutely sure, Senator, and I hope you believe me, I hope everybody in this room believes me, that it's in the water. Call it bacteria, call it fluoride, I don't care what you call it, it's causing and creating cancer problems in people of which there is no cure.

Dr. Hans Nieper came here last Saturday from Germany. I spent 2 hours with him. He is a world famous cancer specialist, and he wanted me to know that we have cancer-causing agents from our water supply here, which they wouldn't drink in Germany, he said. Another thing, the fluoride in the water causes brain damage in children.

So it is a question of where do we go from here, Senator? I hope that if I could get this message across, I would scream it from the housetops: That it seems very foolish to spend millions of dollars. The National Governors Conference, I attended that. They passed a resolution not to fluoridate—not to do anything at all on an adverse policy that they're working on now against fluoridation; all the Governors passed this resolution. The Governor from Wisconsin, Governor Dreyfus, said: "Don't spend the money. Because right now, as far as we're concerned, there is no reason to spend the money."

Victor Kitt from the Environmental Protection Agency is doing a study on adverse reactions, because we've found that the fluoride in the water causes the teeth to be mottled and shows brown spots, and they're trying to avoid that.

What nature puts there is already there; why add to the problem? So in my research dealing with dentists, many prominent people throughout the country I meet in my travels—you know I've been here 11 years now; you know, you've seen me up on the Hill many times, trying to protect everyone's health—I'm asking you to please give it a great deal of consideration not to appropriate this money.

LEVELS OF FLUORIDE

Senator HOLLINGS. It's your position that it's too much fluoride? In other words, you say you get fluoride from the apple——

Ms. ENGEL. Well, you get fluoride from all——

Senator HOLLINGS [continuing]. And a certain amount is all right, but too much is cancerous; is that right?

Ms. ENGEL. Right; now here is—in my message to you today, I have given you a table——

Senator HOLLINGS. Can you measure what too much is, what is cancerous?

Dr. YIAMONYIANNIS. Yes; if I could answer that question. As a matter of fact there is no evidence at all that fluoride at any level is necessary for human development, or as a nutrient. I refer you to the National Academy of Sciences publication, Fluorides, published in 1971, where they examined—Investigators D. Brenzedall and Warren Day—took animals over four generations, reduced the fluoride intake of their diets down to as low as humanly was possible, and found no difference in general health, dental health, or weight gain.

Senator HOLLINGS. But where does it become dangerous? That's what I want to know. In other words, I'm eating that apple. According to Ms. Engel, I'm getting some fluoride from it.

Dr. YIAMONYIANNIS. You're getting some fluoride——

Senator HOLLINGS. And she eats two of those a day, so she is a two-time partaker of fluoride.

Dr. YIAMONYIANNIS. The point is, what you are most concerned with——

Senator HOLLINGS. Twice a day. She at least believes in that much fluoride. Now when should I stop? If I eat five apples, have I got too much fluoride?

Dr. YIAMONYIANNIS. No; what you are basically concerned with here is the concentrations in the apple, not how many apples you eat, but the level of fluoride should not exceed between three-tenths and four-tenths of a part per million fluoride. If you start consuming large quantities say of water at 1 part per million fluoride, then you will be getting an overdose of fluoride.

If you take in fluoride at the concentration of 1 part per million, you are in trouble. At a half-a-part per million, you are marginal. You already get some dental mottling at that level. At three-tenths of a part per million and below, we get into a safe range. And somewhere around the area of the .15 parts per million fluoride that's found in our blood supply is the level of fluoride which probably should not cause any problems at all.

It is not until the .15 parts per million fluoride is exceeded that your kidneys have to work to pull that out of your body.

Ms. ENGEL. We should spend this money, Senator, on education. Congressman Richmond was going to propose the Nutritional Act, which he said he's going to ask for about 20 people to go around the country to speak on radio and television, be at all meetings they possibly can, and explain to the people that if they'll eat their fruits and vegetables and live properly and eat proper food, we don't need additions to anything else we do.

Dr. YIAMONYIANNIS. Let me, in that context, point out that I have six children aged 8 to 16, none of whom have been on fluoridated water, fluoridated toothpaste, or dental fluoride treatments. My eldest daughter is sitting right behind me over here. None of the children have any decayed, missing, or filled permanent teeth.

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Senator HOLLINGS. Very good, sir. We appreciate your appearances here today.

Ms. ENGEL. I think in the notation, also, Senator, you know I should mention $750,000 was given to this child who went to a dentist and he swallowed the fluoride—the child died soon after—and the courts gave the parents $750,000.

Senator HOLLINGS. I understand; we have that in the record.

Ms. ENGEL. Yes, sir.

Senator HOLLINGS. Our next witnesses are interested in programs for the National Eye Institute.

Ms. ENGEL. Thank you, Senator, for being so kind.

Senator HOLLINGS. Thank you.

[The letter and statements follow:]

Letter From John M. Coady, D.D.S., Executive Director, American Dental Association

March 5, 1980

The Honorable Warren G. Magnuson
127 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Magnuson:

We are sending this letter because the Association has received telephone calls from several Congressional Offices recently that an anti-fluoridation group is making unfounded attacks on a public health measure proven to be safe and effective over more than three decades of use in this country.

The timing of these specious attacks is clearly related to the appropriations process. For that reason, we thought the attached material might be useful to you. The Association strongly supports the budget request for fluoridation activities by the Center for Disease Control.

A detailed summary of the history of fluoridation in this country and other countries is available in a General Accounting Office report, Reducing Tooth Decay--More Emphasis on Fluoridation Needed, which is dated April 13, 1979. That report said fluoridation "may be the most thoroughly studied public health measure in modern history."

We would also refer you to the enclosed two-part study published in the summer of 1978 in Consumer Reports magazine, which concludes that the fluoride "fake controversy represents...one of the major triumphs of quackery over science in our generation."

The American Dental Association has ample information and research to refute the half-truths and distortions propounded by these anti-fluoridation groups and will be willing to provide whatever additional materials may be helpful to you in weighing their arguments.

In the meantime, however, we wanted you to have the enclosed material. Please call on this office if the American Dental Association can be of further assistance.

Sincerely,

John M. Coady

John M. Coady, D.D.S.
Executive Director
American Dental Association

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D.C. 20201

Statement on Fluoridation

Increased attention to the prevention of disease and to health maintenance can reduce much of the human suffering and expense that results from ill health. Fluoridation of a community's water supply is an excellent example of a disease prevention effort that can improve the health status of our Nation's citizens and reduce health care costs for children. Fluoridation is the most effective, least costly public health measure for preventing tooth decay --one of the most prevalent health problems, yet only three of every five persons who could be provided the benefits of fluoridation now receive them.

More than 30 years of research and community experience have demonstrated the benefits and safety of fluoridation. Tooth decay, the leading chronic disease in children, can be reduced by as much as two-thirds in children who drink fluoridated water from birth. Many of these children can be completely free of dental decay. Lifetime benefits can be derived from drinking fluoridated water and the cost of children's dental care can be cut in half. Extensive scientific research has uncovered no valid evidence that any health problem is caused or aggravated by drinking optimally fluoridated water.

The Public Health Service strongly endorses the fluoridation of community water supplies at recommended concentrations, and stresses that making fluoridated drinking water available to its residents is the single most important step a community can take to improve dental health. I urge health officials and concerned citizens in communities with fluoride-deficient water supplies to act now to see that this deficit is corrected and to ensure the benefits of fluoridation for their community.

Julius B. Richmond

Julius B. Richmond, M.D.
Surgeon General

October 1978

00-3040

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
CENTER FOR DISEASE CONTROL
ATLANTA, GEORGIA 30333
TELEPHONE: (404) 633-3311

Refer: FL-90
February 1977

OVER 105,000,000 ON FLUORIDATED WATER SUPPLIES AS OF DECEMBER 31, 1975

Most recent statistics show there were more than 105,000,000 persons having access to water supplies whose fluoride content had been adjusted to the optimum level for better dental health or whose natural fluoride content was at optimum or higher levels.

Total U.S. Population	212,851,000
Population on Public Water Supplies	177,000,000*
Population not served by Public Water Supplies	35,851,000
Population on Fluoridated Water	105,338,000
(Adjusted	94,627,000
Natural	10,711,000)
% of Total Population on Fluoridation	49.4
% of Population on Public Water Supplies Using Fluoridation	59.3

Fluoridated Communities**	9,425
Adjusted	6,795
Natural	2,630

Some 24,000,000 people in over 100 cities with populations of 50,000 or more, including Washington, D.C. and Chicago, have had adjusted fluoridation for more than 20 years.

70% of all cities with populations of 100,000 or more have fluoridated water.

22 States, the District of Columbia, and Puerto Rico provide fluoridated water to over half the State's population.

School Fluoridation
As of December 31, 1976

Schools	383
Students	124,475
States with Fluoridated School Supplies	13

Dental Disease Prevention Activity
Bureau of State Services

*EPA Estimate of Population on Community Water Systems, Federal Register, Vol. 40, #248, Dec. 24, 1975, p. 59582.

**These are places as designated in Nationwide Geographical Location Codes, General Services Administration, Office of Finance, Feb. 1972.

American Dental Association
Council on Dental Health and Health Planning
211 East Chicago Avenue
Chicago, Illinois 60611

Fluoridation Status of Major U.S. Cities

Dates indicate initiation of fluoridation.
Cities without notations are fluoride-deficient.

Population one million and over		Population 250,000-499,999	
New York	1965	Atlanta	1969
Chicago	1956	Buffalo	1955
Los Angeles		Cincinnati	1976
Philadelphia	1954	Nashville	1953
Detroit	1967	San Jose	1965-PT
Houston	N-PT	Minneapolis	1957
		Fort Worth	1965
Population 500,000-999,999		Toledo	1955
		Portland	
		Newark	
Baltimore	1952	Oklahoma City	1954
Dallas	1966	Oakland	1976
Washington, D.C.	1952	Louisville	1951
Cleveland	1956	Long Beach	1971
Indianapolis	1951	Omaha	1969
Milwaukee	1953	Tulsa	1953
San Francisco	1952	Miami	1952
San Diego		Honolulu	
San Antonio		El Paso	N
Boston	Approved	St. Paul	1952
Memphis	1970	Norfolk	1952
St. Louis	1955	Birmingham	
New Orleans	1974	Rochester, N.Y.	1952
Phoenix		Tampa	
Columbus, Ohio	1973	Wichita	
Seattle	1969	Akron	1969
Jacksonville	N-PT	Tucson	
Pittsburgh	1952	Jersey City	1974
Denver	1954	Sacramento	
Kansas City, Mo.		Austin	1973
		Richmond	1952

N=Naturally fluoridated

PT=Part fluoridated

January, 1978

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States with Laws Requiring Fluoridation

Connecticut	1965
Minnesota	1967
Illinois	1967
Michigan	1968
South Dakota	1969
Ohio	1969
Georgia	1973
Nebraska	1973

Kentucky has a public health regulation in effect requiring fluoridation for approval of water supplies.

January, 1978

PART ONE OF A TWO-PART REPORT

FLUORIDATION
The Cancer Scare

On the evening of February 10, 1976, millions of Dutch television viewers were watching their sets with more than customary attention. News of a bribery scandal in the United States had just reached Europe, along with rumors that Prince Bernard of Holland was implicated. Those who tuned in were unaware, however, that an unrelated interview later in the newscast would soon affect many of them more directly than the scandal.

The interview involved Dean Burk, Ph.D., an American biochemist formerly with the National Cancer Institute, the Federal agency that conducts or sponsors much of the cancer research in the U.S. Dr. Burk's message was a troubling one. Adding fluoride to drinking water as a dental health measure, he asserted, was causing thousands of cancer deaths annually in the U.S. He claimed that statistical studies done by himself and another biochemist, John Yiamouyiannis, Ph.D., showed a link between fluoridation and cancer. Dr. Burk expressed no reservations about his conclusion. "Fluoridation," he told the audience, "is a form of public mass murder."

Copies of the Burk-Yiamouyiannis report had been circulated to members of the Dutch Parliament before the TV appearance. Soon after, a proposal by the Minister of Health to fluoridate all drinking-water supplies in Holland died in Parliament. By September 1976, a Royal Decree ended fluoridation in Rotterdam and other Dutch cities that had been treating their water for years.

A GROWING SENSE OF ALARM

What happened in Holland is not an isolated incident. Despite widespread endorsement of fluoridation by medical, dental, and public health officials, the practice has come under increasing attack both in the United States and abroad as a potential cause of cancer and other diseases. Three years ago, after a publicity campaign linking fluoride to cancer, Los Angeles voters defeated an ordinance to fluoridate the city's water supply. Since 1973, voters in hundreds of smaller U.S. cities and towns have taken similar action, often out of fear of cancer or other disorders attributed to fluoridation.

How valid are those fears? Is there a genuine scientific controversy surrounding the safety of fluoridation? According to Representative James J. Delaney (D., N.Y.), chairman of the powerful House Rules Committee, the answer is an emphatic "yes." A long-time opponent of fluoridation, Delaney has urged Congress to halt the practice, pending further investigation of its safety. Last fall, a subcommittee of the House's Committee on Government Operations held hearings on the issue. Drs. Burk and Yiamouyiannis testified, as did representatives of the American Dental Association, the National Cancer Institute, and authorities on fluoride research. An extensive array of scientific studies and expert commentaries on fluoridation was also presented.

What emerged from the testimony, in CU's opinion, was an unmistakable sense that millions of Americans are being grossly misled about an issue important to both their health and the cost of their dental bills. Water fluoridation is the only public-health measure that many Americans vote on directly. Yet last fall's hearings received only scant coverage by the press, except in publications that commonly run anti-fluoridation stories. Accordingly, in this two-part report we will tell you the facts about fluoridation--what it is, how it developed, and what it does. This month we will also examine the claims about fluoridation and cancer and consider the people behind those claims. Next month we'll take a look at other charges frequently leveled at fluoridation, including claims about allergies, birth defects, and heart disease.

ON THE TRAIL OF COLORADO STAIN

Fluorides are compounds containing the element fluorine. In its various forms, fluoride is found in practically all soils, plants, and animals, as well as in human blood, bones, and teeth. It's also present in at least trace amounts in all natural water supplies. The concentration in water varies widely, however. In the U.S., natural fluoride levels range from a high of about 8 parts per million (ppm) in areas of the Southwest to as little as 0.05 ppm in the Northeast.

Fluoridation is simply an adjustment of the natural fluoride content to about 1 ppm--a level of intake that strengthens tooth enamel and sharply reduces dental decay, especially among those exposed to fluoridated water from early childhood. The nominal 1-ppm level (actually 0.7 to 1.2 ppm,

according to local conditions) isn't an arbitrary one. Its selection involved a scientific detective story complete with a twist ending.

The initial clue was uncovered early in the century by two scientists investigating a cosmetic defect. F.S. McKay and G.V. Black were trying to find out what caused a mottling of the tooth enamel, a discoloration variously known as "Colorado brown stain" and "Texas teeth." By 1916 they had narrowed the search to something in domestic water supplies. The next step was to identify the substance and get it out of the water. It took until 1931, however, before the substance was identified as fluoride.

Meanwhile, McKay had noticed something else. A practicing dentist, he observed that patients with mottled teeth also had remarkable resistance to tooth decay. The concern of public health officials at the time was still how to get fluoride out of the water. But McKay's observation also spurred further research by the Public Health Service to learn more about fluoride's effect on teeth.

Over the next ten years, research teams led by Dr. H.T. Dean of the Public Health Service studied the dental status of 7257 children in 21 cities having various levels of natural fluoride in their water. The results were unequivocal. The more fluoride in the water, the fewer dental cavities the children experienced. When the water contained approximately 1 ppm or more of fluoride, the children developed about 60 percent fewer cavities than did those who drank water with negligible fluoride content. Furthermore, at the 1-ppm level, the unattractive mottling did not occur. It was associated with levels above 2 ppm. Thus, 1 ppm of fluoride became the benchmark level.

Tooth decay was no minor health problem. During the war year of 1942 some 2,000,000 men were examined as potential members of the armed forces. Almost 10 percent of them were rejected because they didn't have 12 sound teeth in proper position out of a possible 32.

Although the potential dental advantages of fluoridation were obvious, there was a natural reluctance to add a chemical to community water supplies. In the early 1940's, there was no background of scientific data about possible side effects. There were some practical reassurances, though. People had been ingesting fluoride in food and water since the dawn of the human race. Many Southwesterners had been drinking water containing several times the 1-ppm level of fluoride for a lifetime without any discernible side effects except mottled teeth. Eventually, a few cities decided to take the chance.

THE NEWBURGH-KINGSTON EXPERIMENT

Among the pioneers was the New York State Department of Health. Before attempting any widespread introduction of fluoridation, the department proposed a long-term, controlled study of a limited group of children who would be carefully monitored by physicians. After considering various communities, the department chose the cities of Newburgh and Kingston as ideal candidates for the study.

Located some 35 miles apart near the Hudson River, both cities had populations of about 30,000 and were similar in racial, economic, and other demographic characteristics. Each also used reservoirs with water deficient in fluoride.

One city's water supply was to be fluoridated, the other not. Meanwhile, matched groups of children from the two cities were to be followed from infancy onward by means of comprehensive pediatric checkups to detect any side effects from fluoride. Special attention was to be given to growth rates, bone development, blood chemistry, the skin, the thyroid gland, vision, and hearing. Each child would also receive meticulous, regular dental exams.

In March 1944, the City Council of Newburgh agreed to participate in the study and approved the fluoridation of its water to 1 ppm. Kingston agreed to serve as the control city and use its fluoride-deficient water without change. A total of 817 children were enrolled in the Newburgh group and 711 in Kingston. Although most entered at the start of the study, several infants were added during each of the first three years to ensure having some children whose mothers were exposed to fluoridated water throughout pregnancy.

The study went on for 10 years, and a majority of the children in both groups participated through the final examination. The findings can be summarized briefly: The examinations disclosed no differences of medical significance between the two groups that could even remotely be attributed to fluoride. There was one difference of dental significance, however. The Newburgh children experienced nearly 60 percent fewer cavities than the Kingston children.

Numerous studies have since confirmed the benefits of fluoridation. "Fewer cavities" means fewer costly fillings, fewer lost teeth, and, eventually, fewer dentures or partial dentures. The cost of fluoridation to a community, according to a report last year in the New England Journal of Medicine, is only about 10 to 40 cents a year per capita.

THE EVIDENCE FOR SAFETY

Since the early days of the Newburgh-Kingston project, literally thousands of scientific studies have examined the effectiveness and safety of fluoride. Virtually every doubt or question that has been raised, however scanty the evidence, has been studied in depth by one or more groups of researchers. As a dentist representing the American Dental Association noted in the House subcommittee hearings last fall, "Fluoridation may well be the most thoroughly studied community health measure of recent history."

Water fluoridation is the only public-health measure that many Americans vote on directly. And since 1973, hundreds of towns and cities have voted against fluoridating the water supply.

In the late 1960's, the World Health Organization accomplished the Herculean task of pulling much of the known information together. The objective was to provide an impartial review of the scientific literature on fluoridation—a vast international aggregation of population studies, experimental research, animal studies, and clinical investiga-

tions, including human autopsy studies, clinical trials, and X-ray research.

The report, "Fluorides and Human Health," came out in 1970. It addressed numerous questions raised up to that time about the possible effects of fluoride on different organs and its alleged association to various diseases. Again, the conclusions can be summarized briefly: The study found no reliable evidence that any ill effects or symptoms resulted from drinking water fluoridated at recommended levels.

Since the report's publication, the World Health Organization has uncovered no evidence to alter its judgment. In a statement issued in 1975, the organization noted: "The only sign of physiological or pathological change in life-long users of optimally fluoridated water supplies . . . is that they suffer less from tooth decay."

THE LOYAL OPPOSITION

No amount of study, however, has managed to quiet the criticism of fluoride that has been present from the beginning. Writing in the Journal of the American Dental Association in March 1956, the commissioner of New York State's Department of Health, Dr. Herman E. Hilleboe, told of some of the troubles his agency had encountered in the early days of the Newburgh-Kingston project. Soon after the project's approval in March 1944, the local health officer in Newburgh began receiving complaints from some of the town's citizens.

> "The only sign of physiological or pathological change in life-long users of optimally fluoridated water supplies . . . is that they suffer less from tooth decay." [from a World Health Organization report]

Some protested that the fluoridated water was discoloring their saucepans. Others complained that it was giving them digestive troubles. One woman complained to her dentist that the "fluoride water" had caused her denture to crack. "These incidents all occurred before fluoride was added to the water supply," notes Dr. Hilleboe. The complaints stopped abruptly after a Newburgh newspaper criticized the town's imaginary ills.

Despite fluoridation's success in Newburgh, protests against it elsewhere weren't collapsing so readily a decade later. The rise of "a vociferous minority," said Dr. Hilleboe, had succeeded in delaying, or even reversing, the start-up of fluoridation in several areas. The opposition, he reported, came chiefly from food faddists, cultists, chiropractors, and people who misunderstood what fluoridation was. But the efforts of antifluoridationists have also been aided by the caution of various physicians, dentists, and scientists of good standing who initially questioned the safety of fluoridation. Opposition has also come from other professionals and lay people who view fluoridation as a government infringement of individual freedom.

Various groups have been formed for the sole purpose of fighting fluoridation, but none has had much impact outside of its local community. Generally, the real steam behind the antifluoridation movement has come from well-funded, national, multi-issue organizations that have been able to disseminate large amounts of scare propaganda around the country. One such group is the John Birch Society. Another, up until the early 1970's, was the Rodale Press, publisher of Prevention magazine and a frequent proponent of unproved nutrition concepts. The most active and effective group today, however, is the National Health Federation, whose roots run deep into the soil of medical quackery. Those roots are worth a brief examination.

WHEN ROOSTERS HAD BAD TEETH

In the early 1950's, an organization called the Electronic Medical Foundation ran a lucrative diagnosis-by-mail service and also sold electronic treatment devices for "curing" numerous disorders. An estimated 3000 practitioners, mainly chiropractors, would send dried blood specimens from their patients to the foundation. There, the blood spot would be checked by an electronic gadget and a "diagnosis" mailed back by postcard.

This eventually aroused a certain skepticism at the U.S. Food and Drug Administration. Accordingly, the FDA arranged to send a few blood spots of its own.

The first, from a man who had lost his right leg, elicited a diagnosis of arthritis in the right foot and ankle. The blood of a dead man brought back a diagnosis of colitis, and that of a rooster resulted in a report of sinus infection and bad teeth.

The FDA inspectors also investigated the treatment devices. They found that the gadgets simply contained circuits resembling those of an electric doorbell or a small radio transmitter. None could cure anything, reports FDA historian Wallace Janssen.

In 1954 a U.S. District Court ordered the president of the firm, Fred J. Hart, to stop distributing the treatment devices. Shortly thereafter, Hart founded the National Health Federation. Hart continued to distribute the devices, however, and was subsequently prosecuted for criminal contempt and fined $500 in 1962. Between 1957 and 1963, several other officials of the NHF were convicted of misbranding dietary products with false medical claims and received fines or prison sentences. In 1963, the FDA released a report on the NHF that said in part:

> The stated purpose of the federation is to promote "freedom of choice" in health matters. The record shows that what this frequently means is freedom to promote medical nostrums and devices which violate the law. From its inception, the federation has been a front for promoters of unproved remedies, eccentric theories and quackery.

In an updated report on the NHF issued in 1973, the FDA reiterated virtually the same judgment. Throughout its history, the NHF has crusaded against any Government interference with unproven remedies or treatments. At the same time, it has also opposed proven public-health measures—smallpox vaccination, pasteurization of milk, polio

vaccination, and fluoridation of drinking-water supplies.

For the most part, the NHF's opposition to public-health measures has been a losing cause. Until recent years, even fluoridation was slowly gaining acceptance in more communities. About 105 million Americans now have fluoridated water. But in 1974 the NHF decided to mount a new national campaign to "break the back" of fluoridation efforts. It hired Dr. Yiamouyiannis to do the job.

RAISING THE SPECTER OF CANCER

The first big target was Los Angeles, whose City Council had voted in September 1974 to fluoridate the water supply. The NHF's ammunition was a study by Dr. Yiamouyiannis that purported to link fluoridation to an increase in cancer deaths. The study and a couple of publicity handouts that accompanied it were eventually reviewed by various public-health officials, including Thomas Mack, M.D., of Los Angeles, an associate professor of community medicine and an expert in cancer epidemiology. (Epidemiology is a branch of medicine that studies the incidence, causes, and control of a disease in specific populations.) The nature of the Yiamouyiannis study is apparent in an excerpt from Dr. Mack's review:

"I cannot begin without commenting on the form of the documents you sent me," Dr. Mack stated. "Despite the gravity of the question addressed, the form of these sheets is that of a propaganda flyer rather than a serious scientific effort. Specifically, there is no indication that any of the material was ever prepared for submission to a reputable scientific journal. . . . All over the documents one finds . . . conclusions emblazoned essentially in the form of slogans, without cautious interpretation or restrictions. For these reasons, the reader must immediately presume that objectivity has never been considered. . . . At the same time this bias is so pervasive and obvious, the mistaken logic so gross and naive, that the

> Generally, the real steam behind the antifluoridation movement has come from well-funded, national, multi-issue organizations that have been able to disseminate large amounts of scare propaganda around the country.

reader assumes the author to be, however competent in his Ph.D. field, totally unaware of the principles of epidemiology."

Most people are unfamiliar with the principles of epidemiology, however, and a Ph.D. degree can sometimes lend credibility even to claptrap. In Los Angeles it evidently did. The scare tactics of the NHF and other antifluoridationists scored a stunning victory over dental health.

Around the beginning of 1975, Dr. Yiamouyiannis also joined forces with Dr. Burk. Like the National Health Federation, Dr. Burk is a leading advocate of the worthless cancer drug Laetrile (CONSUMER REPORTS, August 1977), and he shares the NHF's aversion to fluoridation.

The collaboration produced a study claiming that 25,000 or more excess cancer deaths occur annually in U.S. cities that fluoridate their water. The assertion was based on a comparison of death rates for specific cancers in some counties that were fluoridated compared with some that were not. In July 1975, Representative Delaney entered the study into the Congressional Record and called for "an immediate suspension of all artificial fluoridation."

The National Cancer Institute reviewed the study and was unimpressed. Unlike a proper epidemiological study, it had failed to take into account widely recognized risk factors known to affect the death rate from specific types of cancers. Using the same data, the NCI reanalyzed the study, taking into account such influences as ethnic composition

> "There is no evidence that fluoride increases the incidence or mortality of cancer in any organ." [from a study by the Royal College of Physicians]

of the population, geographic location, socioeconomic status, and other fundamental risk factors. The purported differences in the cancer death rates promptly disappeared.

Undaunted, Drs. Burk and Yiamouyiannis bounced back with another study. This time they compared overall cancer death rates for 10 large cities that were fluoridated versus 10 large cities that were not. Again, the fluoridated cities came out second best. Over the 20-year period studied, cancer death rates in the fluoridated cities purportedly increased 10 percent more than in the unfluoridated ones. In December 1975, Representative Delaney entered the study into the Congressional Record and demanded that all fluoridation be stopped.

If anything, the new study was even more amateurish than the July entry. In the judgment of one NCI official at the House subcommittee hearings, it represented "the worst piece of work that has been done to date on fluoride." Drs. Burk and Yiamouyiannis had somehow managed to ignore the most fundamental factors involved in cancer mortality rates—age, sex, and race. Old people die from cancer more often than young people; men have a higher cancer death rate than women; and blacks a higher one than whites. Unless those factors are taken into consideration, the results of a cancer-mortality comparison would be meaningless.

When NCI scientists reanalyzed the Burk-Yiamouyiannis data, they found that the difference in the cancer death rate was due entirely to the age and racial makeup of the respective populations. Fluoridation was irrelevant.

ONWARD TO EUROPE

Rebuffed by NCI scientists, Dr. Burk took the National Health Federation studies to Holland and England. As noted earlier, the Dutch trip was a smashing success. But the

British refused to panic. Both the Royal College of Physicians and Oxford University had recently completed studies of fluoridation and cancer. The Royal College of Physicians in January 1976 concluded: "There is no evidence that fluoride increases the incidence or mortality of cancer in any organ." The Oxford study reached a similar conclusion.

Moreover, British scientists had learned of the NCI's refutation of the Burk-Yiamouyiannis studies. They also were aware that an independent study conducted for the National Academy of Sciences at the University of Rochester, N.Y., had confirmed the NCI's findings.

"In the normal course of events," reported an Oxford research group, "that would have been the end of the matter. Unfortunately, however, it has not been." What the British scientists hadn't realized was that the facts were incidental.

The real goal of antifluoridation groups, explains an American Dental Association official, "is to create the illusion of a scientific controversy." The "studies" are merely the ploy. The accuracy of that judgment was evidenced by what happened next. According to an account in The Lancet, a British medical journal, Drs. Burk and Yiamouyiannis began publicizing their cancer claims in Britain. Through the assistance of the National Anti-Fluoridation Campaign, their misleading data were circulated to members of Parliament, health authorities, and water boards as evidence that fluoridation was causing many cancer deaths.

Meanwhile, the National Health Federation began claiming in the U.S. that NCI officials were concealing data, a charge that eventually had an impact in Britain. In Parliament, one member accused British health officials of misleading the public about fluoridation and of denying people the truth "because of the Official Secrets Act."

THE NCI 'COVER-UP'

According to testimony at the House subcommittee hearings, the NCI refused to disclose certain information to the National Health Federation. That refusal, however, was far less sinister than some members of the British Parliament were later led to believe.

The real goal of the antifluoridation groups, explains an American Dental Association official, "is to create the illusion of a scientific controversy."

The NCI initially gave Dr. Burk a copy of the publication "U.S. Cancer Mortality by County: 1950-1969," which he later used in preparing the first Burk-Yiamouyiannis report. After the NCI reviewed that report, Dr. Yiamouyiannis asked for a copy of the NCI's analyses. Those were also dispatched. Then, according to NCI testimony, Dr. Yiamouyiannis used that information to attack the NCI's review. Consequently, when he requested their analyses of his subsequent study, NCI officials denied the request. They pointed out that the basic sources were routine publications of the Bureau of the Census and the National Center for Health Statistics, and they told him, in effect, to do the calculations himself. "The data," said NCI's Dr. Robert N. Hoover at the hearings, "are generally available to anyone with a public library card."

To check that claim, a CU staff member visited the local public library. All but two of the volumes needed, both from 1950, were on the shelves of a suburban library within walking distance of our offices. A phone call by one of the librarians located the two remaining volumes at another nearby branch.

In short, independent investigations by seven of the leading medical and scientific organizations in the English-speaking world have unanimously refuted the National Health Federation's cancer claims.

As a result of the charges and the wide publicity the National Health Federation gained in Britain, Drs. Richard Doll and Leo Kinlen of the Department of Regius Professor of Medicine at Oxford decided to undertake still another study. Their reason, they explained, was "to be sure about the truth of the matter, and because we feared that Burk and Yiamouyiannis's abuse of statistics might be detrimental to the future health of British children." At the same time, the Royal College of Physicians requested a formal opinion of the cancer data from the Council of the Royal Statistical Society in Britain.

The resulting studies appeared respectively in The Lancet and in the Journal of Applied Statistics in 1977. In The Lancet, Drs. Doll and Kinlen reported that none of the evidence "provides any reason to suppose that fluoridation is associated with an increase in cancer mortality, let alone causes it." The study conducted for the Royal Statistical Society, which undertook an even more comprehensive statistical analysis than the NCI or Oxford, came to the same conclusion.

Furthermore, additional studies by the NCI in 1976, the U.S. Center for Disease Control in 1977, and the National Heart, Lung, and Blood Institute in 1977 each found no evidence linking fluoridation and cancer. In short, independent investigations by seven of the leading medical and scientific organizations in the English-speaking world have unanimously refuted the National Health Federation's cancer claims.

Meanwhile, other allegations against fluoride are in wide circulation. Fluoride is said to cause allergic reactions, birth defects, mutations, heart disease, and cancer in animals. We'll examine those allegations next month, in the second part of this report.

The Attack on Fluoridation–Part 2

SIX WAYS TO MISLEAD THE PUBLIC

"There are three kinds of lies," remarked 19th-century British statesman Benjamin Disraeli, "lies, damned lies, and statistics." Probably every type of misrepresentation known to Disraeli, and some he may have overlooked, have been used to attack fluoridation. Misleading information about it appears regularly in a paper called the National Fluoridation News, and the entire gamut of hokum has recently been published in a 176-page issue of the Cancer Control Journal, a pro-Laetrile magazine based in Los Angeles.

In last month's issue of CONSUMER REPORTS, we examined the most prominent charge—that fluoridated water causes cancer—and reported it to be baseless. But fluoride is also accused of causing numerous other ills, ranging from brittle nails to birth defects. Since such claims are resurrected whenever fluoridation comes up for a vote, we'll discuss the most persistent ones and the evidence behind them.

CLAIM: FLUORIDE IS A POISON

Like iron, zinc, and several other minerals, fluorine (in the form of fluoride) is classified by the National Academy of Sciences as an essential trace element in human nutrition. And like many substances essential to life or good health—iron, vitamins A and D, oxygen, and even water itself—fluoride can be toxic in excessive quantities. At high concentrations, fluoride has been used as a poison for insects and rodents. However, at the level in fluoridated water—one part per million (ppm)—you'd have to drink at least several hundred gallons at one sitting to get a lethal dose. The water alone would kill you first.

But what about the possibility of slow poisoning—a little bit at a time over long periods? According to the National Academy of Sciences, the daily intake required to produce symptoms of chronic toxicity after years of consumption is 20 to 80 milligrams or more—far in excess of the average intake in the U.S. Such heavy doses are associated with water supplies that contain at least 10 ppm of natural fluoride, as in some parts of India. There is absolutely no danger of poisoning from imbibing water fluoridated to prevent dental cavities.

An occasional tactic in antifluoridation tracts is to run pictures of cattle or other animals harmed by fluoride poisoning. The photographs are authentic, but the impression conveyed is false. Years ago, steel mills and clay factories in England and Wales sometimes polluted nearby vegetation with tons of fluoride emissions. Similar incidents have also occurred in the U.S. Cattle and other animals that grazed on the vegetation would ingest enormous amounts of fluoride and develop bone fractures and lameness. Their pictures are the ones antifluoridationists use.

In contrast, a controlled experiment with cattle produced far different results. The cattle were fed various amounts of fluoride in their diets for nearly 7½ years. Even at fluoride levels as high as 27 ppm, the cattle did not experience fractures, lameness, or any adverse effects on soft tissues, fertility, or milk production. Nor were there any abnormal effects on their offspring through successive generations.

CLAIM: FLUORIDE CAUSES BIRTH DEFECTS

In the late 1950's, a French physician named Rapaport reported that mongolism occurred more frequently in some cities with fluoridated water than in some cities with little or no fluoride in their water. Experts who reviewed the study found it seriously flawed, however, especially in its method of locating cases. According to Dr. Rapaport's figures, the incidence of mongoloid births in both the fluoridated and unfluoridated cities was less than half the usual rate—a highly questionable finding in itself. Thus, there was a strong likelihood that Dr. Rapaport had failed to uncover the majority of mongoloid births in the cities he chose to study.

That conclusion was soon confirmed by a more carefully controlled study in England. Using more exacting methods

of case-finding, the British researchers reported no difference in the incidence of mongolism whether the water was high or low in fluoride.

Since then, two extensive studies have substantiated the British findings. One surveyed virtually all mongoloid births in Massachusetts from 1950 through 1966. The results, published in the New England Journal of Medicine in 1974, showed no link between fluoridation and mongolism. An even larger study published in 1976 covered approximately 1.4 million births in six major U.S. cities. Researchers at the Center for Disease Control investigated not only mongolism, but also cleft palate, heart abnormalities, clubfoot, and other common birth defects. Again, there was no association between fluoride and any of the defects. In short, the antifluoridationists' claim is based solely on the discredited Rapaport study.

CLAIM: FLUORIDE IS MUTAGENIC

A variation on the birth-defects theme is the charge that fluoride is a genetic hazard. Until recently, this claim was based on irrelevant or questionable experiments with fruit flies and plants. Then, in 1976, two researchers in Kansas City, Mo., reported that various levels of fluoride damaged chromosomes in the bone-marrow cells and sperm cells of mice. Although experts who reviewed the experiment noted several inconsistencies in the results, the question it raised was judged important enough to warrant further research.

Accordingly, joint studies were undertaken by the Laboratory of Developmental Biology and Anomalies at the National Institute of Dental Research, the Department of Biochemistry at the University of Minnesota, and the Laboratory of Cellular and Comparative Physiology at the National Institute on Aging. The scientists conducted four separate experiments, including tests on mice receiving acute doses of fluoride and mice raised for several generations on water containing 50 ppm of fluoride. None of the studies produced any evidence that fluoride damages chromosomes, even at levels 100 times that in fluoridated water supplies.

In Germany, meanwhile, an independent group of researchers reported similar results with human white blood cells, which are especially sensitive to mutagenic agents. Not only did fluoride fail to produce damage, it also evidenced an antimutagenic effect by *protecting* chromosomes against a known mutagen.

CLAIM: FLUORIDE CAUSES ALLERGIC REACTIONS

The charge that people can suffer allergic reactions or "intolerance" to fluoride gained prominence from anecdotal accounts by George L. Waldbott, M.D., an early opponent of fluoridation who founded the National Fluoridation News. Between 1955 and 1965, Dr. Waldbott reported numerous instances of patients experiencing nausea, headaches, "spastic colitis," or various other symptoms that he attributed to fluoride ingestion.

In the World Health Organization study described last month, a review of the Waldbott reports found no reliable evidence to support his contentions. The cases were judged to represent "a variety of unrelated conditions." Following the WHO study, the Public Health Service asked the American Academy of Allergy to evaluate the issue. After a review of the existing clinical reports, the executive committee of the academy concluded unanimously: "There is no evidence of allergy or intolerance to fluorides as used in the fluoridation of community water supplies."

CLAIM: FLUORIDE CAUSES CANCER IN ANIMALS

Possibly the most absurd evidence marshalled against fluoridation is material purporting to show that fluoride induces cancer in animals. One series of studies frequently quoted by antifluoridationists was conducted by researchers in Texas in the 1950's. The first study involved a strain of mice that ordinarily gets cancer. Supposedly, the mice given fluoridated water developed tumors slightly earlier than similar mice on fluoride-free water. There were a few minor hitches in the experiment, however. All the mice were also fed a dog chow that, unknown to the investigator, contained 42 ppm of fluoride—or 10 to 100 times the amount any of the mice got in their water, thus making any comparison between the two groups invalid. A further botching occurred when the investigator miscalculated the amounts of fluoride in the water. Two scientists from the National Institutes of Health reviewed the study in 1951 and dismissed it. Other experiments by the same investigator and a co-worker have long been discredited by subsequent research. Nevertheless, opponents of fluoridation still cite the Texas experiments as significant evidence that fluoride is carcinogenic. *Continued* ►

Another study currently getting star billing in antifluoridation tracts is an experiment conducted with fruit flies in 1963. This time, legitimate findings are being substantially distorted. In that study, two strains of fruit flies exposed to 20 to 50 ppm of fluoride in their food experienced an increased incidence of melanotic tumors. Opponents of fluoridation interpret that to mean that fluoride can cause cancer. That's not so, according to scientists working at the National Cancer Institute. While humans may be physiological cousins to the mouse and other mammals, their kinship to the fruit fly is somewhat more distant.

Specifically, a *melanotic* tumor in a fruit fly is not the same as a cancerous tumor in a human or mammal. It is more akin to scar tissue, and, unlike a cancerous tumor, it's not malignant or harmful. It can be induced by a wide range of substances, including some vitamins and even lysine and tryptophan, two amino acids essential for human growth and health. Fruit flies can also get malignant tumors, but there's no evidence that fluoride has ever caused any. Indeed, fluoride has never proved to be carcinogenic in tests on a variety of animals, including rats, mice, guinea pigs, rabbits, hamsters, dogs, and sheep.

CLAIM: FLUORIDE CONTRIBUTES TO HEART DISEASE

In Wisconsin, opponents of fluoridation have often charged that it increases the number of deaths from heart disease. They base their claim on statistics that show a rise in heart deaths in the town of Antigo, Wis., since the introduction of fluoridation there.

The National Heart and Lung Institute has called the data a "misrepresentation of statistics." As one scientist points out, "The well-known fact that deaths from heart disease become more frequent as people grow older was overlooked." Since fluoridation was introduced in Antigo in 1949, the percentage of elderly people there has doubled. Between 1950 and 1970, for example, the segment of the population 75 years old or older increased 106 percent. When that factor is taken into account, the alleged effect of fluoride vanishes.

According to a 1972 study by the National Heart and Lung Institute, comparisons of fluoridated and unfluoridated communities reveal no difference in the rate of heart deaths. Furthermore, reported the institute, evidence from autopsy studies, from examinations of people exposed to acute doses of fluoride in industrial accidents, and from medical data on people who have drunk water naturally high in fluoride for a lifetime "all consistently indicate no adverse effect on cardiovascular health."

THE FACTS: ANTIGO LEARNED THEM THE HARD WAY

Of all the numerous ills that have been attributed to fluoridation—from cancer in humans to constipation in dogs—none has ever been shown to be valid. In fact, the only known hazard of fluoridated water has nothing to do with drinking it. Patients undergoing kidney dialysis can be exposed to about 50 to 100 times the amount of fluid consumed by the average person. Accordingly, the National Institute of Arthritis and Metabolic Disease recommends that fluoride—as well as calcium, magnesium, and copper—be removed from the tap water *before it is used in an artificial kidney machine*. Aside from that precaution, there is no genuine reason to worry about fluoridation.

In 1960, however, the residents of Antigo, Wis., didn't realize that scare stories being circulated by local opponents of fluoridation were false. Antigo voted to discontinue its 11-year practice of fluoridating the water supply. The decision eventually led to a study by public health officials, who wanted to learn what effects the end of fluoridation would have on the dental health of Antigo youngsters.

During 1960, dental personnel from the Wisconsin Division of Health examined nearly all children in the kindergarten, second, fourth, and sixth grades of Antigo's schools. The examiners recorded the number of decayed, missing, or filled teeth for each child. Four years later, they repeated the examination among children in all of the same grades except the sixth.

The kindergarteners in 1964 had a rate of dental problems 92 percent higher than their counterparts four years earlier. Among second-graders, the decay rate in permanent teeth was up 183 percent. Among fourth-graders, it was up 41 percent. A subsequent examination of sixth-graders showed a 91 percent increase in decay rates. In 1965, Antigo voted to reinstate fluoridation.

Despite persisting claims about heart deaths by local antifluoridationists, the people of Antigo today still drink fluoridated water. Meanwhile, about 100 million Americans do not, largely because of the fears raised by opponents of fluoridation. The simple truth is that there's no "scientific controversy" over the safety of fluoridation. The practice is safe, economical, and beneficial. The survival of this fake controversy represents, in CU's opinion, one of the major triumphs of quackery over science in our generation.

A Fluoridation Lawsuit: CU Wins Its Day in Court

In a decision reaffirming the right of the press to speak freely in a public controversy, Judge Richard Owen of the United States District Court for the Southern District of New York has dismissed an $8-million libel suit filed against CU by a prominent opponent of water fluoridation.

The suit was filed last October by John Yiamouyiannis, Ph.D., of the National Health Federation. Dr. Yiamouyiannis charged that he had been defamed by CU's two-part report on fluoridation (CONSUMER REPORTS, July and August, 1978). The July report had criticized as baseless and misleading Dr. Yiamouyiannis's claims that fluoridation causes cancer. In its report, CU supported the practice of fluoridation as safe, economical, and beneficial.

In dismissing the suit, Judge Owen stated: ". . . the suggestion is strong that the plaintiff's object in bringing this action is to use this court to discourage the publication of opposing views."

Dr. Yiamouyiannis contended that CU, in its two-part report, had been guilty of "actual malice," a legal term meaning that the material had been published either with knowledge that it was false or with reckless disregard for whether it was false or not. In opposition, CU filed a motion for a summary judgment dismissing the complaint as meritless.

In support of that motion, CU submitted several affidavits, including extensive documentation of the facts in the report and a description of CU's research and review procedures for the report.

In granting summary judgment in favor of CU and against Dr. Yiamouyiannis, Judge Owen said:

"There is overwhelming evidence in defendant's affidavits, unrebutted by plaintiff, that the articles were prepared in a conscientious and professional manner after a thorough review of reputable sources and standard reference works on medicine and science. No serious question is raised that either the author or the editors who reviewed and approved the articles for publication had the slightest doubt as to their truth and accuracy."

Consumer Reports
Mount Vernon, N.Y.

STATEMENT OF DEAN BURK

My name is Dean Burk. I have been a research biochemist with the Federal Government for 47 years (1929-1976), including 35 years in the U.S. National Cancer Institute (1939-1974), as briefly indicated in my Curriculum Vitae attached at the end of this testimony. I wish to speak to you on the medical and financial inadvisability of adding fluorides to public drinking waters.

As indicated in Item 1 attached, I estimate that there now some 40,000 cancer deaths a year in the United States that are linked with and induced by the fluoridated drinking water that 40% of the American population is forced to drink whether it wants to or not. At the widely accepted figure of about $25,000 total cost per cancer patient death, this amounts to a national loss of the order of a billion dollars a year.

Forty thousand fluoridation-linked cancer deaths a year represent one-tenth of the total annual cancer mortality in the United States. In terms of deaths and dollars, this tragic end result of enforced fluoridation astronomically outweighs any dental benefits from fluoridation that have been claimed but seldom adequately documented. In addition to cancer, there are a large number of other medical disabilities induced by fluoridation that have been reported in detail from all over the world, and summarized in many reviews and books, such as the recent book by Dr. George L. Waldbott, M.D., et al on "Fluoridation, the Great Dilemma,"1978, 423 pp.; Cancer Control Journal, Vol. V, No. 1 and 2, 1979, 180 pp.; and in the 1977 Hearings (560 pp.) of the House of Representative Subcommittee on Government Operations (Chairman, Hon. L. H. Fountain).

I have conducted fluoridation research personally in Australia, Canada, England, Scotland, Norway, Sweden, Holland, and South Africa, in all of which countries I have been invited to consult and lecture on this subject.

Attachments 2 and 3 show graphically the abrupt and steep rise in cancer death rate induced in Birmingham, England after only a few years of artificial fluoridation of its water supply up to 1 part per million of fluoride, just as was found in the 10 largest cities in the United States, as evident in Attachment 1. The time course of cancer development here parallels closely the time course of development of cancers following the Japanese atomic bombing near the end of World War II, as reported in publications by the U.S. National Academy of Sciences and elsewhere.

All our fluoridation investigations to date have been brought to the attention of the British DHSS (Department of Health and Social Security, London), at its request, following an earlier conference held last September, attended by Health Minister Vaughan and his aides, along with Lord Douglas of Barloch (Deputy Speaker of the House of Lords), Hon. Ivan Lawrence (Chairman, Select Committee on Fluoridation, House of Commons), Sir Emmanual Kaye, Prof. Hugh Sinclair of Oxford University, and myself. Attachment 4 is a report in the London Daily Express of last October 12 in which Health Minister Gerard Vaughan announced instigation of an investigation into the safety of public water fluoridation. The concluding sentence of the article reports on the divided opinion among the medical profession as to the extent of prevention of tooth decay by fluoridation.

Attachment 5 is an abstract of a paper I have offered for presentation at the 4th International Symposium on the Prevention and Detection of Cancer to be held in London-Wembley July 26-31, 1980. As Sir Emmanuel Kaye wrote to Prime Minister Thatcher on August 8, 1979, "None of our Common Market partners has fluoridated water. Thus, there is no fluoridation in Belgium, Denmark, France, Germany, Holland, Italy or Luxembourg. There is also no fluoridation in Austria, Greece, Norway, Spain or Sweden. Of these countries, Belgium, Holland, Germany and Sweden have all had some fluoridation and have stopped it. I am sure you will agree that the authorities of these twelve countries who have no fluoridation cannot all be fools."

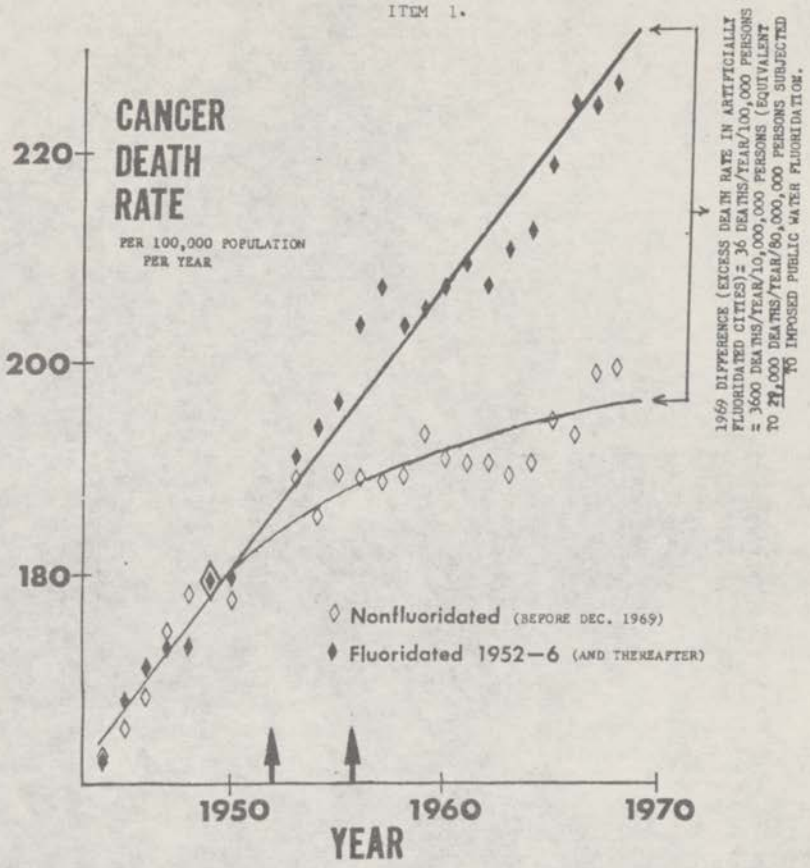
Attachment 6 is the first page of a 60-paged report by Dr. John Yiamouyiannis summarizing the most often cited articles regarding water fluoridation and cancer relations, in which, after corrections where needed, the overwhelmingly positive evidence for a cancer-fluoridation link is set forth (July 1979). Attachment 7 is a very recent statement by Dr. Yiamouyiannis on fluoride as a recognized poison affecting many life processes in addition to carcinogenesis, and the political and financial issues at stake in fluoridation.

Next month an Illinois Court is scheduled to begin hearings on a suit aimed at elimination of public water fluoridation in the State of Illinois, following upon a similar suit in Pittsburgh in 1978 in which the trial judge ordered a halt to fluoridation in the area involved.

The Province of Quebec, after extensive investigation over a period of years, instituted a moratorium in 1977 on any further public water fluoridation in that Province, and has recently curtailed or eliminated provincial funds for a small pre-existing fluoridation involving 13% of the provincial population.

Four years ago the Dutch Government by Royal Decree banned all public water fluoridation in Holland, following a detailed study of Attachment 1 and the extensive evidence supporting it.

ITEM 1.



COMPARISON OF THE 10 LARGEST AMERICAN CITIES FLUORIDATED SINCE 1952-1956: CHICAGO (1956), PHILADELPHIA (1954), BALTIMORE (1952), CLEVELAND (1956), WASHINGTON (1952), ST. LOUIS (1955), SAN FRANCISCO (1952), MILWAUKEE (1952), PITTSBURGH (1952), AND BUFFALO (1955)..... WITH 10 LARGEST AMERICAN CITIES WITH COMPARABLE CANCER DEATH RATES DURING THE PREFLUORIDATION TIME PERIOD, 1944-1950, BUT NOT FLUORIDATED AS OF 1969: LOS ANGELES, BOSTON, NEW ORLEANS, SEATTLE, CINNCINNATI, ATLANTA, KANSAS CITY (Mo.), COLUMBUS, NEWARK (N.J.), AND PORTLAND (Ore.). TOTAL RESPECTIVE POPULATIONS OF THE TWO GROUPS: 11,500,000 AND 7,000,000 PERSONS. DEATH RATES ARE PER 100,000 PER YEAR (NO DEATH RATES AVAILABLE FOR 1951-1952), TAKEN FROM "VITAL STATISTICS OF THE UNITED STATES" PUBLISHED ANNUALLY BY THE NATIONAL CENTER FOR HEALTH STATISTICS, US CENSUS ARROWS INDICATE THE YEARS OF FLUORIDATION INITIATION IN THE UPPER GROUP. SUGGESTED LINES DRAWN THROUGH THE DATA POINTS BY Dr. W. EDWARDS DEMING, CONSULTANT IN STATISTICAL SURVEYS. ALL CITIES ARE "CENTRAL CITIES". (December 1975)

Item 2.

Figure 3''. = BIRMINGHAM COUNTY BOROUGH (CB) CDRs adjusted to OPCS revised population data available here-1979 (cf. Table II' vs. former Fig. 3 and Table II).

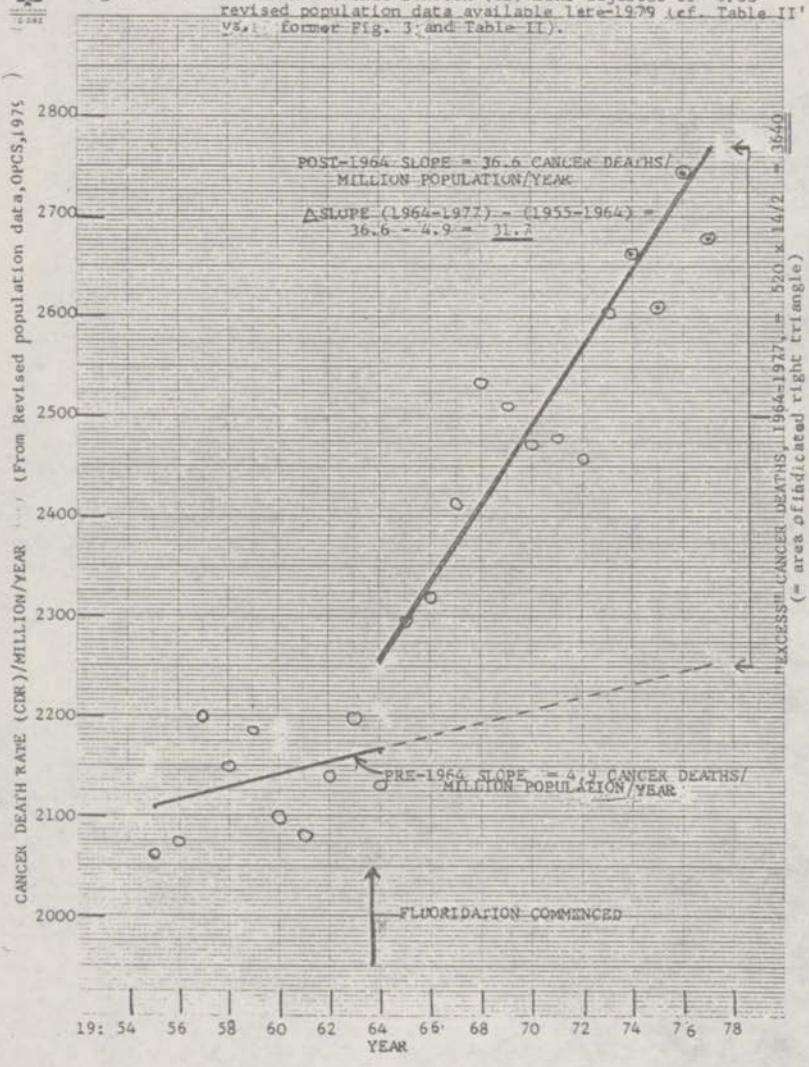
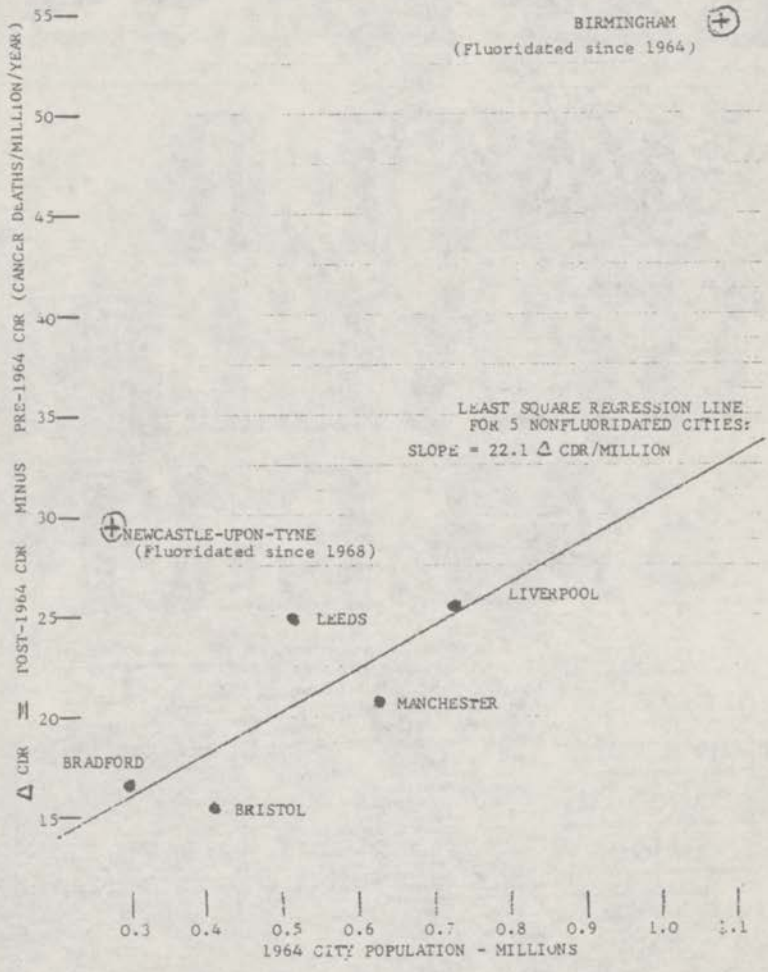


Fig. 7. A Comparison of Cancer Death Rate Increases in the 2 Major Fluoridated Cities in England with 5 Major Nonfluoridated Cities in England as a Function of City Population (Data in Tables II'', II' [Item])



Item 4.

DAILY EXPRESS
THE VOICE OF BRITAIN

No. 24,656 Friday October 12 1979 Weather: Rain 10p

WATER HEALTH ALERT



GERARD VAUGHAN

Minister orders top-level probe into fluoride

THE Government began to show doubt last night over the question : Is fluoride in drinking water safe?

A new inquiry was ordered into the controversy that has raged for 20 years.

The move follows a meeting between Health Minister Dr Gerard Vaughan and an American scientist, Dr Dean Burke.

A report by Dr Burke said that in 10 American cities with fluoride in water supplies, cancer deaths rose by between five and eight per cent.

Later Dr Burke widened research to England and claimed to have found a five per cent rise in cancer mortality in Birmingham, the first city here to introduce fluoride.

By Michael O'Flaherty

Last night a Birmingham and West Midlands health authority spokesman said: "Another investigation will be a waste of time"—for Dr Burke's figures were not supported.

However Dr Vaughan said: "I regard Dr Burke's evidence as too important to ignore and I have asked my officials to go into it thoroughly and report to me."

DIVIDED

The "pro" lobby for fluoride claims it prevents decay in children's teeth, but the medical profession is generally divided.

Item 5.

ABSTRACT FORM
The Fourth International Symposium on the
PREVENTION AND DETECTION OF CANCER
London, July 26-31, 1980

Do not fold across abstract form. Fold this page only on dotted line.
Use an envelope for mailing that is larger than the abstract form to avoid folding.

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CANCER MORTALITY LINKED WITH ARTIFICIAL FLUORIDATION IN BIRMINGHAM, ENGLAND. Burk, D. Dean Burk Foundation, 4719 44th St., Washington, D.C. 20016, U.S.A. Upon fluoridation of the Birmingham County Borough (CB) public water supply in October 1964, its ~ 1.1 million population showed one of the highest documented, abrupt, increases in cancer death rate (Δ CDR) of any large city in the world, far greater than occurred in e.g., the ~ 600,000 population of nonfluoridated Manchester CB or the ~ 300,000 population of only-15-miles-away Coventry CB, over the 10-year epoch of 1964-1973 after fluoridation compared to the 10-year epoch 1955-1964 before fluoridation. The Δ CDRs, based on linear least square regression slopes (CDR x time), for the respective three cities and two epochs, were: 38.4 - 4.9 = 33.5, 40.7 - 37.0 = 3.7, and 37.0 - 31.9 = 5.1 CD/million population/year, corresponding to a differential CDR increase in Birmingham CB, compared to Manchester CB or Coventry CB, of 30 CD/million population/year, or an annual increase of about 1.2% of the mean, annual, 1964-1973, Birmingham CDR (~ 2500), which is larger than the ~ 0.25%/year average, standardized differential for the 10 largest fluoridated cities in the US compared to 10 large nonfluoridated cities (Yiamouyiannis and Burk, Fluoride, 10, 102-123, 1977) /FLUORIDATION/CANCER MORTALITY/ BIRMINGHAM CB)/

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Abstracts will not be considered unless accompanied by the registration fee and form. Cheques must be made payable to: 4th ISPDC. All cheques originating outside the United States should be made payable in U.S. Dollars drawn on a correspondent U.S. Bank.

I wish to present a paper for: ☒Podium Session ☐Poster ☐Exhibit ☐Film

Postal address of author for correspondence:
4719 44th Street, Washington, D.C. 20016, U.S.A.
(After July 1, 1980, 23 Willow Road, Hampstead, London NW3, England)

The deadline for submission of abstracts is: January 31, 1980.
Abstacts MUST be typewritten in accordance with the instructions.

Signature Dean Burk Date January 29, 1980 (revised from Dec. 31, 1979.)

Thank you!

Page 1
(goes to ca 60 Hz)

Item 6

FLUORIDATION AND CANCER:

A REVIEW OF HUMAN EPIDEMIOLOGICAL STUDIES

A number of studies concerning a possible relationship between fluoridation and cancer have been published. The following table lists several of the investigators and the positive results of their studies after errors and omissions have been corrected.

Author	Year	Increase in Cancer Death Rate	Increase in Cancer Incidence
Austin	1975	40%	18%
Burk-Yiamouyiannis	1975-78	5-10%	
Cecilioni	1977	15-25%	
Doll and Kinlen	1977	5%	
Erickson	1978	5%	
Hagan	1954	7%	
Heasman	1964	8% (gastric)	
Hoover	1975		8-10%
Kinlen	1974		5%
Knutson	1962	22%	
Oldham and Newell	1977	5%	
Taves	1977-78	5%	

On the basis of their results, many of the above investigators claimed no link between fluoridation and cancer. The purpose of this paper is to summarize and critically review the most important and the most often cited papers regarding fluoridation and cancer in an attempt to resolve this paradox.

John Yiamouyiannis, Ph.D.
Science Director
The National Health Federation
6439 Taggart Road
Delaware, Ohio 43015
U.S.A.

July 1979

Item 7.

Fluoridation and Cancer:

Science vs. Politics

By Dr. John Yiamouyiannis

The significance of the political struggle over fluoridation goes far beyond the issue of whether or not fluoridation is harmful to health. Scientifically, there is no question that fluoridation creates a public health hazard. The 1979 *Physicians' Desk Reference*, the basic reference source for drugs in the United States, points out, on page 1692:

"Dental fluorosis (mottling) may result from exceeding the recommended dose, i.e., the dose found in one pint of fluoridated water.

"In hypersensitive individuals, fluoride occasionally causes skin eruptions such as atopic dermatitis, eczema, or urticaria.

"Gastric distress, headache and weakness have also been reported.

"These hypersensitive reactions usually disappear promptly after discontinuation of the fluoride."

As pointed out on pages 70 to 73 of the U.S. National Academy of Sciences publication *Fluoride* (1971) a number of enzymes (proteins responsible for the mediation of all life functions) are inhibited by fluoride at levels down to and including the 1 part per million used to fluoridate public water systems.

In 1976, this level of fluoride was shown by Drs. W. Klein, and coworkers of the Seibersdorf Research Center in Austria to inhibit an enzyme responsible for maintaining the genetic integrity of all living things, including man. During the same year, Dr. Mohamed, well-known geneticist and acting chairman of the Department of Biology at the University of Missouri (U.S.A.) reported that 1 ppm sodium fluoride caused genetic damage in bone marrow and testes cells.

Substances which cause genetic damage are termed "mutagenic." It is a well-accepted fact that mutagenic substances also tend to be carcinogenic, or cancer causing. In fact, this is exactly what has been found.

In 1963, Drs. Herskowitz and Norton of St. Louis University (U.S.A.) found that low levels of fluoride increased the incidence of melanotic tumors in fruit flies by 12 to 100%. The results of their study were published in volume 48 of the prestigious journal *Genetics*, pages 307 to 310. Two years later Drs. Taylor and Taylor of the University of Texas found that adding 1 ppm fluoride to the drinking water of cancer prone mice increased tumor growth rate 25% and published their results in volume 119 of the *Proceedings of the Society of Experimental Biology and Medicine*, pages 252 to 255.

Considering these studies, Dr. Dean Burk, former chief chemist of the U.S. National Cancer Institute, and I initiated further studies to determine whether similar increases in cancer death rates could be observed in human populations. The results were published in the official journal of the International Society of Fluoride Research and pointed to a 5% increase in cancer death rate after taking age, race and sex into account. Profluoridationists claimed that when age, race and sex were corrected for simultaneously by the "SMR method" no differences in cancer death rates could be observed. This claim was laid to rest when Dr. Burk and I pointed out that those making these claims had purposely left out 80-90% of the data and made a mathematical error and that when these errors and omissions were corrected, the SMR method confirmed our results, showing a 4-5% increase in cancer death rate.

As a result of the overwhelming scientific evidence showing the adverse effects of fluoridation, it is not surprising that the Pittsburgh (U.S.A.) Court, after listening to top experts (including representatives from the U.S. National Cancer Institute, the U.S. National Institute of Dental Research, the U.S. Academy of sciences, the Royal College of Physicians, and the Royal Statistical Society) from around the world, stated: "Point by point, every criticism defendants made of the Burk-Yiamouyiannis study was met and explained. Often, the point was turned around against defendants." The Court ruled that it was "compellingly convinced" of the adverse effects of fluoridation and ordered a halt to it as a public health hazard.

Yet some still insist: "All studies show that fluoridation of domestic water is safe." The reason, of course, is political (not medical or scientific).

A number of "prestigious" organizations, on the basis of inadequate and incomplete data endorsed the addition of subacute doses of a poisonous substance, fluoride, to the water supplies. Now spokesmen for these organizations find it hard to admit that they could have been wrong, preferring instead to cover up the death and destruction wrought by fluoridation by citing the endorsements of each other's organizations, by villifying scientists who report on the adverse effect of fluoridation, and by citing "Dozens of world-wide studies" which they carefully neglect to identify.

If the fight to stop fluoridation is lost, it will mean that politics has finally won out over science-in-the-public-interest and that the health of the people must take a back seat to the "reputations" of "prestigious" organizations who will not admit their mistakes and to the corporate profits that are dependent on economically dumping their waste products, such as fluoride, into the air we breathe and the water we drink.



Dr. John Yiamouyiannis, internationally-known fluoridation expert, has been science director of the National Health Federation since 1974. He received his B.S. in biochemistry from the University of Chicago and his Ph.D. in biochemistry from the University of Rhode Island. He is co-editor of the scientific journal, FLUORIDE. His work with Dr. Dean Burk relating fluoridation to cancer triggered full-scale hearings before a House subcommittee of the Committee on Government Operations in 1977.

Item 8

FROM MARQUIS WHO'S WHO IN AMERICA

Vol. 38, 1974-75 (to date)

AND

MARQUIS WHO'S WHO IN THE WORLD

Vol. II (1974-75) (to date)

Burk, Dean, biochemist; b. Oakland, Calif., Mar. 21, 1904; s. Frederic and Caroline (Frear) B.; B.S. U. of Calif., 1923, Ph.D., 1927; fellow Nat. Research Council and Internat. Edn. Bd., 1927-29 at U. of London (Univ. Coll.), Kaiser Wilhelm Inst. for Biology, Harvard; married Mildred Chaundy, January 28, 1929; children — Diana (Mrs. Richard A. Barker), Wendy (Mrs. Charles Maiorana), Frederic Chaundy; Asso. Phys. Chemist Fixed Nitrogen Research Lab., Dept. Agr., Wash., 1929, chemist, 1937-39; sr. chemist Nat. Cancer Inst., Nat. Insts. Health, Bethesda, 1939-48, prin. chemist, 1948-51, head chemist 1951-58, chief chemist 1958-74; asso. prof. biochemist Cornell U. Med. Coll., 1939-41; research master grad. faculty George Washington U., since 1947. Guest research worker U.S.S.R. Acad. Scis. (Biochem Inst.), Moscow, 1935. Mem. bd of dirs. Science Resources Foundation; Recipient of Domagk prize for cancer research, 1965; decorated Knight comdr. Med. Order Bethlehem; Fellow A.A.A.S. (organizer, chmn. research confs. on cancer, 1942-45); Mem. Am. Chem. Soc. (Hillebrand Award, 1952), Am. Soc. Biol. Chemists, Am. Assn. Cancer Research, Am. Soc. Plant Physiologists, Soc. Exptl. Biology and Med., (Chmn. 1949-50, sec.-treas. 1948-49), Am. Inst. Biol. Scis., N.Y., Washington Acad. Sci., Soc. Gen. Physiology, L.I. Biol. Assn., Harvey Soc, Chem Soc. Washington, Max Planck Assn. Goettingen, Inst. for Cell Physiology, Berlin, Royal Society Medicine, London; National Trust, Gt. Britain; Dolmetsch Found. Haslemere (foreign); Gamma Alpha, Sigma Xi; Clubs, Cosmos Club Wash. and Commonwealth Club of California; Author: Cancer, 1945; Approaches to Tumor Chemotherapy, 1947; Cell Chemistry, 1953. asso. editor: Record Chem. Progress, 1943; Proceedings Soc. Exptl. Biol. and Med., 1948-53, Enzymologia since 1937. Contbr. 250 sci. articles, Home: 4719 - 44 St. N.W. Washington, D.C. 20016.

Appointments and Awards, 1973-1974

1. Foreign Scientific Member, Max Planck — Institute of Biochemistry, Munich, Germany.
2. Honorary President, German Society of Medical Tumortherapy, Heidelberg, Germany.
3. Editorial Board, Krebsgeschen, Heidelberg, Germany.
4. Editorial Board, Cancer Biochemistry and Biophysics, Brunswick, N.J.
5. Cancer Control Society Humanitarian Award, Los Angeles.
6. Wisdom Society Award of Honor, Los Angeles.
7. Knight of Mark Twain Society (Succession to Sir Alexander Fleming), Missouri.
8. Distinguished Service Award in Biochemistry, Dictionary of Interntaional Biography, England.
9. Humanitarian Award, International Association of Cancer Victims and Friends, Los Angeles.
10. Guest Scientist, U.S. Naval Medical Research Center, Bethesda, Maryland 20014, 1974-1976.

THE DEAN BURK FOUNDATION

The Dean Burk Foundation, Inc., with headquarters at 4719 - 44th Street N.W., Washington, D.C. 20016 (Tel. 202-363-6279) was incorporated in the District of Columbia on November 18, 1974 as a non-profit corporation and non-private (public) foundation, and will be devoted to research on health, nutrition, chronic and degenerative diseases including cancer, will publish reports on same, will assist other groups and individuals with common goals, and will provide related educational material. The Foundation is exempt from federal income tax under section 501(c)(3) of the Internal Revenue Code.

STATEMENT OF GERTRUDE ENGEL

My name is Gertrude Engel. I represent the Save the United States Movement, dedicated to health practices, founder and national chairman, Bob Hoffman, Ph.D., of York, Pennsylvania; and the National Health Federation, based in Monrovia, California.

It is indeed a privilege to be here, and I thank you for the honor. We humbly request, please, that the appropriation in the proposed budget for 1981, to the Center of Disease Control, incidental to water fluoridation be rejected.

Today is my birthday. We are affirming my theme song, "Let there be health, the greatest of all possessions on earth, and let it begin with a cast of thousands which includes you and me to live longer and look younger."

What is water fluoridation?
It is the controlled adjustment of a water supply for a concentration of about one part of the fluoride ion in a million parts of water or 1/10,000 of one percent fluorides in water.

The fluoride ion is a chemical element that occurs in the environment of man, in soil, vegetation and water. Trace amounts are present in air. Fluoride is found in varied amounts in nearly all regions of the entire world. Nearly all food items contain some fluoride. To totally avoid intake of fluoride in food, you literally would have to starve to death.

Fluoridation does not affect the taste, the odor or the color of water in its use for any cosmetic or industrial purposes. Hardness of the water has no effect. One hundred five million people in America drink fluoridated water. How unfortunate!

Flourine (in the form of fluoride) is classified by the National Academy of Sciences as an essential trace element which can be toxic in excessive quantities. At high concentration, fluoride has been used as a poison for insects and rodents.

The Food and Drug Administration admits that fluoride is not listed on the Generally Recognized as Safe (GRAS) list. It is a toxic material. It is regulated food additive and must have clearances for dosages and is subject to safety and usage information.
Fluoride is still classified as a schedule "A" poison in the State of California.

Dr. Georgina Jagiello and Dr. Ja-Shine Lin, Columbia University, recently confirmed that fluoride as a potential mutagen in organisms tested had the power to damage the nucleic acid and the chromosomes which is the first step toward cancer. (Chromosome: the body within a cell that contains the genes, which are responsible for the child's inheritance of the parents' appearance and traits.)

Dr. Aly Mohamed, a professor of biology at the University of Missouri, Kansas City, reported that as little as 1 ppm of fluoride in drinking water can produce permanent genetic damage in mice. The chromosomal damage and breakage observed in his study, Mohamed says, is believed to be the direct result of fluoride's acting on DNA, (abbreviation for deoxyribonucleic acid, the fundamental component of living matter.)

Dr. William Foege, director, Center for Disease Control, appeared before the Senate Appropriations Subcommittee. He asked for an increase of $3 million for a fluoridation grant program to improve dental health. He was supported with $6.2 million in late November, 1979. "Our aim is to have reached more than 700 communities by the end of 1981, and over

a ten year period, to reach near universal fluoridation of approximately 8,600 currently fluoride deficient water systems."

Senator Harrison Schmitt (R. New Mexico) chaired the meeting. He said, "I am being the devil's advocate. Will the states be using some of their own money?" He questioned the rightness of giving money to the states. He then asked about the correlation of flouridation to cancer.

Dr. Foege continued, "The National Cancer Institute has not been able to show fluoridation affecting cancer cases." In our research we discovered that a report submitted by the NCI dated September, 1977, to the Intergovernmental Relations and Human Resources Subcommittee, demographic veriables of age, sex, and race were taken into account, and it was reported they found no contribution of fluoridation of water to cancer risk in these data.

However, the data from all the studies were independently reviewed by Dr. Donald Taves of the University of Rochester at the request of the National Academy of Sciences Safe Drinking Water Committee. Dr. Taves concluded that the available evidence does not suggest that fluoridation has increased or decreased cancer mortality rates. This evidence does not establish much accreditation. There was no experimental work. Therefore, we consider the report to be faulty, out of date, and irrelevant.

Emanuel Roth, chairman of the Coalition for Pure Water, Allentown, Pa., questioned the validity of the appropriations and showed a copy of a letter sent from Dr. Foege to Senator Jacob Javits (R. New York) which read, "The fluoridation public awareness component is an educational approach designed to make the population aware of the benefits and safety of fluoridation." Roth sent his message to members of Congress, informing them that the tax monies were being spent for promotion of fluoridation. Roth said, "This hypocrisy must come to an end!"

I ask, "Why should we be educated to poison ourselves?"

At the House Appropriations Subcommittee meeting Congressman Carl Pursell (D. Michigan) made inquiries. Dr. Foege reiterated his request for $ 9.5 million to provide technical assistance and advice for the basic thrust of extending to the states a fluoridation program. This would involve nine additional states, including 194 school districts, affecting 5.2 million people.

Dr. Foege replied, "The states do not have the money."
Pursell said, "I differ with you. The states do have the resources."

The city council of Lansing, Michigan, voted to put the issue on the November, 1980 ballot and let the people decide the fate of flouridated drinking water.

At the National Governors' Association conference passed a resolution: The statement called for an extension of the deadline of the Environmental Protection Agency flouridation standards until the completion of independent studies that will allow policymakers to balance health concerns with economic considerations. Wisconsin's Governor Lee Dreyfus said, "We should not spend the money."

Victor Kimm of EPA informed me that they are researching the adverse reactions to fluoridation - the severity of flurosis which means mottling of the enamel of the teeth due to excess fluorides in drinking water.

William Donald Kelley, D.D.S., Washington (State) commented, "Fluoridation of water supplies has been indicted as contributing to many diseases. We have found another harm to fluoridation. That it causes weight gains. This will upset people more than the possibility of fluoride causing cancer.

Fluoride inhibits all the enzymes in the body. (Enzyme: a substance manufactured by living tissue which stimulates specific chemical change.)

"My oldest daughter did an experiment of the effect of fluoride in animals.

"She won a state prize. She found that 1 part per million (the concentration in flouridated water) had as many destructive effects as 150 parts per million. The University of Texas is finishing a 2 year study along similar lines."

Dr. Hans Nieper, world famous renowned cancer spealist from Germany, visited Washington February 28, 1980. My interview was most informative. We learned that fluoride is carcinogenic and also causes brain damage in children.

Since the President has asked for cuts in the Federal budget, we believe that millions of dollars could be eliminated by allowing local communities to finance their own projects.

Nutrition plays an important part of our lives. Considering the percentage of fluoride in the food we consume, it behooves us to realize how much fluoride is in fruits, vegetables, et cetra. The analysis of individual foods listing fluoride content is presented to give an estimate of fluoride levels in comparable foodstuffs in the 1940's and 1960's. Fluoride levels in foods are likely to be higher in areas with fluoridated water because of the use of cooking water. Beverages have fluoride levels much higher than water. Fish has a high fluoride concentration. Food prepared in fluoridated water increases fluoride intake.

All dental literature uses similar statements regarding children-"tooth cavities must be preventd." Hence, the call to fluoridated water. Dental associations surely must know that sugar is the culprit. Dentists know that sugar is a cavity producer. Tell our children to eat nuts, fresh fruits and vegetables. Disease is conquered by inner purification. What happens as one grows older? We hardly touch upon gum disease which is prevalent among adults.

From Dr. Jack Alpan, D.D.S. (Let's Live Magazine March, 1980)
"Should we put fluoride on children's teeth?
Fluoride treatments are the last thing, I'd recommend for two important reasons. Cavaties do not originate from the outside, but from deep within the teeth as the result of a metabolic imbalance throughout the entire body. You should listen to what nature is telling you and take a long, hard look at what your children eat at home and at school. A nutritionally minded dentist, skilled in reastablishing normal glandular function through balanced body chemistry can do wonders for your children's teeth as well as their total health.

"Rampant tooth decay is merely a sympton of a much more serious health problem-an imbalanced body chemistry. The second reason I don't recommend fluoride treatments is because fluoride is a potent poison that can harm the body in a number of different ways.

"Fluoride prevents the body from utilizing calcium permanently. If this is true, then painting the teeth with fluoride would not only be dangerous but directly counter-productive, since efficient calcium utilization is essential to good teeth."

Dr. Joe Nichols, chairman of the board, Natural Foods Association, Atlanta, Texas.

"Fluoride is one of the most toxic chemicals in use today. It is a powerful protoplasmic poison and an enzyme inhibitor. It has been the most commonly used ingredient of rat poison for many years.

"Fluoride is a vitamin antagonist and an enzyme inhibitor. It is one of the causes of birth defects.

"I suggested to the Texas delegates that we had no right to endorse a resolution that would force our young mothers to drink poisoned water that would increase the incidence of birth defects.

A majority of the delegates voted NO. The Texas State Medical Association has never endorsed this wicked unscientific hoax. Artificial fluoridation has been banned in most European countries and also in South Africa.

"There is a dramatic increase in the incidence of cancer in cities where artificial fluoridation has been forced on the people.

"There is no way to control the dose of this poison when you dump it in the water supply. Many people drink more than one quart of water every day."

When it was revealed in 1979 that the illnesses of nearly 100 babies were due to infant formulas, the American Academy of Pediatrics recommended removal of fluoride water from the formulas. Food and Drug Administration's Dr. Allen Forbes remarked at a recent consumers meeting that this has been accomplished.

National Health Federation's Science Director Dr. John Yiamouyannis is investigating the accidental discharge of excessive gallons of fluoride into the water system of Annapolis, Maryland, which caused the death of one man and the illness of seven other dialysis patients. Other persons are believed to have suffered fluoride poisoning. More data is expected.

The National Health Federation has definitely established,"Fluoridation of water supplies has increased the risk of cancer. Through the years Dr. John Yiamouyannis and Dr. Dean Burk have substantiated fluoridation facts. (Burk Foundation)

Dr. John R. Lee from Hill Valley, California

"The ultimate shocker is the toxic effect fluoride has on genes.

"Painstaking research at the International Institute for the study of Human Reproduction, Columbia University College of Physicians and Surgeons, as well as at the University of Missouri, has proven beyond doubt that fluoride is mutagenic, i.e., it damages genes in mammals at doses approximating those we humans receive from artificial fluoridation exposure.

"Fluoride poisoning is enzymatic and biochemical functioning. Its manifestations are the result of many co-incidental, contingent factors.

Let us rid our society of this one deliberately added toxin at least and get on to other aspects of optimal health.

National digest

Judge halts fluoridation

PITTSBURGH — A judge has ordered a halt to adding fluoride to the water supply of nearly 30 suburbs because he says a new study shows fluoridation might cause cancer. In a decision he said would have "international repercussions," Judge John Flaherty yesterday ordered the West View Water Authority to stop adding fluoride to its water. The decision, which affects 27 Pittsburgh area communities, was handed down on a suit filed in Allegheny County Common Pleas Court last March 1 by the Citizens Committee Against Fluoridation for Western Pennsylvania, and others. The suit charged that adding fluoride at a level of one part per million is a menace to public health because of the possible link between fluoride and cancer. The company's water naturally contains 0.34 parts of fluoride per million parts of water.

Fri., Nov. 17, 1978 ☆ S.F. EXAMINER—Page 15

Judge Bans Fluoridation

Pittsburgh

Allegheny county Common Pleas Judge John Flaherty, saying he is convinced of a possible fluoride-cancer link, ordered the West View Water Authority yesterday to stop adding fluoride to water it supplies to 77 communities near Pittsburgh.

The decision was handed down in a suit filed last March by the Citizens Committee Against Fluoridation for Western Pennsylvania.

The suit charged that adding fluoride to water at a level of one part per million is a menace to public health because of the possible link between fluoride and cancer.

The company's water naturally contains 0.34 parts of fluoride per million parts of water.

In 1968, the state gave West View Water permission to add fluoride to its supply of water for 160,000 residents in the North Hills and Ohio river areas of Pittsburgh.

In his ruling, Flaherty said there is "a significant increase in cancer mortality in the fluoridated cities."

Saying his ruling will have "international repercussions," he cited telephone calls to his office from Ireland, Sweden and Canada.

The judge said a number of suits have been filed in recent years against the chemical, textile and shipbuilding industries by victims of cancer and other diseases, "who are now suffering ten, 20 and 30 years later from exposure to carcinogens.

United Press

San Francisco Chronicle ★ Fri., Nov. 17, 1978

Exhibit A

6.

Fluorides in Various Foods Cited by McClure (1949)[13] (ppm, fresh wt.)		Fluorides in Food Groups from San Filippo & Battistone (1970)[14] (Range of 4 diet samples) (ppm fresh wt.)
Whole Milk	0.7-0.22	Group I. Dairy Products, 0.11-0.22
Commercial Milk (Range 0.1-0.7)	0.1-0.3	
Chicken	1.4	Group II. Meat, fish and poultry 0.42-1.04
Beef	2.0-2.9	
Pork	0.34-1.2	
Fish (filets)	1.49	
Salmon (canned)	4.5	
Codfish	7.0	
Tuna (canned)	0.1	
Eggs (Range 0.1-7.0)	0.13-0.46	
White bread	0.54-1.0	Group III. Grain and Cereal Products 0.26-0.59
Bisquits (Range 0.54-2.0)	0-2.0	
Potatoes	0.13-0.45	Group IV. Potatoes, 0.13-0.2
Cabbage	0.3	Group V. Leafy vegetables, 0.13-0.85
Spinach	0.2-1.8	
Celery (Range 0.1-1.0)	0.1-0.7	
Green beans	0.11-0.15	Group VI. Legume vegetables, 0.19-0.25
Peas (Range 0.11-0.6)	0.6	
Beets	0.2	Group VII. Root vegetables, 0.06-0.22
Carrots	0.4	
Onion	0.24, 0.6	
Turnips (Range 0.2-0.6)	0.3	
Tomatos	0.24	Group VIII. Garden Fruit, 0.07-0.41
Cucumbers	0.2	
Eggplant (Range 0.2-0.4)	0.4	
Grapefruit	0.36	Group IX. Fruits, 0.10-0.11
Oranges	0.15-0.34	
Apples	0.035-1.3	
Apricots	0.02-0.22	
Peaches	0.21	
Grapes	0.16	
Plums	0.21	
Strawberries (Range 0.02-0.36)	0.18	
--		Group X. Oils & Fats, 0.12-0.45
Sugar	0.32	Group XI. Sugar & Adjunct, 0.3-0.56
Malt	1.0, 1.5	
Tea (brewed)	1.19	Group XII. Beverages, 1.1-1.22

While it is not strictly valid to compare mixtures of commodities (as from San Filippo and Battistone) with the older individual commodities, it can be seen that there does not appear to be a large or consistent elevation of present day foods above similar foods of a few decades ago. The effect of the use of fluoridated water for canning must be accounted for, however.[1] The following table illustrates some more recent analyses of canned foods and a comparison with similar foods from McClures' report:

	Canned Goods (Fluoride Content in ppm)			Fresh Goods
	Marier & Rose (1966)[1]		Osis, Kramer, Wiatrowski & Spencer (1974)[2] (Data from 1967-1972)	McClure (1949)[13]
	Canned in Non-Fluoridated Water	Canned in Fluoridated Water		
Green Beans	0.2	0.89	0.43 (0.32-0.72)	0.11-0.15
Potatoes	0.38	0.76	0.6 (0.32-0.95)*	0.13-0.2
Carrots	0.19	0.61	0.86 (0.34-2.02)	0.4
Peas	0.1	—	0.59 (0.24-1.07)	0.6
Tomatos	—	—	0.46 (0.14-0.63)	0.24
Pork & Beans	0.27	0.77	—	1.4**

* Prepared for serving in hospital menu in city with fluoridated water.
**Canned goods.

Again, differences in sampling and analysis prevent precise comparison, but it would appear that the use of fluoridated water in canning has resulted in some increase in the fluoride level of certain foods, as would be expected. However, the amount of this elevation for the diet as a whole cannot be estimated from any available information.

The extrapolation from individual items to estimates of population's fluoride intake is another problem. McClure (1949) based his estimates on grouping foods roughly by fluoride value and estimating the likely mix that would give a diet of normal caloric intake.[13,15] His estimate was from 0.25 - 0.3 mg/day from food. An estimate from the later marketbasket survey was made by considering the likely mixture of amounts of twelve food commodities

SATURDAY, JANUARY 20, 1979
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$750,000 Given In Child's Death In Fluoride Case

Boy, 3, Was in City Clinic for Routine Cleaning

By ROBERT D. McFADDEN

A State Supreme Court jury awarded $750,000 yesterday to the parents of a 3-year-old Brooklyn boy who, on his first trip to the dentist in 1974, was given a lethal dose of fluoride at a city dental clinic and then ignored for nearly five hours in the waiting rooms of a pediatric clinic and Brookdale Hospital while his mother pleaded for help, and he lapsed into a coma and died.

The award — $600,000 for the wrongful death of the boy, William Kennerly, and $150,000 for the pain and suffering he endured in the hours before his death — was by far the largest ever made in New York State for the death of a 3-year-old, according to the lawyers for the parents, Clay Kennerly, 45, an $8,000-a-year city exterminator, and his wife, Inez, 42, of 300 Dumont Avenue in the Brownsville section.

The child, according to testimony at a four-day trial in State Supreme Court in Brooklyn, suffered spasms of vomiting and nausia, headaches and dizziness, and had to be revived from a coma by an injection of adrenalin into his heart several hours after his ordeal began.

The boy was then made to wait — in shock, another coma and finally in a state of cardiac arrest — for more than an hour before getting further treatment, witnesses said.

Stomach-Pumping Suggested

Other testimony indicated that the boy might have been saved at almost any time during the four hours and 20 minutes before he died by having had his stomach pumped or by having him drink some milk or lime water, which would have changed the fatal fluoride compound he had been given into a nontoxic calcium fluoride.

The defendants in the case were New York City, its Health and Hospitals Corporation and one of its clinics, the Brownsville Dental Health Center; Brookdale Hospital and its Brookdale Ambulatory Pediatric Care Unit; Dr. Bradford George, a dentist; Roslyn Cohen, a dental technician, and Dr. Preeti Bathia, a Brookdale pediatric clinic physician.

After more than a day of testimony by Mrs. Kennerly and medical and toxicological experts, and what were described as thorough investigations by the city and Brookdale Hospital, lawyers for the defendants on Thursday conceded liability, and the jury of five women and one man was instructed by Justice John A. Monteleone to return a verdict for the plaintiffs and to decide the damages to be assessed.

After the jury's verdict at 2:30 P.M., the defendants' lawyers, George W. Weiler for the city and James Hayes for Brookdale Hospital, moved to set the award aside as excessive. Justice Monteleone denied the motion, but said he would consider written motions for a reduction.

Some Reduction Proposed

Morton L. Penkert, the lawyer for the Kennerlys, who have eight other children, said the family would not object to a reduction of the $600,000 award for wrongful death to $500,000 because that was the amount originally asked in the suit. But he said the family had sought $500,000 more for the child's suffering and

Continued on Page 34, Column 3

THE NEW YORK TIMES,

$750,000 Is Awarded In Death of a Child, 3, From Dose of Fluoride

Continued From Page 23

would resist efforts to cut the $150,000 awarded for that.

The story of the boy's death was related by his mother during the trial. She recalled that she took William, born on Feb. 7, 1971, for his first dental checkup on May 24, 1974, to the Brownsville Dental Health Center, a city clinic at 259 Bristol Street.

There, he was examined by Dr. George, who found no dental caries and turned the boy over to Miss Cohen, a dental hygienist, for a routine teeth-cleaning procedure. After cleaning William's teeth, witnesses explained, Miss Cohen, using a swab, spread a stannous fluoride solution in the form of a jell over the boy's teeth as a decay-preventive measure.

Fluoride in small amounts is mixed into various brands of toothpaste and the drinking water of some communities to prevent tooth decay. When used by a dentist or dental hygienist after a teeth cleaning, the fluoride jell is in a relatively strong solution, and a patient is told not to swallow it.

Instead, after the solution is allowed to remain on the teeth briefly, the patient is given water and told to wash his mouth out and expectorate.

Fatal Solution Swallowed

According to Mrs. Kennerly, Miss Cohen was engrossed in conversation with a co-worker while working on William and, after handing him a cup of water, failed to instruct him to wash his mouth out with it and spit out the solution. Mrs. Kennerly said that Miss Cohen was not paying attention when William drank the water about 9:30 A.M.

In drinking the water, according to a Nassau County toxicologist, Dr. Jesse Bidanset, William ingested 45 cubic centimeters of 2 percent stannous fluoride solution, triple an amount sufficient to have been fatal.

Upon leaving the dentist's chair, William began vomiting, sweating and complaining of headache and dizziness. His mother, appealing to the dentist, was told the child had been given only routine treatment. But she was not satisfied, and was sent to the Brookdale Ambulatory Pediatric Care Unit in the same building.

REMEMBER THE NEEDIEST!

Fluoridation Is Forced Medication

Fluoridation is the addition of fluoride chemicals to the public water supplies at a concentration of 1 part per million (1 ppm) for the alleged purpose of reducing tooth decay in children up to age 10 (while the enamel is being formed). Fluoride is regulated as a prescription drug by the U.S. Food & Drug Administration, so fluoridation is forced mass medication and a violation of civil liberties. The function of a public water supply is to provide pure, safe water for everybody, NOT to serve as a vehicle for dispensing drugs.

Fluoride Is An Accumulative Poison & Enzyme Inhibitor

Fluorides are highly toxic and have long been used as insecticides and rodenticides. Fluoride accumulates in the body like lead, inflicting its damage over long periods of time. Even at concentrations lower than that used for fluoridation, fluoride inhibits enzymes vital to normal biochemical processes in the body. It is most dangerous to those with kidney or thyroid disorders, diabetes, cardiovascular disease and allergic tendencies.

Fluoridation Does Not Reduce Tooth Decay Permanently

It merely delays its onset from 1 to 2 years. Baltimore, fluoridated since 1952, has one of the highest tooth decay rates in the country.

At Least 30% Of Children Consuming Fluoridated Water Develop Irreversible Mottling and Staining of the Permanent Teeth

This mottling, known as dental fluorosis, is a recognized criterion of harm and is visible proof of damage caused by fluoridation.

Fluoridation Pollutes

Fluoride is recognized as a pollutant by the Federal Environmental Protection Agency. This agency tested 79 water supplies in 1975 and found them all to contain traces of hazardous chemicals. Fluoridation deliberately adds thousands of tons of toxic chemicals to our already contaminated drinking water supplies. The synergistic effects of fluoride with other pollutants have not been studied.

Total Fluoride Intake Has Dangerously Increased In Recent Years

Fluoride now reaches us from foods and beverages processed with fluoridated water, pharmaceuticals, aerosols, pesticides, herbicides, industrial air pollution and auto exhausts. Adults living in fluoridated areas now ingest from 3 to 5 mg. of fluoride per day which far exceeds safe levels of fluoride intake established by the U.S. Food and Drug Administration.

Fluoridation Wastes Your Tax Dollars

Less than .04% of the water supply is consumed by children under age 10, yet the taxpayer must pay to fluoridate the remaining 99.6%. Free fluoride tablets could be made available for 1/5 the cost of fluoridation (as in Clifton, New Jersey). Overall costs of dental care are not lower in fluoridated areas.

Fluoridation Is Not Necessary

Alternative sources of fluoride are readily available as tablets, rinses, fluoridated vitamins, dental applications, toothpastes, etc. These methods are optional, the dosage can be better controlled, and the treatment can be stopped when no longer needed, desired, or if an intolerance should develop.

Fluoridation Is Unscientific and Medically Unsound

Sound medical practice requires precise dosages of a drug be given according to individual needs. Fluoridation administers haphazard dosages, determined by the quantity of water consumed. Whole populations are randomly medicated for a lifetime although no benefit is claimed for those over age 10. Unlike chlorine, which partially evaporates from water during boiling, fluoride does not evaporate, and becomes more concentrated as the water boils off.

Artificially Fluoridated Water Is More Dangerous Than Water Containing Natural Fluoride

Where fluoride occurs naturally, it is generally in hard waters containing other minerals such as calcium and magnesium which mitigate its harmful effects in the body.

Fluoridation Has Been Rejected By Most of Western Europe
And Is Legally Banned In Holland, Denmark and Sweeden

These medically advanced nations have carefully studied the issue and found that proponents' claims of safety and effectiveness cannot be substantiated.

Fluoridation Is A Major Medical-Dental Mistake

Fluoridation was prematurely endorsed by the medical-dental-public health establishment in the early 1950's. There is no face-saving way to back down from these endorsements, so qualified critics of fluoridation are ignored or maligned, and adverse evidence is routinely excluded from major medical and dental journals. The average doctor and dentist knows little about the scientific evidence against fluoridation or the politics behind the issue.

Would you want fluoride in your water if you knew it was harmful to your family's health?
Would you force it on your neighbor?

Report of the Governor's Task Force on Fluorides

State of Michigan December 1979

excerpts

Recent research indicates that there are a number of elements which can affect the incidence of dental caries.

While much has been written on the natural sources of fluoride in the environment (such as volcanic gases and soluble fluorides in the earth's crust) a significant portion of the fluoride which now enters the human body is from modern, human-made sources in the air, water, food and forage.

Of primary concern are the effects of ingested fluoride on the skeleton, its relationship to the kidneys and the possibility of either allergic reactions or an intolerance to fluoride which may result in systemic intoxication.

Prolonged excessive fluoride intake can result in a variety of gastrointestinal and arthritic symptoms and eventually results in crippling skeletal fluorosis. Skeletal fluorosis . . . may occur in industrial settings and in persons with excessive thirst and kidney impairment who ingest or retain fluoridated water in greater amounts than normal.

Persons with insufficient renal function may not adequately clear fluoride from the blood for excretion in urine resulting in excessive deposition in the skeleton.

Another condition which functionally impairs the kidney, "diabetes insipidus," raises the possibility of an additional very small segment of the population which may have a greater than normal risk from fluoride intake.

Fluoride may have been a complicating or causative factor in certain bone diseases experienced by patients undergoing dialysis with fluid made with fluoridated water . . .

The level of intake of fluoride by humans is of great concern because, as with many minerals that are considered essential trace elements in human nutrition, fluoride can be toxic when ingested in amounts slightly above levels which are tolerable.

The current total daily intake of fluorides by adults in Michigan communities with fluoridated water is estimated to be from 2 mg to 5 mg.

While it is often maintained that the optimal level of daily fluoride intake is that dose associated with 1 ppm in drinking water, the criteria for this assumption are unclear.

Consideration of the average total intake of fluoride from all sources is necessary for the determination of optimal fluoride prophylaxis, and minimal associated risks.

The effects of fluoride intake on persons with nutritional deficiencies has not been well studied. Neither has the possible existence of pre-skeletal fluorosis in a small number of persons been adequately studied . . . There exists a possibility that a small portion of the population has an intolerance to fluoride at levels of intake obtained from food and waterborne fluoride.

We have not attempted to weigh the rights of these individuals against the benefits to the community as a whole, believing this to be a political rather than a scientific decision, but we recommend that provision is made to permit such individuals to avoid exposure to fluoridated water if they so desire.

Recognizing the trend of increasing intake of fluoride observed in the last 25 years, it is possible that the concentration of fluoride in artificially fluoridated systems may require downward revision at some time, to maintain the optimum trade-off point between dental fluorosis and caries prevention.

B-12 THE STATE JOURNAL Sun., Sept. 23, 1979

Fluoride worth good checkups — maybe

By JERRY MOSKAL
Capitol Bureau

Fluoride is still worth all those good dental checkups as far as eight Michigan researchers are concerned, even though they concede it could harm some people's health.

The governor's task force has been at work on the knotty issue for nine months now, compiling the most comprehensive study in recent years. The final report is expected in three or four weeks.

THE TEAM from the Governor's Office on Science and Technology is expected to recommend continuation of water fluoridation, but not with a great deal of fervor.

"For the general population, there does not appear to be a risk," said Craig Nern, the office's program director. "But for some of the sub-group populations, there might be."

However, he said, researchers found that groups at risk from fluorides make up less than 1 percent of the state's 9.1 million population.

THESE INCLUDE persons suffering from kidney ailments and those who are allergic to fluoride. About 2,000 kidney patients are on dialysis machines in Michigan.

Nern said there is also controversy over whether fluoride benefits or harms kidney patients. Some claim the extra buildup of fluoride on bones strengthens them. Others contend it weakens the bones.

While the task force ruled out fluoride as a cause of cancer, it was unable to find firm scientific data to disprove that fluoride harmed persons who are allergic to it, he added.

"WE HAVE TO leave it at, 'Well, this thing might happen,'" he explained. "Again, this is a very small group."

Fifty-one percent of the Michigan communities with 75 percent of the state's population fluoridate their water supplies — one part fluoride per million parts of water.

Scientists estimate that ingestion of three to four parts per million of fluoride could turn some people's teeth brown, more than five parts could cause nausea, weakness and dizziness, and more than 10 parts could be toxic.

"Three to four parts per million of fluoride could turn people's teeth brown."

symptoms of "allergic" reactions to fluoride

reported by Hobart T. Feldman, M.S., P.A.
Diplomate, American Board of Allergy & Immunology
letter to Governor Milliken's Office of Science & Technology, 9 May 1979

vomiting
sneezing
wheezing (asthma)
hives
drowsiness
runny nose
chest pain
various intestinal symptoms
nausea
nasal congestion
coughing
headache
dizziness
sore throat
profound desire to sleep

Coalition For Pure Water

P.O. Box 2107, Allentown, Pa. 18001

TOP PRIORITY
URGENT

September 4, 1979 Please Address Reply to:

DELETE THE $ 9 MILLION FLUORIDATION ALLOCATION FROM THE FISCAL 1981 LABOR/HEW APPROPRIATIONS BILL.

TO EVERY MEMBER OF THE UNITED STATES SENATE:

Honorable Senator

THE VOTERS WHO ELECTED YOU DO NOT WANT FLUORIDATION!!!!

City after city has rejected fluoridation! Hundreds of cities have thrown out fluoridation after trying it!

While the Federal and State governments appropriate funds to fluoridate, your constituents have rejected this violation of their rights and their bodies!!!

IF YOU REPRESENT YOUR CONSTITUENTS, YOU WILL REJECT FLUORIDATION?!

Several months ago, the city of Houston voted not to fluoridate, after studying the report of a scientific panel.

In California, the city of Los Angeles voters rejected fluoridation overwhelmingly in a referendum! The city of San Diego discontinued fluoridation after trying it.

Mandatory fluoridation was defeated in New York State a few weeks ago!

Canton, Ohio and Kansas City, Missouri threw out fluoridation after trying it, as did Eugene, Oregon. 36 out of 39 cities in Ohio have rejected fluoridation.

Wichita, Kansas has rejected fluoridation!

MAINE defeated a bill which would have removed referendums for fluoridation!

FLORIDA defeated a bill requiring mandatory fluoridation. TALLAHASSEE, the state capitol rejected fluoridation.

In WILLIAMSPORT, Pa., Judge Thomas Wood, who ruled for fluoridation, was defeated, the first judge to be defeated under Pennsylvania's retention system.

In Pittsburgh, Pa., Judge John Flaherty who ruled against fluoridation won an overwhelming victory and a seat on the Pennsylvania Supreme Court.

In Allentown, Pa. 4 city officials who voted for fluoridation were defeated - The fluoridation ordinance was rescinded!

In Bethlehem, Pa. 3 city officials who voted for fluoridation were defeated!

THE PATTERN IS CLEAR! IF YOU REPRESENT YOUR CONSTITUENTS - (Voters) - You will reject fluoridation! Your constituents/Voters are asking you to recognize the proven dangers of fluoridation and its violation of their rights to decide what goes into their bodies!!!!!!

DELETE FROM THE FISCAL 1981 LABOR/HEW APPROPRIATIONS BILL THE $ 9 MILLION DOLLARS ALLOCATED FOR PROMOTION OF COMPULSORY WATER FLUORIDATION! REPRESENT THE AMERICAN VOTERS

Aiming for a Safer, Cleaner Environment in America

THE OAKLAND PRESS

Editorial Page December 22, 1979

Fluoride study raises some disquieting doubts

The perfect recommendation is, perhaps, a document which satisfies no one completely.

In that sense, the recent report of the Governor's Task Force on Fluorides is perfect.

Both opponents and proponents of the addition of fluoride to public water supplies can find some vindication in it.

Fluoride, as you know, is added to water in many areas to help prevent tooth cavities.

Proponents have claimed for 35 years that the practice does indeed help reduce the number of cavities.

And the report by the special nine-member task force agrees.

In fact it goes so far as to recommend that such fluoridation be continued.

It concludes fluoridation of the water is an "effective public health measure."

But the task force also raises some questions about fluoridation — questions which ought to be disquieting, and questions whose answers it generally ducks.

It seems to second-guess its own conclusion that fluoridation be continued.

For example, the report notes that excessive levels of fluoride consumption can cause problems in those whose tolerance various from the normal because of age, diet or general health.

That is precisely what persons nervous or skeptical about fluoridation have been saying for years.

But while the task force notes that the individual rights of vulnerable persons ought to be weighed against the benefits of fluoridation to the community at large, it leaves the decision to policymakers — politicians.

What the task force finally does is recommend that such persons ought to be able to opt out of fluoridation.

It says policymakers must make sure whatever level of fluoridation is adequate to prevent cavities "does not place an undue burden on individual members of society."

Significantly, the task force notes it "did not examine the efficacy, safety or practicality of other methods of fluoride administration (other than putting it in everyone's water).

The questions the report raises are very serious.

For example, should the state of Michigan encourage the introduction of a chemical — a toxic chemical, at that. — into the water supply if a significant number of individuals have to try to avoid it by drinking bottled water?

Is that an "undue burden?"

Is it up to susceptible persons to become ill first and avoid fluoride later, or is the state going to pay for tolerance tests for everyone?

Should the state encourage — or even permit — fluoridation in order to reduce tooth cavities, or should it explore the cost and effectiveness or some other, voluntary method for citizens to acquire the treatment?

Other methods such as direct application to teeth by dentists already exist.

Dropping mass fluoridation would, at least, avoid even accidental exposure for the vulnerable.

And what is the legal liability of the state or any of its municipalities now that all have been warned fluoridated water can harm some citizens?

It is obvious — and the report so states — that further research would be valuable.

On balance it seems that the task force confirms the concerns of those who believe mass, involuntary fluoride medication — while beneficial or at least harmless to most of us — is a real threat to some of us.

In that light, the governor and the legislature ought to immediately weigh what the task force did not — "the question of individual choice versus the public good."

NEIL MUNRO

STATEMENT OF DR. JOHN YIAMONYINNIS

On September 21 and October 12, 1977, Rep. L. H. Fountain's Subcommittee on Intergovernmental Relations held hearings on the fluoridation issue. The Subcommittee confirmed the National Cancer Institute's passing on of erroneous, biased, and incomplete data to scientist's in Britian who subsequently published it as their own to give the impression that NCI's purported refutation of the fluoride-cancer link was independently confirmed:

> Mr. FOUNTAIN. I am placing in the record several documents which suggest apparent noncooperation by NCI. The first is a June 18, 1976, letter from you, Dr. Hoover, to Dr. Leo Kinlen of Oxford University in England, in which you state that you were enclosing the relevant data for 1950, 1960, and 1970, which have been obtained from published data from the Bureau of the Census and the National Center for Health Statistics.
>
> Apparently this data had been denied by NCI to Drs. Yiamouyiannis and Burk, and in your letter you cautioned Dr. Kinlen as follows:
>
> If you are queried as to how you obtained the data, I would appreciate it if you would indicate that all the raw data are available from routine publications available to anyone.
>
> Mr. FOUNTAIN. Apparently Dr. Kinlen took your admonition seriously, for, in his paper "Fluoridation of Water and Cancer Mortality in the USA" published in the June 18, 1977 issue of *Lancet*, a British medical journal, he states at page 1301, and I quote:
>
> In these circumstances, it may be of interest to reproduce the demographic data for the twenty cities which are published in the reports of the Bureau of the Census and the National Center for Health Statistics and are widely available in the United States and, to a lesser extent, in medical libraries in the United Kingdom. These data were used in arriving at Fredrickson's and Taves' results, and we have ourselves used them to check their findings.
>
> At the end of the paper at page 1302 Dr. Kinlen states: "All the evidence is publicly available, and none is protected by the Official Secrets Act."
>
> I think it appears to be significant to me that nowhere in Dr. Kinlen's paper does he acknowledge that he received the data from NCI. He implies in his published article that he used the publicly available reports of the U.S. Bureau of the Census and the U.S. National Center for Health Statistics.
>
> However, it would seem that he used the data furnished by you, Dr. Hoover, because of NCI's erroneous mathematical calculation that also appears in Dr. Kinlen's published article.
>
> Is it not a fact, Dr. Newell, that the data published in Dr. Kinlen's article was provided by Dr. Hoover?
>
> Dr. HOOVER. Yes. I would say so. In fact, I did not recognize that fact myself until Dr. Yiamouyiannis pointed out that there was this error.

At the conclusion of these hearings, Chairman Fountain pointed out: "I am not suggesting that fluorides do cause cancer. I do not know. Rather, I am saying that at the present time the carcinogenicity, or lack of carcinogenicity, of this substance is a question which remains unanswered."

Subsequent to these Subcommitte Hearings, a suit in equity was filed in Pittsburgh to enjoin fluoridation as a public health hazard. In these court hearings, which lasted from March to November, 1978, and in which top experts on both sides of the question were summoned from all over the world [including the U.S.P.H.S.] it

was proven by a preponderance of the evidence that fluoridation is harmful. The presiding judge, the Hon. John P. Flaherty pointed out: ".... the evidence is quite convincing that the addition of sodium fluoride to the public water supply at one part per million is extremely deleterious to the human body. and, a review of the evidence will disclose that there was no convincing evidence to the contrary." In 1979., Judge Flaherty's decision was confirmed by the Enviromental Ministry of Quebec [Report available on request].

A large amount of time during the court case was spent showing that after the 80-90% of the data purposely omitted by the NCI was put back, the same method used by the NCI to correct cancer data for age, race, and sex simultaneously showed 10,000 cancer deaths per year attributable to fluoridation of public water systems. Although we have used this and other methods of corrections for age, race, and sex and have come up with the same conclusion, i.e. 10,000 fluoridation-linked cancer deaths per year, NCI and CDC have purposely misled Congress by stating that we never made such corrections.

CDC Director Dr. Foege has made false claims that for every $1 spent on fluoridation, $50 is saved in dental bills. I am presently completing a study for publication which, in fact, shows no difference in per capita dental costs in fluoridated and nonfluoridated areas.

When Dr. Foege was asked by Sen. Percy's office to produce just one objective laboratory or epidemiological (blind or double-blind) study showing that fluoridation reduced tooth decay, he was unable to.

In view of the facts that the U.S.P.H.S. cannot even defend the safety of fluoridation in a court of law and that the U.S.P.H.S. cannot even provide one objective laboratory or epidemiological study showing that fluoridation is effective, I submit that this Subcommittee delete the $9.5 million fluoridation appropriation from the CDC budget request.

National Eye Institute

STATEMENTS OF:

DR. STEWART FINE, ON BEHALF OF A. EDWARD MAUMENEE, M.D., PROFESSOR OF OPHTHALMOLOGY WILMER INSTITUTE OF THE JOHNS HOPKINS UNIVERSITY SCHOOL OF MEDICINE, AND ON BEHALF OF THE CITIZENS BUDGET

DR. HERBERT KAUFMAN, LOUISIANA EYE CENTER

JOHN W. CHANDLER, M.D., FRIENDS OF EYE RESEARCH, REHABILITATION, AND TREATMENT

JOHN P. MURRAY, JR., DIRECTOR, FRIENDS OF EYE RESEARCH, REHABILITATION, AND TREATMENT

SYLVIA N. RACHLIN, EXECUTIVE VICE PRESIDENT, MYOPIA INTERNATIONAL RESEARCH FOUNDATION, INC.

CITIZENS BUDGET ON NATIONAL EYE INSTITUTE

Senator Hollings. If you will introduce yourselves, please, and proceed however you wish to.

Dr. Fine, do you want to introduce your group and start us off?

Dr. Fine. Thank you, Mr. Chairman. As you know, I am speaking on behalf of the Citizens Budget in support of the National Eye Institute. I am representing Dr. A. Edward Maumenee, professor of Ophthalmology at Wilmer, who is well known to everyone on this committee from his numerous appearances here over the last 10 to 15 years. You already have a copy of Dr. Maumenee's statement, which will be inserted in the congressional record, and I will simply highlight some of the major points from that statement.

This is not a good year to be asking for more money, and I recognize that as a taxpayer as does everyone else, as others have mentioned today. What I hope to do in the few minutes allotted is to convince you that the $2 or $3 spent this year for eye research will pay off handsomely, not in 20 or 30 years, but next year and the year thereafter in thousands of dollars saved in this country. Let me just cite three examples that I have witnessed in my brief career in ophthalmology, just over 10 years, and corresponds to the decade in which the National Eye Institute has been in existence.

ADVANCEMENTS THROUGH EYE RESEARCH

When I began my training in 1969, the average patient stayed in the hospital 10 days for a cataract operation. Recognize, of course, that that is the commonest operation performed in this country. The average stay in the hospital now for a cataract operation is 3 days. This, translated to dollars, means a savings of a half billion dollars each year for cataract surgery alone.

When I began my residency just over 10 years ago, patients who had diabetic retinopathy, which was the commonest cause of blindness in this country in people under the age of 50, were told of the diagnosis and that no treatment was available. Every single week, almost every day I would see people in their 20's and 30's, young mothers, young fathers out earning a living for their families, who had diabetic retinopathy and there was absolutely nothing that we could do. Through the generous support of the Eye Institute over the past 10 years, we

have witnessed the demonstration, the unequivocal demonstration, that 60 to 80 percent of the patients with severe diabetic retinopathy can now be treated effectively and kept on the working force. In dollars, this translates to a savings of $220 million a year keeping these people young, active, productive people working, rather than on public support. This is considerably more than the Eye Institute is asking for in its entire budget for this year, or in the Citizens Budget request for the Eye Institute.

Another example in which I am personally involved concerns the area of macular degeneration. This is the commonest cause of severe visual loss in this country in people beyond the age of 60, and it results from a deterioration in cells in back of the eye.

I have been instrumental in the past 4 years in initiating a major nationwide study similar to the diabetic retinopathy study supported by the Eye Institute in which we will try to demonstrate whether or not laser treatment is effective in preventing severe visual loss and blindness in patients with diabetic retinopathy.

We know from studies conducted at the Wilmer Institute by Dr. Maumenee and Dr. Pax and myself, that up to 90 percent of our senior citizens who lose their reading vision because of macular degeneration do so through a process that is potentially treatable with the laser.

Now I've talked about how implementation and support of three specific disease areas can assist in preventing blindness and keeping people working through active and productive periods of their lives. Let me leave these disease-oriented areas for a moment and talk in general terms.

RESEARCH AND TRAINING SUPPORT

I think the thing that we're all banking on is the support of young scientists and young investigators, and that is where the bulk of the budget moneys are to be spent. There are more young people today entering and staying in the field of eye research than ever before, but they are dependent upon Federal dollars for support. And when the Federal dollars are not there, of necessity they are going to have to pick up their marbles and go somewhere else and work in an area where they can get support. And once these people leave, they have left not for 1 or 2 years, but they have probably left for a lifetime.

The other thing that is sorely lacking in eye research today are the bricks and mortar. All the other disease oriented institutes came into existence in the 1950's and early 1960's, before we had the severe financial constraint on Federal spending. And there were hundreds of thousands of dollars spent to support heart institutes, cancer institutes, and kidney institutes.

There has not been any significant money spent to build eye research facilities, and we are requesting $15 million allocated specifically for the construction and renovation of the now-existing but woefully inadequate eye research facilities.

I should point out that the National Advisory Eye Council solicited proposals throughout academic ophthalmology in this country and obtained requests that could justify between $70 and $80 million expenditure on new construction and renovation. So by that comparison, a $15 million request seems modest.

You have Dr. Maumenee's testimony, you've heard my brief remarks, I am going to conclude now in the interest of the others and hope that I will be able to answer some questions later.

Thank you.

Senator HOLLINGS. Thank you, Dr. Fine.

[The statement follows:]

STATEMENT OF A. EDWARD MAUMENEE, M.D.

I am grateful to this Committee for the opportunity to appear before you and to testify on behalf of the National Eye Institute. Throughout my career in ophthalmology it has been my good fortune to be involved in or closely associated with all major aspects of eye research and ophthalmic practice both in this country and abroad, and especially as carried out in the nation's medical schools. The latter, as you are well aware, are the principle arenas for the study of the entire spectrum of eye diseases that are the causes of worldwide blindness and serious loss of vision. These medical schools depend almost entirely upon the National Eye Institute for major support of their activities in vision research. I believe that the creation of the National Eye Institute by the Congress was the most significant step toward the control of blinding diseases that has taken place in the history of medicine. I know that my colleagues throughout ophthalmology join me in congratulating the Congress once again for that historic action.

It is interesting to recall today, as we observe the achievements of this still-young Eye Institute, that it was established long after other disease-related Institutes were already flourishing with substantial Federal support. Yet I believe you will agree with me that the Eye Institute has amassed a record of productivity -- operating since its beginning under the strictures of a bleak economic climate -- and success unmatched by any other component of the National Institutes of Health. Through the interest and concern of this Committee especially, our medical schools departments of ophthalmology have used the funds disbursed through the Eye Institute to achieve what once would have been considered miracles in saving sight.

It is my privilege today to provide this Committee with information which I hope will elicit your support of a budget of $162,977,000 for the National Eye Institute for Fiscal Year 1981.

As I have indicated, this Institute is no stranger to economic limitations -- it was born with a tightened belt. As a result, it was the first among the National Institutes to come before the Congress with a detailed, comprehensive plan for reasonable growth over a six-year period. That plan was developed with the guidance of some 200 experienced leaders in ophthalmology. It outlined specific needs, priorities and areas of maximum opportunity. It related each of these to anticipated costs. It was a model of cautious, efficient planning, balancing obviously desperate needs against reasonable expectations of support. The budget which we now ask you to approve for Fiscal Year 1981 is at a level lower than that which the plan had projected for 1980. The Administration Budget is at the level below that projected for 1978. So, you see, the belt continues to be a tight one.

The Congress has been an eminently fair judge of the value of eye research. It has repeatedly asked, "Does eye research pay?" And, invariably, it has found an overwhelmingly affirmative response in Public Health statistics, not only in terms of human life and dignity, but in consideration of the financial impact of eye research upon the pocketbooks of the American people. Government reports several years ago placed the cost of care and services associated with blindness in the United States at seven billion dollars each year. That staggering amount is an annual cost, repeated year after year, and constantly increasing with every new rise in the inflationary spiral. The only way to limit such costs is to prevent blindness from happening. The results of recent eye research are now saving -- and even restoring-- the sight and the self-responsibility of thousands who in another time would certainly have been placed in a position of economic and physical dependency.

Today I ask you to consider other figures that have a more visible impact upon the average citizen -- figures directly measurable in one of the most critical areas of health costs that deeply concern the American people and the Congress -- the cost of hospi-

talization. A recent study of hospital data presented at the American Academy of Ophthalmology meeting last Fall indicates that, as a result of advances in research and technology, the average length of hospital stay for cataract surgery patients was reduced by almost three days in the period from 1968 through 1976. There have been further advances since that period, and I believe that average hospitalization for cataract is now close to three days, as against 7 to 10 days in the 1960's. Consider now that more than 400,000 cataract extractions were performed in the United States during the past year. With hospital room costs now soaring beyond the $200-a-day level, and as high as $300 in many metropolitan areas, the value of research may be measured in savings approaching half a billion dollars a year. That saving is three times more than our entire Citizens' Budget Request for the National Eye Institute for Fiscal Year 1981!

It should be a matter of great interest to the Congress that the number of cataract extractions has risen by more than 4.2 per cent each year over the past decade. There are many factors involved in this increase, not the least of which is the availability of funds for medical treatment of the poor and the aging. But a predominant factor is the advance of ophthalmic therapy -- the development of microsurgery, cyrosurgery and other revolutionary procedures, the introduction of artificial lens implants, advances in pharmacology and post-operative care -- effectively reducing the physical and psychological trauma of cataract extraction. Thus the benefits of surgery are now routinely available to many elderly patients who could not have tolerated earlier procedures. It is a pleasure to report to you that large numbers of such once-inoperable patients are now among the 400,000 to whom the blessings of sight are preserved or restored each year.

We are most cognizant that the ultimate answer to cataract -- or any other eye disorder -- is not surgical intervention. While the immediate consequences of cataract are being dealt with, the search for a medical solution -- a preventive or retardant -- is being sharp-

ly accelerated. A major step was the discovery in experiments with laboratory animals, that one form of cataracts, the so-called "sugar cataracts" of diabetes, are due to the action of an enzyme present in the eye, called aldose reductase. This enzyme has also been implicated as a possible cause of diabetic retinopathy and perhaps of diseases of small blood vessels that occur in other parts of the body as a result of diabetes. It is now known that the action of this enzyme can be inhibited by various chemical substances, such as a group of compounds called flavonoids, thereby delaying the process of cataract formation. These substances have been extensively manipulated and tested in the effort to develop a potent, safe and effective medical therapy that is suitable for human therapy. This research has progressed to the point at which certain of these compounds are undergoing preliminary testing in humans. The savings that would result from success in this area of research are almost incalculable.

An important element in your deliberations on this budget is the fact that almost 25 million Americans -- 11 per cent of the population -- are presently over the age of 65. By the year 2000 there will be close to 32 million in that age bracket, with projections increasing still more sharply beyond that. Among serious eye disorders found in patients over 65, senile macular degeneration is named by ophthalmologists as one of the most common, and the most difficult to treat. There is presently no cure for the disorder, no way of preventing it and no truly effective therapy. For a huge segment of our population which is constantly increasing in numbers and vitality, the gift of longevity is too often tragically marred by loss of sight. The solution must come from research. It is only in the past decade that the problems of macular degeneration, diabetic retinopathy, retinitis pigmentosa and other retinal disorders have begun to be explored at a level of intensity that their severity demands. I will presently discuss briefly some of the hopeful developments that have taken place in this area of research. So critical is the need for

understanding of the retina and its diseases, and so prepared are today's scientists to move effectively in that respect, that approximately 40 per cent of the Citizen's Budget Proposal would be directed to retinal and choroidal disease programs. What research is doing to free the aging from cataract, it is hoped may also be achieved toward the solution of these extremely complex and widely prevalent eye problems.

One of the most heartening reports we have concerns what appears to be a limited breakthrough in the treatment of an unusual inherited eye disease closely related to retinitis pigmentosa. The disorder -- called gyrate atrophy of the retina and choroid -- produces tunnel vision, night blindness and progressive reduction of central vision, and finally blindness by age 40-50. Degenerative and genetically determined diseases of the retina and choroid are among the leading causes of untreatable blindness. There are approximately fifty different diseases within this category. It recently has been discovered that gyrate atrophy is associated with a deficiency in the activity of an enzyme called ornithine transaminase. Researchers have found that when these patients were treated with large doses of Vitamin B_6, chemical changes were observed among them which indicated that the activity of the enzyme was increased. These are admittedly early findings, but we are nevertheless encouraged that such treatment of certain patients with gyrate atrophy may lead to the slowing, or even arrest of the disease process. Moreover, the research proceeding from the discovery of this enzyme defect raises our hope that other more common retinal disorders may be related to similarly defective enzyme action which may respond to treatment.

Among the most tragic complications of diabetes is one that has become the second leading cause of new adult blindess. Diabetic retinopathy is characterized principally by the proliferation and hemorrhaging of retinal vessels. In addition to the damage done to the retina itself, the proliferating vessels often extend into the vitreous, where the hemorrhage pervades the normally clear vitreous, preventing the passage of light and causing blindness. There are more than

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10 million known diabetics in the United States, a large percentage of whom will develop diabetic retinopathy if they live long enough. We are happy to report that effective new treatments have been developed to forestall and even reverse severe visual loss from diabetic retinopathy. Moreover, basic research into the causes and process of the eye disease is contributing much to knowledge of diabetes itself and may provide the basis for more effective treatment.

Several years ago this Committee was informed by the Eye Institute of the results of a controlled clinical trial of laser treatment to destroy abnormal blood vessels and diseased tissue in the retina. We know today that this technique of photocoagulation therapy can reduce by more than one-half the risk of blindness in advanced stages of diabetic retinopathy. A new controlled clinical trial therapy for this disorder has now been launched, involving 22 medical centers and some 4,000 patients across the country. Called the Early Treatment Diabetic Retinopathy Study, it has the purpose of evaluating laser treatment in much earlier stages of diabetic retinopathy than were treated in the previous trial. The new study will attempt to evaluate the potential for early treatment to delay, or perhaps even prevent, the progression of the mild disease to more severe stages that threaten the patient with blindness. Also under study will be the possible effects of aspirin therapy in association with photocoagulation as a means of preventing or delaying the progress of retinopathy.

It is interesting to note that the experience gained by a number of researchers in the Diabetic Retinopathy Study has encouraged them to originate clinical trials on their own, initiated outside the National Eye Institute and supported by research grants from the Institute, rather than by contracts. In these trials, the effectiveness of laser treatment is being tested in other critically important retinal problems. These include retinal branch vein occlusion, senile macular degeneration and ocular histoplasmosis. Together

with diabetic retinopathy they constitute disorders which in the recent past have been considered largely untreatable.

Today's vision researchers consider nothing impossible. I had the pleasure of reporting to you several years ago on the success of a revolutionary treatment called vitrectomy, which enabled the eye surgeon for the first time to safely remove diseased material from within the central cavity of the eye. Until the development of this procedure, any such attempt would almost certainly have resulted in unalterable damage to the integrity of the eye and the loss of any hope for restoration of visual function. Today, vitrectomy is a familiar procedure used throughout the world. It has been a special boon to diabetics, restoring sight to thousands who once would have been considered hopelessly blind and preserving the sight of many more from the threat of serious visual loss. And the procedure is finding use beyond the area of diabetes, including the treatment of intractable, chronic uveitis, an inflammatory condition that invades the tissues within the eye and which often defies the most intensive efforts at therapy.

It is not possible in the time allotted me to review for you the gains that are being made today throughout ophthalmology as a result of your interest and the support you have legislated for the vast, diverse field of eye research. In every major area -- retinal disease, cataract, glaucoma, corneal disease, oculomotor disorders-- the evidence of progress reaches out to people of all ages. Corneal cells essential to sight are being replicated in tissue culture and may one day be accessible for transplantation to replace cells destroyed through surgery or trauma. The ophthalmic surgeon replaces the opaque lens with a soft or hard contact lens, or with a bit of plastic implanted within the eye. Scarred corneas are routinely replaced by clear tissue. A tiny valve may be implanted in the eye to control pressure in a severe, intractable case of neovascular glaucoma. Developments in pharmacology are producing more effective med-

ications for the treatment of herpes infections, the major cause of corneal blindness in the United States. The discovery of a naturally-occuring biochemical accelerates the healing of ocular wounds and reduces scarring of damaged tissue. On every front, the findings of eye research are contributing dramatically to the saving of sight, while at the same time extending their influence into diverse areas of biomedical research, adding importantly to knowledge of disease processes that affect the most important functions of the human body.

Were you to visit important centers of eye research today, I am sure you would be amazed at the scope and diverstiy of the biomedical interests that are now being employed in the preservation of sight. And I know you would be struck, too, by the intensity, the enthusiasm and the vibrant dedication of those who carry on this research, largely in anonymity, absorbed in the challenge of finding solutions to once-unsolvable problems. The outstanding young men and women engaged in eye research today recognize no obstacles to the conquest of blinding diseases. They are successfully pitting their intellect against problems of vision and its disorders that past generations have had neither the technical nor the financial resources to fully explore. They are people in whom Federal funds are well invested. It is most important to the future of eye research that the continuity of their work be assured, that the projects in which they are involved and the practical scientific objectives which they have set are not lost to society for reasons of false economy.

Vision research is pulling itself up by its bootstraps. With few exceptions it continues to take place in inadequate facilities, fighting desperately for space that is absolutely essential to the tasks which they have been called upon to perform. The need for increased research space is one of the imperatives on which we have placed special emphasis in arriving at the Citizens' Budget Proposal for Fiscal Year 1981. Our request for building funds is a

modest one. Recognizing the great need for eye research space, the Congress last year appropriated $3,000,000 to permit the funding of Research Laboratory Construction and Renovation, and the Institute has moved to make these funds available for that purpose. In developing this new phase of the eye research effort, the Institute, in response to a nationwide inquiry last year, found that eye research facilities in this country could intelligently and effectively utilize as much as $77,000,000 in funds to renovate and/or construct new research laboratory space. In an conservative step to help fill that well-documented need, we are requesting only $15,000,000 for this purpose as part of the total Citizens' budget for FY 81.

It is my urgent request that this Committee recommend approval of the appended Citizens' Budget Request of $162,977,000 for the National Eye Institute for Fiscal Year 1981. The request contemplates expenditures in the following program areas: for Retinal and Choroidal Diseases, $64,931,000; for Corneal Diseases, $17,003,000; for Cataract, $13,575,000; for Glaucoma, $15,584,000; for Sensory-Motor Disorders and Rehabilitation, $20,906,000; for Intramural Laboratory and Clinical Research, $11,169,000; for Research Laboratory Construction and Renovation, $15,000,000; and for Research Management and Program Services, $4,809,000. Financial tables related to the proposed budget of $162,977,000 for Fiscal Year 1981 is appended to my statement.

I deeply appreciate the opportunity to present this testimony and I welcome the Committee's questions. Thank you.

National Eye Institute Financing-Citizens Proposal, FY 1981

BY ACTIVITY:	FY 1980 Appropriation	FY 1981 President's Budget Request	FY 1981 Citizen's Proposal
Grants:			
Research	$ 79,496,000	$ 88,736,000	$ 101,792,000
Research Laboratory Construction & Renovation	3,000,000	-0-	15,000,000
Core Center Grants	4,197,000	3,208,000	4,218,000
Specialized Clinical Research Centers	1,593,000	837,000	837,000
Developmental Research Centers	-0-	-0-	8,000,000
Individual Training	1,513,000	1,558,000	2,897,000
Institutional Training	3,530,000	1,743,000	4,255,000
Total Grants	93,329,000	96,082,000	136,999,000
Direct Operations:			
Intramural Laboratory and Clinical Research	8,820,000	9,643,000	10,469,000
Research and Development Contracts	6,000,000	5,801,000	10,000,000
Biometry, Epidemiology and Field Services	675,000	700,000	700,000
Research Management and Program Services	4,176,000	4,336,000	4,809,000
Total Direct Operations	22,671,000	20,480,000	25,978,000
Total Obligations	$113,000,000	$116,562,000	$162,977,000

BY PROGRAM:			
Retinal and Choroidal Diseases	$ 41,712,000	$ 44,141,000	$ 64,931,000
Corneal Diseases	14,031,000	14,871,000	17,003,000
Cataract	9,695,000	10,217,000	13,575,000
Glaucoma	10,951,000	11,773,000	15,584,000
Sensory-Motor Disorders and Rehabilitation	19,940,000	20,881,000	20,906,000
Intramural Laboratory and Clinical Research	9,495,000	10,343,000	11,169,000
Research Laboratory Construction & Renovation	3,000,000	-0-	15,000,000
Research Management and Program Services	4,176,000	4,336,000	4,809,000
Total Obligations	$113,000,000	$116,562,000	$162,977,000

Note: Fiscal Year 1981 begins Oct. 1, 1980.

Myopia International Research Foundation, Inc.

Mrs. Rachlin. Thank you, Senator. Mr. Chairman and committee: I am Sylvia Rachlin, and this is the 16th anniversary of my having the opportunity of appearing before your honorable committee. My statement is before you, and I would just like to add some notes.

In 1982, there will be a world congress that will probably never again occur in this century; a gathering of eye specialists not only throughout the United States, but from most nations of the world. They will meet in San Francisco.

We the patients afflicted with eye disorders appeal to you to support the entire, conservative budget requested for the National Eye Institute. What a wonderful opportunity to help so many people. I'm not going to repeat what some of my distinguished colleagues will be saying today, but what pride we can have in pointing to American advances in research. Some of the greatest men in the world, whom I have already

had the pleasure of meeting, will be bringing their pioneer research here and are looking to the National Eye Institute for sharing communication and evaluation.

Please know that your friends—your many friends in AFL–CIO, in Catholic Daughters of America, in Federation of Jewish Women's Organization, in Protestant Church Women, in the Ad Hoc Black Leaders Committee, and in others with whom we are affiliated—please know how grateful they are to you for all the help you have given to us despite the many pressures upon you. For it is within your power to save millions from blindness, and especially a million American children who are doomed because there has been no adequate research for progressive pathological myopia.

Thank you.

Senator HOLLINGS. Thank you very, very much.

[The statement follows:]

STATEMENT OF SYLVIA N. RACHLIN

The Myopia International Research Foundation urges increased dedication to all research that would promote early detection, treatment and prevention of eye disorders. Healthy eyes in childhood offer greater promise for a happy and productive life.

Deep is our concern for the public health and, more particularly, eye care. Americans spend over $5 billion annually for eye care. In addition, eye disorders account for suffering to individuals and their families that is beyond all statistical measurement.

The Myopia International Research Foundation has, therefore, sought and secured the joint support of consumer groups in its crusade on behalf of high standards of public health and eye care. Among these groups are the Catholic Daughters of America, the Federation of Jewish Women's Organizations, the National Council of Jewish Women, groups of protestant churchwomen, leaders in the labor movement, and the Ad Hoc Black Leaders Committee.

The Myopia International Research Foundation is convinced that research into the causes, treatment and prevention of myopia 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 requests of the National Eye Institute to make possible increased grants for research. The returns will prove most beneficial to our national health and economy.

PERTINENT FACTS

The Myopia International Research Foundation, Inc. launched the first comprehensive, interdisciplinary research program in the United States into the causes, treatment, and prevention of nearsightedness.

Our immediate goal is to save the eyesight of more than 1 million American children (besides millions around the world), who are doomed to blindness because of progressive, pathological myopia for which there is no known cure. This, we are doing with the cooperation of doctors in the United States and elsewhere throughout the world.

The Myopia International Research Foundation sponsored the First International Conference on Myopia in 1964.

Since 1965 the Myopia International Research Foundation has appeared before appropriations subcommittees of the U.S. Senate and House of Representatives appealing for increased support of eye research through the National Eye Institute. In recent years, the Foundation has been one of the two public witnesses invited by these committees to present testimony on needed eye research for the entire Nation under the National Eye Institute.

The Myopia International Research Foundation has been invited to exhibit at conventions of the American Academy of Opthalmology and Otolaryngology. An increasing number of opthalmologists has become interested in our program.

By invitation, the Myopia International Research Foundation has had exhibits at the International Congresses of Opthalmology. These presentations were enthusiastically received by eminent doctors from all continents.

The Voice of America broadcast details of our program to all nations on two occasions.

Through gifts of printing, myopia research papers are published and distributed without charge to interested doctors throughout the world. The Myopia International Research Foundation is idealistic in its operation. No money whatsoever is spent on any administrative salaries or professional fundraisers.

Our intensive efforts continue daily to help widen the channels of communication among doctors interested in myopia research.

FRIENDS OF EYE RESEARCH, REHABILITATION, AND TREATMENT

Mr. MURRAY. Senator, my name is John Murray and it is a privilege to be here. I am neither a scientist nor a doctor. I am a businessman from Princeton, N.J. I am the president of a tennis company, but I have a very deep-seated interest in either preventing or helping to prevent and/or correct blindness.

I have submitted my statement, but I would like to read my summary: The National Eye Institute requires a budget for 1981 of $163 million. Why?

The basic reason is for laborious, hard knocking research to help prevent blindness, and most importantly to find some way to allow a blind person to see. As an example, an artificial retina is something achievable if full attention is given to the problem.

It is within the grasp of science to give people sight if adequate funds are made available, and the allocation of those funds are pinpointed properly into basic research.

An overall project to give sight back to people without it is almost too awesome to contemplate, and the impact worldwide is beyond measure. This single accomplishment could be the greatest contribution given the world by science.

Many people have been helped already. Many have retained sight because of past research, but the big job still lies ahead. Without adequate funds, darkness will continue to plague the unfortunate people around the world. No one who cannot see could ever imagine the helplessness of those who cannot.

The greatest statement a person could make might we be: At one time on this Earth there were people who could not see, but mankind through science has cured that problem.

Given the funds, everyone involved in this project could be one of the architects of such a statement. Thank you.

Senator HOLLINGS. Go right ahead. Thank you, Mr. Murray.

[The statement follows:]

STATEMENT OF JOHN P. MURRAY, JR.

It is a privilege for me to appear before your committee in an effort to convince the committee of the need of adequate funds to help cure and prevent blindness. I have had personal experience with blindness both in my community in Princeton, N.J. and unfortunately in my own home. It is impossible to describe the change in status experienced by a person who can no longer see. It is humiliating, frustrating, certainly debilitating and most certainly unproductive. To know the full measure of what blindness means, you would really have to bind your eyes and attempt to spend one normal day

of your life not being able to see. Anyone bothering to put himself or herself through such an experience would certainly cherish their sight once the binders were removed.

Through science, a duplication of what I previously described could actually happen with people who are now blind. To do this science needs money. In 1981 the National Eye Institute needs $163 million. When the National Eye Institute 5-year plan was presented to this committee in 1978, it was approximately the number of $163 million that was projected in the plan that would be required at fiscal 1981. Unfortunately, inflation that was running 10 percent and now 15–20 percent has really altered those 5-year projections to a point where we should actually be coming in requesting over $200 million. Everybody wants money and everybody has a fine and justifiable reason for the money. In my opinion, it is far more important for a person to see than it is for a person to eat. It is far more important for a person to see than it is for a person to be sheltered or to wear comfortable clothes. The most important of our senses is to see.

We feel that $163 million is not too much nor too little, but only sufficient to continue attacking the problem of sight. We don't need any more fancy buildings, what we need are people in the buildings we already have. The scientists required to so the job, require income for themselves and their families so thay can devote their full attention to this singular problem of correcting and preventing blindness. In its purest sense this is research and development.

In my business, which happens to be tennis, we devote not only our attention to research and development, but a generous percentage of our annual sales to make certain that we have an ongoing understanding of what is available to our marketing division as reported by the technicians. Research and development has been a very important factor in my company becoming the strongest tennis company in the United States. It is this same attitude that I urge the committee to adopt in its approach to evaluating the many social problems that they must.

The three most important parts of research and development regarding sight, would be laboratory research, clinical research, and then training. The most important segment of those three items is laboratory research. It is here that we need the money. It is in that area where the administration of the funds can best be utilized to produce results. It is in this area where you can measure results for dollars expended. It costs our country $8 billion a year to care for blind people—$163 million is certainly a modest amount to ask for in attempting to correct such an expensive drain of public funds.

So much wonderful work has been done to help people with vision problems, but as long as there is one blind person left in this world, we must all extend ourselves to help that person recover his lost sight. Unfortunately, there are millions of blind people throughout the world. Additionally unfortunate is the fact that most of the blind people must remain in an unproductive situation regarding careers. They cannot even help one another, and they rely on us to help them. The biggest way we can help them is to correct the problem and prevent the problem from happening in the first place. There is only one way to prevent and corrent the problem and that is to put together a winning team of scientists, set up parameters and objectives, and keep that team working sedulously toward the ultimate result. Private funds are inadequate and the problem is too large. The only viable way to accomplish our goals is for this committee to award the National Eye Institute its budget in full. Anything less prolongs the problem and certainly, if any one of us were a part of the problem, we would find it impossible to understand why men who make the decisions to help, could possibly make one that gave less than its fullest support.

FRIENDS OF EYE RESEARCH, REHABILITATION, AND TREATMENT BUDGET REQUEST

Dr. CHANDLER. I am John Chandler, and like Mr. Murray I am here on behalf of the Friends of Eye Research, Rehabilitation, and Treatment. I will just hit the summary points in my written testimony for the sake of time.

First of all I would like to point out that the administration's proposed budget for fiscal year 1981 of $116 million would represent a second consecutive year of decreased funding in actual constant dollars for the National Eye Institute.

Second, since the National Eye Institute is only 10 years old, this level of support will create chaos and result in the loss of current investigators and a failure to attract new investigators—the very thing that Dr. Fine touched upon. It will take approximately another decade to recover from that setback.

The total estimated cost of blindness to Americans in 1980 is $8 billion. Therefore, in comparison, a 2-percent research and development budget of $163 million is quite small. This is the Citizens Budget that Dr. Fine spoke on behalf of, for research to prevent blindness, and one that we also advocate.

A budget of $116 million—that is the administration's proposed budget—would mean support only for committed, noncompeting grants. No funding would be available for new, approved individual grant applications, clinical research training, or construction.

A budget of somewhere in the neighborhood of $137 million would provide, barely cover for the National Eye Institute to meet its current commitments—that is, the ongoing, noncompeting renewals and to fund approximately 50 percent of new, approved individual grants—and that's the level that Congress in the past has recommended. But this budget would provide essentially no moneys for growth. That would just keep us at the level that we are at now.

A budget of $163 million would provide funds for honoring the current commitments, and provide reasonable funds for growth of this young Institute at this critical time. It would also bring the funding of the National Eye Institute into closer alinement with the projected $171 million in the 5-year plan created by the National Advisory Eye Council. This is the plan about which both Dr. Maumenee and I discussed with you last year, that was written to be implemented in 1978 to run through 1982, and I believe we left you with three volumes then. We are currently actually running a year behind that. But the proposal would be for $171 million. So our $163 million comes a bit closer to that target, and the targets that were set in the proposal. Thank you.

[The statement follows:]

Statement of John W. Chandler, M.D.

I would like to speak with you regarding the budget of the National Eye Institute for fiscal year 1981 as a spokesperson for Friends of Eye Research, Rehabilitation, and Treatment (FERRAT). This organization represents the views of concerned citizens, patients with blinding eye diseases, and physicians and scientists who serve these patients. FERRAT represents these persons as well as blind and visually handicapped organizations in all fifty (50) states. Despite our diverse backgrounds, we share certain common concerns - the personal hardships of blinded individuals; the enormous costs, both personal and to the taxpaying public, of blinding diseases; and the critical need for an adequate budget for the National Eye Institute to carry out research to sucessfully prevent diagnose and treat these eye diseases.

My specific purpose is to demonstrate to you, that the National Eye Institute requires a budget in excess of the $116 million requested in the administration's proposal for fiscal year 1981. FERRAT recognizes that there are strong reasons, both economic and international, to exercise fiscal constraint. However, the current fiscal year appropriation and the proposed appropriation both represent large reductions in real dollars available for research supported by the National Eye Institute. This situation undoubtedly will result in a negative impact for at least a decade. This is especially bad because the National Eye Institute is only ten years old. Yet, it has been instrumental in developing a solid group of basic and clinical scientists across the country. Their research programs are reaching their most fruitful periods and they, in turn, are attracting bright, new scientists to eye research. These new scientists add a new dimension - they are trained and skilled in disciplines that are required to advance research on blinding diseases, their cures and prevention. However, these scientists must enter a partnership with established ophthalmic researchers in order that new efforts can be focused in appropriate directions. Therefore, FERRAT also supports the budget of $163 million recommended by Research to Prevent Blindness. This level of support of the National Eye Institute would provide an ideal milieu for research that will lead to cures and successful treatment of eye diseases. This approach would represent a very modest investment in research when compared to the dollar costs to Americans for the care and rehabilitation of blind persons which is estimated to cost eight (8) billion dollars in fiscal year 1980. This figure is based on estimated costs of treatment, hospitalization, lost time from work, and governmental assistance programs. Recent statistics published by the American Foundation for the Blind show that some 10 million Americans are victims of major eye problems that currently cannot be corrected by regular medical, surgical or optometric intervention. Our proposed budget for fiscal year 1981 represents approximately 2 percent of the cost of the problem. This is a very small budget for research and development. Yet, it holds great promise in controlling and reducing the enourmous costs of blindness and improving the quality of life of these visually impaired persons.

The 1977 report of the National Advisory Eye Council entitled, "Vison Research, A National Plan: 1978-1982" was carefully developed to allow a comprehensive, efficient approach to research. Funding has lagged behind that plan and, therefore, so has progress. Yet, the National Eye Institute is frequently cited as being among the institutes that has enjoyed the biggest funding increases and has, in turn, funded a much greater percentage of approved grants. These assertions are apparent, not real. Since the National Eye Institute is a new institute and started ten years ago with a small funding base, even small increases look large when one looks at these as percent increases. Similarly, the National Institutes of Health "Fact Book" provides some very illuminating information. If one looks at the 1969 budget for the National Eye Institute, it was $21.5 million in current dollars (or $20.4 million in constant 1968 dollars). In 1977, the budget was $63.7 million. This suggests that funding had tripled. However, when the 1977 budget is translated into 1968 constant dollars, it was $35.6 million. In fact, that budget was only 1½ times larger!

The National Eye Institute has placed great emphasis on the support of individual research grants instead of large long-term program projects, and contracts. In a new institute, individuals must become accomplished investigators before committing funds to larger, long-term research programs.

In addition, peer review allows a critical analysis of the progress of a scientist's research. Finally, the reason the National Eye Institute funds a higher percent of approved grants is because the average yearly budget is $70,000 per grant versus $110,000 for the rest of the National Institutes of Health. So, one can not directly compare funding rates without taking this large disparity into account. In brief, a budget of $163 million would bring the National Eye Institue to a level that ensures that its solid foundation can be maintained and planned growth can occur.

In contrast, the administration's proposed budget would bring a large reduction in real dollars. It would barely allow the National Eye Institute to contine funding existing research commitments. Probably no new approved, competing grant applications could be funded. This would mean that new investigators would be lost to the field. No money would be available for training new scientists. These two negative impacts could deprive countless blind individuals of the ideas, research and scientists who are the keys to solving the puzzles of blinding diseases and their cures. A budget of $137 million is required simply to allow the National Eye Institute to fund 50% of approved investigator grants (a level recommended by congress) and to meet other current funding commitments and provide some funds for training new scientists. However, $163 million would provide funding for reasonable growth especially for approved individual grants and clinical research. It would also bring the National Eye Institute budget in closer approximation to the $171 million projected in the previously mentioned five year plan. The difference in the monetary investment for success and that for detrimental chaos in vision research are small. But the decision is critical and to slight vision research will produce adverse consequences for a decade because of the loss of manpower.

In summary, the budget for the National Eye Institute for fiscal year 1981 needs to be large enough to accomplish several objectives:

1. Fund all noncompeting commitments for research projects.
2. Fund at least 50 percent, and preferably 65 percent of approved competing individual project research applications.
3. Honor all core center grant commitments, and award at least six new core center grants.
4. Honor all specialized clinical research center grant commitments.
5. Provide approximately $6 million for support of training to prepare young scientists for life-time, productive careers in ophthalmic research.
6. Honor commitments to approved clinical trials.
7. Provide funds to maintain and enhance intramural research, development and administration.
8. Provide funds of $10-15 million for the construction of research facilities.
9. Provide funds for National Eye Institute sponsored workshops to disseminate knowledge and information between scientists from various disciplines.

These are all key parts in the long-term plan to provide this country with top quality research on blinding disorders and their prevention and cure. This is a critical year. The vision research community is small. Two years of decreased support of the National Eye Institute will be disastrous for many years. On the other hand, adequate support will pay large dividends in terms of decreasing the personal and public effects of blindness. Most especially, adequate funding of individual grants, centers and training must be achieved.

CONSTRUCTION FUNDS

Senator HOLLINGS. How much, Dr. Chandler, would you include in that for bricks and mortar, if any?

Dr. CHANDLER. If we could, in the $163 million, it comes to somewhere around $15 million. If you drop back to the $137 million, that leaves you somewhere in the neighborhood of $10 million for bricks and mortar. We share the same concerns. Everywhere people have been able to carve out, to some extent, unreasonable, somewhat antiquated facilities for most of our research. Adequate facilities is becoming a

critical need that has never been served for the eye research community.

Obviously the first demand in the young institute has got to be moneys to support the people. If we don't have the people, the bricks and mortar and the p'aces for them to work are of somewhat less priority, but they do go hand in hand. We need both.

We are starting to reach a critical mass. By a "critical mass," I mean a group of integrated scientists, not just opthalmologists and opthalmic researchers, but the people from other disciplines that now see their kinds of research having a clinical application, to have bearing on something very fruitful to them and to people with blinding diseases, or people who potentially have them.

Senator HOLLINGS. Dr. Fine, there's a bit of a difference of opinion, I take it, about the bricks and the mortar, the construction funds that are necessary? Is that correct?

Dr. FINE. I don't think so. I think we're both speaking to the same problem. I think if one is asked to choose between supporting an investigator and building a building, I think you would choose the investigator and figure out where he's going to work.

Senator HOLLINGS. Right.

Dr. FINE. But as I have visited on site visits some of the eye research facilities in this country, I would liken it to having the U.S. Senate occupy this room for its entire office structure, with the secretaries and staff in the outside waiting room. It is just incredible how laboratories have been placed in makeshift spaces that were formerly laboratories and waiting rooms. Six or seven people will be working in a laboratory that was designed for one or two. The work is being done through prodigious efforts, but at an incalculable risk to human life at some times.

Senator HOLLINGS. Very good. We appreciate your appearance here today. Thank you very much.

NIH RESEARCH RESOURCES

STATEMENT OF RONALD HUNT, M.D., ON BEHALF OF THE NEW ENGLAND PRIMATE RESEARCH CENTER, HARVARD MEDICAL SCHOOL

NIH RESEARCH CENTERS

Dr. HUNT. Senator Hollings, I am here to represent the seven regional primate research centers in the United States which comprise one of the most unique and valuable animal resources within our Nation. The Congress can be congratulated on the wisdom that they displayed in creating this program in the early 1960's; but without a substantial increase in funding, I have been informed by the Primate Research Center's program director of the National Institutes of Health, one or more of the centers may have to be closed.

This would have very serious consequences on many biomedical research programs supported by the National Institutes of Health at many universities, including those which do not have one of these seven regional centers.

I would like to make a few comments concerning nonhuman primates. These comprise some 200 species of monkeys and various great apes, chimpanzees, gorillas. They are very unique animals. They are man's closest relative. Because of that, they are really indispensable to many programs in biomedical research.

What the Primate Centers are doing are providing the backbone for the use of primates in research. They are conducting the necessary research to better understand their health, to insure their conservation, and simultaneously contributing more understanding of human disease.

PRIMATES IN DISEASE RESEARCH

There are some studies which can only be done within primates. I might use an example at my own center, a small monkey known as a cotton-top marmoset. It's the only species known to mankind that is susceptible to the one and only virus which is thought to cause cancer in human beings—namely, the Epstein Barre virus. No other animal species is susceptible to this virus.

These species are endangered. The only colonies of any size exist within primate centers. We don't know how to breed them well; we don't know how to maintain their health. If we don't do the necessary research to learn this, the species may be lost to mankind.

There are many other examples which could be cited. In studying these animals, we not only learn about the animal, but many interesting other observations are made. Sometimes they could be labeled as "breakthroughs."

For example, in studying this small cotton-top marmoset at our center, we uncovered a virus, in trying to understand their normal viral diseases, and were able to demonstrate for the very first time in medical history that a virus related to the common cold sore in human beings could cause cancer in a mammalian species. It had been demonstrated earlier in chickens, but we were able to demonstrate this in a monkey and are now conducting studies to potentially develop a vaccine for a particular form of cancer group we're studying, which is leukemia.

There are many examples from all the centers. Currently there are over 360 different research projects within the seven primate research centers. These include such subjects as: Cancer, hypertension, athrosclerosis, learning abilities, communication, environmental pollution—to mention a few of them.

RESOURCE POOL

Now one of the important roles of the primate centers is that they are not islands unto themselves; but these serve as regional resources to the entire biomedical community—not just the university that serves as host to the centers, but any investigator who has approved programs—generally programs approved by the National Institutes of Health—can come and use these facilities.

For example, at the Harvard facility we have investigators from Mt. Sinai School of Medicine in New York, Yale University, Brown University, University of Massachusetts, Worster Foundation, the University of Chicago, Massachusetts Institute of Technology, just to mention a few.

These people have NIH-approved grants to conduct studies on primates to better understand human health. I am able to meet approximately one-third of the funded requests which come to my door.

This is because monkeys are no longer available from the wild. India has placed a total embargo on the export of all animals. Brazil has done the same thing. Colombia has done it. The United States has to breed their own animals. Without primate centers, we are not going to have these valuable species.

BUDGET REQUEST

Although there have been some modest increases in the budget, the operating expenses have increased so tremendously that we are actually falling behind. Last year Congress did appropriate a $1 million increase for the seven primate center programs.

After indirect costs are removed from this, this amount is about a $60,000 increase. I want to emphasize that the total appropriation for primate research centers includes all indirect cost expenses. It is not like most research grants. So if you view an indirect cost rate of 70 percent-plus, which is what happens with most universities, a very large chunk of the proposed $17.1 million budget of the primate research centers goes to indirect costs—that is oil, electricity, heat, administration, et cetera. So we are talking about a very modest budget.

I feel to maintain our activities—not to expand the program—the budget should be increased from $17.1 to $22.1 million. This will allow the centers at least to exist, and continue at their present rate—albeit, this cannot even meet the demands placed upon us by the National Institutes of Health.

I think it is an extremely modest investment, when compared to the total rewards. And I think even if the total NIH budget should be reduced, very serious consideration should be given to some redistribution of funds to save this program.

I would encourage members of the committee possibly to contact the program director at the National Institutes of Health who, as I said, just last week told me that without an increase one or more of the centers may be closed—which I think, for the size of the investment we are talking about that I'm recommending, a $22 million program—that is something the country cannot afford not to do.

Senator HOLLINGS. What effect, if any, has the export ban on rhesus monkeys from India had?

Dr. HUNT. We have not been able to bring a rhesus monkey into the United States in almost 2 years now. The effect that it has had is that investigators who wanted to use the rhesus monkey, which was in essence sort of the work horse of the monkey field—we knew more about rhesus monkeys than any other monkeys—have not been able to do rhesus monkey research.

They are turning to some other species, but they have to go back and relearn everything they have learned on the rhesus. When I mentioned 200 species of monkeys, these are separate species. It's not like comparing a Great Dane and a Chihuahua; they are the same species. The rhesus monkey is unique. There are several other monkeys within that genus, but they're all separate species of animals. It's like comparing dogs and cats.

Senator HOLLINGS. Very good. We thank you a lot for your presentation.

[The statement follows:]

Statement of Ronald Hunt, M.D.

I am Dr. Ronald D. Hunt, Director of the New England Regional Primate Research Center and Professor of Comparative Pathology at the Harvard Medical School. It is a privilege to appear before you as a representative for the seven regional Primate Research Centers. I am requesting an additional 5 million dollars for this program, over the 1 million dollar increase in the proposed budget.

The seven regional Primate Research Centers comprise one of the most unique and valuable resources within the Nation. The wisdom that Congress displayed in creating this long-term program in the 1960's showed forethought. Without a substantial increase in funding, however, I have been informed by officials at the National Institutes of Health that one or more of the seven Centers may have to be closed. Reduction in the effort at a time when we should be considering expansion of the program would have very serious consequences to biomedical research supported by the National Institutes of Health.

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. Non-human primates are of proven need and value as experimental animals, but without the Primate Centers' program, they may become unavailable. Non-human primates are man's closest relative in the animal kingdom and are therefore indispensable in the effort to understand and control problems of human health. Many critical studies of human health can only be conducted in nonhuman primates. For example, a small monkey known as the cotton-top marmoset is the only species known to mankind that is susceptible to the one and only virus thought to cause cancer in human beings. This species can no longer be imported from the wild and is exceedingly difficult to maintain in captivity. No one knows how to breed the species, understands its dietary requirements or why the death rate is so high. We have made

great progress in these areas at Primate Research Centers, but without our effort the species may be lost.

Our knowledge of all species of non-human primates has greatly expanded as a direct result of the Primate Centers Program, but there are many gaps to be filled. These types of studies can only be conducted within the environment of a Primate Research Center.

In addition to our activities in resources research, each Center provides an environment for 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. These programs are for the most part supported by grants or contracts from categorical institutes of the N.I.H. The Centers provide the environment in support of these programs. I will not expand on the specific studies but the programs collectively are concerned with over 360 different research projects, including studies on cancer, hypertension, atherosclerosis, diabetes, drug addiction, vision, leukemia, nutrition, reproductive physiology, allergy, multiple sclerosis, infant mortality, learning, genetics, and environmental pollution.

The Primate Centers are not islands unto themselves, but serve as resources for the entire biomedical community. As a resource, the Centers provide facilities for the care, management, and utilization of non-human primates; provide professional and technical experts to assist the collaborative research programs; ensure supply of non-human primates. Supply is one of the most important and pressing problems for the Centers as well as the Nation as a whole. The majority of countries which have indigenous populations of non-human primates have placed total embargoes on their exportation. This means we must breed our own in facilities not designed for this purpose. At my own Center, we are only able to meet one-third of the needs of N.I.H. supported research in the community. There are about 416 collaborating and affiliated scientists who depend upon the resources of the Centers. At the New England Center, our resources support programs at Harvard Medical School, Harvard Schools of Dental Medicine and Public Health, Boston

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University, Tufts University, Brown University, Yale University, University of Lowell, University of Massachusetts, Children's Hospital in Boston, The Worcester Foundation, the University of Chicago, Massachusetts Institute of Technology, to mention a few.

The budget of the Primate Research Centers has declined despite modest increases. Last year Congress awarded a one million dollar increase. This translated, after deductions for indirect costs, into about $60,000 per Center. This does not even allow for modest increases in salaries, let alone the dramatic effects of inflation. It is important for this Committee to recognize that the total appropriation for Primate Centers includes indirect costs. Indirect costs are not a separate negotiable item as they are with the usual government grants system. I don't have to bring to your attention the escalating costs of oil or electricity which I must pay out of the Center's operating Grant. The physical facilities are now over 15 years old, requiring increased expenditure for maintenance, again reducing available dollars for research and resources.

The budget as proposed by the Administration includes a one million dollar increase which, I want to emphasize again, will translate into about $60,000 per Center. It will be impossible to maintain the current program at this level of funding. Programs, jobs and support of several million dollars of N.I.H. reviewed and supported research grants will be lost. Loss of jobs also means 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 budget must be significantly increased.

As the Primate Centers Program budget is included in the Animal Resources Program budget of the Division of Research Resources, the increase must be designated for Primate Research Centers.

In view of our total health budget, this increase is a very small investment when compared with the rewards of improved health for our Nation.

NATIONAL INSTITUTE ON AGING

STATEMENT OF WILLIAM MACAUSLAND, JR., PRESIDENT, AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

MUSCULAR SKELETAL RESEARCH

Senator HOLLINGS. Our final witness today is Dr. MacAusland, who would like to testify on a variety of health programs.

Dr. MACAUSLAND. Mr. Chairman, I am Dr. William R. MacAusland, Jr., currently president of the American Academy of Orthopaedic Surgeons. I am a practicing surgeon from Boston, Mass., and I appreciate the honor and privilege of appearing before this committee.

I appear here to urge your continued and considered support of muscular skeletal research in the NIH. I would like to demonstrate two methods of effectiveness of NIH research that has currently aided us as clinicians.

I would like to first of all call your attention to the fact that we have, through NIH's past granting and continued funding, now developed a program for stimulating bone union. Most fractures heal when properly taken care of; but many don't, for many reasons. And to heal these fractures has in the past called for many repeated hospitalizations, repeated surgery, and indeed sometimes loss of limb in order to get the patient out of his situation.

As a result of past and ongoing funding from NIH, we have now come up with a technique of electrical stimulation in which this apparatus I have brought with me can be applied to the given extremity, for example, around the leg where the fracture is. This can be done at home through this current. An electrical current is passed over the fracture site. Now this has been used successfully——

Senator HOLLINGS. Can that be applied to muscles, as well?

Dr. MACAUSLAND. No, this is just for bone unions.

Senator HOLLINGS. Just for bone unions, but not muscles. It won't promote the union of a muscle?

Dr. MACAUSLAND. No, this would not affect the union of a muscle. There is a similar program going on for muscle stimulation for external support.

Senator HOLLINGS. There is?

Dr. MACAUSLAND. Yes.

Senator HOLLINGS. Is it as advanced as this is? I am thinking of Barry Goldwater. He hopes his fracture grows together. He doesn't know whether it will.

Dr. MACAUSLAND. I believe his problem is the hip, isn't it?

Senator HOLLINGS. No; it's down there on his leg. You can look at his cast.

Dr. MACAUSLAND. I can't answer that question, sir. I don't know his specific problem.

Senator HOLLINGS. Well, he had hip troubles, but this is another——

COST SAVINGS OF ELECTRIC CURRENT SOURCE

Dr. MACAUSLAND. He had hip problems, which I would like to come to. But this machinery, which uses an electrical stimulation, can be done at home. We have figures, which I will just check and read exactly, that in 1,800 cases this has been used successfully. The estimated savings in hospital costs, surgery, and the dilemma of the individual has been about $10 million.

If you take the estimated number of delayed and nonunion long-bone fractures in this country, some 40,000, and if this technique can be expanded, perfected through continued research to make it simpler, less cumbersome, and less time consuming, we estimate that—and this is a published figure in the Journal of Bone Joint Surgery—a savings of $1.5 billion in hospital costs and surgical fees.

JOINT REPLACEMENT

So we feel that this, as an exemplary item of biochemical research funded by NIH, should be supported. I would like to touch on a second subject, which is perhaps more commonly known, and this is joint replacement.

Currently in this country some 80,000 people are having their hip joints replaced every year. The hip joint replacement basically is this apparatus which goes into the thigh bone and becomes the ball for the arthritic hip, the degenerative arthritic hip. And this is a perfectly fitted polyethylene plastic, and this goes into the pelvis.

Now the design of this replacement, the chemical formation of this, and the mechanical design of the replacement has been perfected in this country through support from NIH. We have ongoing programs throughout the orthopedic community to continue to perfect and to simplify this technique.

One of our major problems that we are currently devoting a lot of interest to is demonstrated by this model, in which the prosthetic head is now in the bone—and this is an actual human bone. The plastic demonstrated here by the putty, methylmethacrylate, or we use the term "cement," has been good.

We have now used this for about 10 or 12 years, but we are beginning to see signs of loosening, where the prosthesis through wear and tear is beginning to loosen, and we are seeing a certain number of these people that have to be reoperated on.

The major reason for this is that we have as yet not developed a perfect type of a bonding mechanism to take an inert, inorganic substance and make it stick, literally stick to an organic, living material. Research on this in NIH has been going on for years. We want to continue this support. It is effective, but there is a lot more that needs to be done.

The third item I would like to touch on briefly, without props, is the statistical figure that we have some over 240,000 broken hips a year in this country—90 percent of these are in elderly women, postmenopausal women who have lost the calcium content of their bones.

The problem we and NIH is facing is the degree to which we can restore the strength of the bone through diet, through hormone therapy,

through basic bench laboratory research to develop better metabolic reaction to the human body to the aging process, and therefore prevent the problem of fractured hips.

With these three subjects, I would urge, and I have prepared a written statement which I would hope would be included——

Senator HOLLINGS. It will be included.

Dr. MACAUSLAND [continuing]. We urge the continued support of the NIH in muscular skeletal research.

I thank you for the privilege of being here.

Senator HOLLINGS. I thank you very much for coming and presenting this this afternoon.

[The statements and following testimony on programs or topics related to the March 10, 1980, public witness testimony were submitted for the record:]

STATEMENT OF WILLIAM MACAUSLAND, JR.

Mr. Chairman, I am William MacAusland, M.D. and I am in the private practice of orthopaedic surgery in Boston, Massachusetts and President of the American Academy of Orthopaedic Surgeons.

I am pleased to appear before you today to present the Academy's position on the need for continued and, if possible, expanded funding of research on the musculoskeletal system, as well as to request adequate funding for the National Institute of Handicapped Research, Sports Medicine and Emergency Medical Systems.

First, Iwould like to briefly describe the American Academy of Orthopaedic Surgeons. The Academy's membership consists of approximately 9,000 Board Certified orthopaedic surgeons. Over 90% are in private practice. One objective of the Academy is to foster, promote, support and encourage investigative knowledge of orthopaedic surgery and the prevention of disorders of the musculoskeletal system -- bones, joints, muscles, ligaments and tendons.

Musculoskeletal diseases afflicted about 20,000,000 people in this country. They rank first among diseases which affect the quality of life, as indicated by the extent of activity limitation, disability, impairment and handicap.

When one looks closely at the more common musculoskeletal conditions known to cripple and handicap our citizens and the accompanying economic burden, the case for additional research into the causes, prevention and treatment of these diseases becomes obvious. I would like at this point to identify a few of these conditions:

- over 16 million Americans experience the pain and progressive joint degeneration of osteoarthritis; many of whom become candidates for joint replacement;
- most elderly women are victims of osteoporosis which substantially increase both the risk and actual numbers for fractures past the age of 60

years, resulting in immobility and prolonged bed rest;

- the majority of the population is at some time affected by back pain, the most frequent cause of activity limitation in persons under 45 years of age in the United States and a major cause of absenteeism and lost earnings;
- fractures, dislocations and sprains affect at least one out of every ten Americans each year and account for reduced productivity and a substantial portion of the costs related to medical care.

Although substantial progress has been made over the last decade in diagnosis and treatment of these diseases, much more work needs to be done. In terms of orthopaedic research, the most exciting development of the last decade has been the development of the artificial hip. This achievement is now serving as a model for design of knee, ankle, wrist and other joint implants. This breakthrough has improved the quality of life of thousands of our citizens, while allowing them to remain mobile and productive members of society.

Another important development has been the use of electrical stimulation to help the healing process in patients with fracture complications. Without this technique, patients often require several operations and a long recuperating period. Conventional treatment adds substantial costs to the health care system. This technology represents a definite return on the investment of research dollars.

Fellows of the Academy recognize that the Congress is faced with difficult financial questions. However, we strongly believe that research -- from the laboratory, through the animal testing and human clinical trials -- must continue to have the support of the Congress. Research and <u>research training</u> provide for a healthy and sound future, and it is with this in mind that we recommend that the National Institute of Arthritis, Metabolism and Digestive

Diseases (NIAMDD) be appropriated $395,000,000 for 1981; and urge the Committee to direct NIAMDD to apply a substantial portion of these additional funds to support research in the prevention and treatment of arthritis and other musculoskeletal conditions.

With regard to the National Institute on Aging, we believe a funding level of $90 million is required in order to adequately support on-going research in this area; and in particular the special aging diseases of bone, muscles, ligaments and tendons found in the elderly.

At this point Mr. Chairman, I would like to call your attention to the National Institute of Handicapped Research. First, I would like to commend the Congress for establishing this Institute. Problems presented by the handicapped, needless to say, are numerous, complex and expensive.

The Academy believes that the establishment of this new Institute, with proper funding, will provide for a comprehensive and coordinated approach to the myriad of medical, rehabilitative, social and economic problems facing our handicapped citizens. There is a considerable amount of research work which still needs to be done to permit society to maximize the health, physical and emotional status of handicapped persons, their functional ability, self-sufficiency and self-development.

The Academy believes that the President's budget for this Institute is modest and represents a sound first step toward making the handicapped first class citizens. We urge the Congress to approve the funding request for this Institute at that modest level.

The next area I would like to turn to is sports medicine and sports injuries. This is an area of considerable interest to orthopaedic surgeons because of the increasing number of sports-related injuries we treat each year. With more and more individuals participating in both recreational and organized, professional or unorganized sports, injuries to the upper and lower extremities have become more frequent. As orthopaedic surgeons, we need more knowledge of the mechanical problems that lead to

"athletic injuries" in an effort to reduce the number of injuries and identify measures likely to reduce the incidence of degenerative arthritis in later years.

The Congress wisely recognized the seriousness of this problem and made special provision for Sports Medicine Research under Section 1907 of the Public Health Service Act. This Section states that there shall be established a program of grants to conduct research into the problem of athletic injuries. As of this date, the U.S. Public Health Service has not complied with the Congressional mandate to establish this program.

Because of its importance, the American Academy of Orthopaedic Surgeons respectfully request that the Congress appropriate $1,500,000 for a Sports Medicine Research Program as mandated by the Public Health Service Act.

There is a corollary program to the one I just mentioned; namely the establishment of State Councils on Physical Fitness. As you know, the Surgeon General recently issued his report entitled "Healthy People." In that report the Surgeon General identifies the need for health promotion activities. Mr. Chairman, I believe that an important ingredient to a successful health promotion effort is the establishment of the State Councils on Physical Fitness, as called for in Section 1706 of the Public Health Service Act. We believe these Councils will assist our citizens to better care for their bodies and will, in particular, help our youth learn the proper methods of body conditioning.

The last area of interest I would like to speak to is the Emergency Medical Systems. This is a program that the orthopaedic community has been involved in from the start. In fact, the program came about in great part as a result of the work of our Committee on Injuries.

As orthopaedic surgeons, we see everyday the outstanding work of the advanced life support systems, staffed by trained personnel, in reducing the morbidity and mortality rate from accidents and other conditions. The success of the program is well documented in the literature.

It should be noted that the programs -- once established and fully operational -- have been adopted by the States and supported with State and local money. Thus, it is not an open ended program totally dependent on Federal money.

I wish to emphasize that this effort has been one of the truly visible, more cost effective government programs of all time in the public health field. The current proposal to phase it out is premature, in my judgment.

The Academy urges continued funding of the Emergency Medical Systems Program at a level of $40,000,000.

Mr. Chairman, that concludes my remarks, and once again I want to thank the Committee for giving me this opportunity to present the Academy's views on the 1981 budget. I will be happy to answer any questions.

AMERICAN ACADEMY OF ORTHOPAEDIC SURGEONS

Summary of Recommendations - 1981 Budget

• National Institute of Arthritis, Metabolism and Digestive Diseases	$395,000,000
• National Institute on Aging	90,000,000
• National Institute of Handicapped Research	37,000,000
• Emergency Medical Systems	39,625,000
• Sports Medicine Research	1,500,000

OVERVIEW—HEALTH AND HUMAN SERVICES

Letter From Alton B. Cobb, M.D., President, the Association of State and Territorial Health Officials

March 12, 1980

The Honorable Warren G. Magnuson
Chariman
Labor-HEW Appropriations Subcommittee
1108 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Senator Magnuson:

I am writing on behalf of the Association of State and Territorial Health Officials to present our concerns on the priorities for federal health expenditures as proposed in the President's health budget. Specifically, we wish to recommend an appropriation of $95 million for Health Incentive Grants to States, Section 314(d) of the Public Health Service Act; $20 million for Formula Grants to States for Preventive Health Services Programs, Section 315 of the PHS Act; and $14.629 million for the Cooperative Health Statistics System program.

Health Incentive Grants to States

The 95th Congress passed P.L. 95-626, the Health Services and Centers Amendments of 1978; this Act included the Health Incentives Grant Program. In adopting this section, the Congress declared that:

(A) Individual health status can be effectively and economically improved through an adequate investment in community public health programs and services;

(B) The Federal government and the states and their communities share in the financial responsibility for funding public health programs;

(C) The Federal contribution to funds for public health programs should serve as an incentive to an additional investment by state and local governments;

(D) Existing categorical programs of federal financial assistance to combat specific public health problems should be supplemented by a national program of stable generic support for such public health activities as the prevention and control of environmental health hazards, prevention and control of health problems of particularly vulnerable population groups and development and regulation of health care facilities and health services delivery systems; and

(E) The states and their communities, not the Federal Government, should have primary responsibility for identifying and measuring the impact of public health problems and the allocation of resources for their amelioration.

We strongly concur with this policy. The best and least expensive form of health care is the kind that intervenes in the disease process before it happens, not afterward. And we believe this goal is best accomplished through an alliance among Federal, State, and local governments.

The good health most Americans enjoy and take for granted is no accident. In large measure it is a product of the vigilance of State and local health agencies, who see to it that our water is pure, our food and milk and restaurants safe. Control of such communicable illnesses as tuberculosis and venereal disease is the responsibility of these agencies, as are insect and rodent control. It is clear that in the future there will be a growing need for public health departments that will assure inspection and control of environmental hazards such as PCBs, Mirex, and Kepone.

We, as public health workers from all states, urge you to provide adequate Federal support for non-categorical public health services. In this time of spiraling health care costs, we must fully take advantage of all cost-effective preventive mearures or pay the much higher costs of illness and disability.

The Federal government continues to pour health dollars into the treatment of illness while cutting back funding for prevention services. In FY '80, the Administration succeeded in reducing considerably the appropriation for 314(d). We already are seeing the serious results of this cut, as in the rising incidence of tuberculosis throughout the United States. The Administration's request of $52 million for 314(d) in FY '81 represents a further reduction of $16 million. The apparent trend of reduction in these funds will severely jeopardize the ability of the states to provide comprehensive public health services. Past successes of public health will be eroded, leading to even more costly measures to correct the individual's and community's health.

If we hope to pay the lower cost of health rather than the higher price of sickness, we need fair share funding for prevention by the Federal government. The Association of State and Territorial Health Officials urges you to seriously consider the President's request and recommend a higher appropriation for 314(d) of $95 million.

Formula Grants to States for Preventive Health Services Programs

P.L. 95-626 authorized Section 315 of the Public Health Service Act, a new program of formula grants to states for prevention programs targeted to the five leading causes of death and illness in the state. The states are expected to develop specific activities designed to reduce through prevention of risk factors or causative conditions the rate of death and disease indicence. For example, smoking, hypertension, high cholesterol, and lack of exercise are risk factors for heart disease, the leading cause of death in this country.

This program is a natural complement to the 314(d) program. With the Health Incentive grants, the states can concentrate their efforts on acute health problems, establishing their own priorities as needed. Through the 314(d) program, however, states rarely have funds available for activities to prevent degenerative diseases. The 315 program is designed to build state capacity to implement new and expanded prevention efforts. Support for these two programs should not be an either/or proposition.

ASTHO recommends an appropriation of $20 million for the Formula Grants to States for Preventive Health Services programs.

Cooperative Health Statistics System

The Cooperative Health Statistics System was established by Congress for the purpose of producing comparable and uniform health information and statistics at the National, State, and local levels. Congress has since enacted other legislation that recognizes the need to utilize CHSS to avoid duplication of effort in the collection of needed health data.

The President's request of $6.673 million for CHSS is a reduction of $7.956 million from FY '80. It is recognized that there is a need to carefully scrutinize the 1981 budget and make reductions where appropriate. However, the burgeoning medical care budget, in excess of $150 billion annually, clearly indicates a need for a better understanding of those factors that contribute to good health and the high-risk factors that contribute to poor health. The almost eight million dollars cut from the Cooperative Health Statistics Program must be restored to ensure that a minimum of the State and local health data needs continue to be met. Failure to restore these funds will result in the use of inadequate data for development and support of strategies to control health care costs.

ASTHO recommends a continuation of the FY '80 level of $14.629 million for the Cooperative Health Statistics System program.

Thank you for your attention to these recommendations that:

1) The appropriation for Health Incentive Grants to States be raised to $95 million;

2) There be appropriated for Formula Grants to States for Preventive Health Services Programs $20 million; and

3) The FY '80 level of $14.629 million for the Cooperative Health Statistics System program be continued in FY '81.

The Association respectfully requests the inclusion of this letter in the hearing record.

Sincerely yours,

Alton B Cobb

Alton B. Cobb, M.D.

HEALTH SERVICES ADMINISTRATION PROGRAMS AND TOPICS

Statement of the American Association of Nurse Anesthetists

This testimony is presented on behalf of the American Association of Nurse Anesthetists, an association of the 15,000 nurse anesthetists currently practicing in the United States. The Association, through its Council, serves as the accrediting body for the training programs in this field.

A nurse anesthetist is a registered nurse who has achieved his or her initial nursing degree and certification and who has been trained in the administration of anesthesia in a graduate program which is of 18- to 24-months duration. A nurse anesthetist must also take a national examination and be certified as a nurse anesthetist; hence, the professional designation of Certified Registered Nurse Anesthetist ("CRNA").

Under the Nurse Training Act Amendments of 1978, a new program was established to support traineeships in this field. The program is authorized for FY 1980 at $2 million, and like all Nurse Training Act programs, must be extended into FY 1981 and later years. The Administration has proposed a $1 million reprogramming of funds to start this program in FY 1980 and new budget authority of $1 million for FY 1981. The Administration has proposed the extension of this program into FY 1981 and its extension is included in a bill recently introduced by Senator Kennedy.

Funding of this program in FY 1980 and FY 1981 is critical. There is a serious shortage of nurse anesthetists and this shortage jeopardizes programs in many areas of the country, particularly those with smaller hospitals. The importance of nurse anesthetists is attested to by the fact that 65% to 67% of all anesthesia administered in hospitals of 1 to 99 beds is administered by nurse anesthetists. A little over 50% of all anesthesia services is provided by nurse anesthetists, while about 38% is provided by anesthesiologists, and the remainder by physicians not specializing in anesthesiology.

A 1976 HEW study by the Bureau of Health Manpower established a need for nurse anesthetists in 1980 at between 22,000 and 25,000. This estimate is based on varying assumptions of the appropriate number of anesthetists practicing in a team with a physician. The estimates range from 2-to-1 to 4-to-1. At present, there are only 15,000 nurse anesthetists and therefore at least 50% more are estimated to be needed by the HEW study.

The use of nurse anesthetists in a team working with an anesthesiologist or in some hospital settings without anesthesiologists (40% of all hospitals surveyed in 1971 had only anesthetists on staff) is an efficient method of delivering services. Seventy percent (70%) of nurse anesthetists are salaried hospital employees and 25% are salaried employees of anesthesiologist group practices. Their salaries are about $18,000 to $20,000. This compares favorably from a cost savings point of view to the salaries of anesthesiologists. Without an expanded number of nurse anesthetists, anesthesia will either be administered by more costly methods, which cost Medicare and Medicaid will have to absorb, surgery will be delayed for lack of personnel or anesthesia will be administered by untrained personnel. Certainly, the administration of anesthesia is a highly technical skill which if practiced by the unskilled can have very serious effects.

Training support in this program will be provided to accredited nurse anesthetist training programs of which there are now 165. There were 225 about 3 years ago, but many failed for lack of support. The programs are all hospital-based at present and not part of universities or diploma nursing programs. For this reason, they and their students are not eligible for any student aid offered by the Office of Education or the other Nurse Training Act programs.

The grants will be used only for traineeships and will cover the costs of tuition and fees, and a stipend and living allowance. Tuition ranges in amount, but the Department estimates that the cost of education alone at about $5,000 to $6,000 per year. Certainly, living allowances for a student are at least that. Due to the heavy clinical and other course requirements, students cannot work during their program to supplement their incomes. Thus, many students cannot afford to enter this field. Hospitals seek to provide living allowances as well, as bearingthe costs of space, equipement and staff time that go into teaching this specialty. However, 66% of the hospitals surveyed by us indicated a need for further student support. Hospitals cannot afford to expand enrollments without traineeship support to cover the cost of living.

The $1 million request by the Administration will support grants to about 75 programs or 45% of those in existence. Each traineeship would average about $4,333. This would represent a substantial portion of the cost of education and living for trainees, but far from the full cost of both. Many of these students are married with families. We would recommend full funding of this program which would permit grants to about 80% of the accredited institutions with awards averaging closer to $5,000.

We urge the Subcommittee to provide $2 million in the FY 1980 supplemental appropriation and the same amount in the FY 1981 bill.

STATEMENT OF WILLIAM R. CUNNICK, JR., M.D., PRESIDENT,
AMERICAN SOCIAL HEALTH ASSOCIATION

On behalf of the American Social Health Association, I wish to express my appreciation for the opportunity to submit testimony regarding the Fiscal Year 1981 Labor-HEW Appropriations Bill. The American Social Health Association, a non-profit voluntary health organization founded in 1912, is the only national agency singularly focused on the prevention, control, and eventual elimination of epidemic venereal disease in the United States.

Among ASHA's programs and services are the Venereal Diseases Research Fund, which provides training grants for postdoctoral research on sexually transmissible diseases; the VD National Hotline, a toll-free 24-hour venereal disease information and referral service; HELP, a program to provide information and support to the millions of sufferers of herpes; and professional and public information programs.

Although it seems the problem of venereal disease has always been with us, it is an issue of great dynamics, and particularly in just the past several years the dimensions and components of the problem have shifted dramatically. There are many new factors in the overall equation, which are developing and changing rapidly, and we must begin to address the issue anew in light of these needs.

The most important new concerns in the effort to control VD are: 1) Sexually transmissible diseases in pandemic proportions among adolescents and pre-adolescents; 2) A "new generation" of sexually transmitted diseases which are increasing faster than gonorrhea or syphilis; and 3) the major impact of these diseases on mothers and their infants, and on human reproduction and fertility.

Scope of the Epidemic

It is conservatively estimated that at least 10 million Americans will contract a venereal disease this year. HEW estimates that 33 percent of these cases are among teenagers, 86 percent among young people 15 to 29 years old. Assuming that 3.3 million teenagers get VD this year, this translates to an attack rate of one in every eight teenagers infected with a venereal disease.

Aside from the major acute emotional and medical difficulties experienced by most of these young victims, the most compelling tragedy is the fact that nearly 50,000 young women under 25 years of age will be left pathologically sterile by the diseases. Today VD is the single greatest cause of unintended sterility of women of child-bearing age.

Sexual activity is beginning for both males and females at younger and younger ages, and marriage occuring later, thus there is an increasing proportion of young people who are not only sexually active, but who have had more than one sexual partner.

These young people run higher risks of developing serious medical complications from the diseases because they are less likely to seek medical treatment. They are woefully uninformed and misinformed about the symptoms and dangers of VD. There are but a few school districts in the country that offer good comprehensive VD education programs. Fiscal year 1980 was the first year that legislation required that at least five percent of appropriated funds for CDC's VD Control program be provided for information and education programs, which are crucial to reach this young group.

This is not to imply that young people are the only high-risk population. There is another new segment of the population joining the ranks of the high-risk VD category. This is a function of another American phenomenon -- divorce. The soaring divorce rates in the nation have created a tremendous population of older single people, traditionally not high-risk for VD, but who are now single and sexually active.

Data from ASHA's VD National Hotline have shown that callers to the Hotline span a remarkably wide age spread. Callers in the 14 - 25 age group number about the same as callers in the older 25 - 45 category. This group is as ill-informed as the teenagers. They have been married and monogamous and therefore VD was not an issue in their lives. The only information they might have received about VD was in the armed services. There is a great need to address this lack of information.

The New Generation of Diseases: Herpes

Herpes simplex virus (HSV) disease has emerged as the most prominent sexually transmissible disease of the past decade. Herpes is different from

other sexually transmissible diseases in that it is caused by a virus, and is chronic, recurring, and lacking any effective therapy or prevention. A victim will remain infected and suffer painful recurrences of active disease throughout life.

The disease and its frequent complications affects perhaps 20 percent of sexually active adults in all socioeconomic strata. Incurable and unpreventable, and hence not subject to control in any sense, the reservoir of persons who are plagued with this disease could easily double or triple in the next few years.

Aside from the concern over the sheer magnitude of this problem, there are some severe medical consequences and a tremendous burden of anxiety each herpes sufferer has about them:

1) Genital herpes can seriously endanger a fetus during birth. Transmission of the disease, which can often be prevented with Caesarean birth, can cause serious neonatal disease or death. Herpes can also be responsible for spontaneous abortion or stillbirth. Of infants who contract the disease, roughly two-thirds die, and of the remaining one-third, over half suffer some form of sensory impairment or brain damage. Few aspects of herpes evoke as much concern as the threat the virus poses to the health of newborns of infected mothers, for few diseases can be as destructive or tragic.

2) The long-term consequence of herpesvirus infection has been linked to carcinoma of the cervix, a serious malignancy in women. Studies have shown such cancer occurs as much as ten times more frequently among women with herpes than among uninfected women.

3) Herpes has been shown to be a cause of male impotence, and has even been implicated in the formation of male genital cancer.

4) The herpes virus can be inadvertently transmitted into the eyes. Dr. Herbert Blough of the Scheie Eye Institute at the University of Pennsylvania cites ocular herpes as the most frequent cause of infectious blindness in the United States today, causing approximately 20,000 persons to lose their sight each year. The National Institute of Allergy and Infectious Diseases estimates that 500,000 cases of herpes of the eye occur each year, and although it can be treated, it, too, is a recurring virus, and must be treated with each episode.

5) The pain and discomfort of the disease, the knowledge of and anxiety about its possible implications for childbirth or malignancy, and the fear and guilt of transmitting the disease to another person create serious psychological trauma for herpes patients as well. Isolation, depression, loss of self-esteem, fear, guilt, social and relational dysfunction, and even suicide result among victims of this disease.

The New Generation: Chlamydia Trachomatis Infections

Each year in the United States more than three million Americans suffer the serious consequences of chlamydial infections. It is only in the past two years that medical science has come to realize these infections as a major public health threat. The organism is the major cause of NGU (nongonococcal urethritis) in men, which we now know is several times more common than gonorrhea. Statistics from Great Britain show that in that country NGU has increased six-fold in the past 20 years. A painful complication in men is epididymitis, which is potentially sterilizing.

Only recently we have realized that chlamydia produces serious complications in women. The organism can cause tubal infection (PID or pelvic inflammatory disease) which also can result in sterility or cause ectopic pregnancy. There are also implications for newborns, as chlamydia is the most frequent cause of infant eye infection and pneumonia in infants. In addition, chlamydia has been implicated as an agent in Sudden Infant Death Syndrome.

Chlamydial infections are spreading in staggering proportions due in large part to the fact that diagnosis is expensive and not readily available. Thus, many infections go without appropriate treatment. NGU is now the most common venereal disease among college students and among young people ages 16 to 25. It is important to note that both herpes and NGU have become firmly entrenched in the upper ranges of the socio-economic scale, with herpes often being termed the "middle class VD".

Complications for Women and Babies

As noted above, chlamydial infections can produce sterility in women as a result of pelvic inflammatory disease (PID). Another major cause of PID is gonorrhea; in fact, an estimated 10 to 20 percent of women with gonococcal infection will suffer from this painful condition, which, even

when treated, can result in recurrent salpingitis, ectopic pregnancy, and infertility, often requiring surgical removal of reproductive organs. An estimated 100,000 women of child-bearing age will become infertile this year from these complications, half of them under 25 years of age.

In 1977 ectopic pregnancies (tubal pregnancies) were responsible for more than 41,000 fetal deaths. Studies have shown increases in ectopic pregnancies over the past decade in direct relation to increased rates of sexually transmitted disease. Each ectopic pregnancy causes one fetal death, and such pregnancies account for 10 percent of maternal deaths.

Prenatal testing and treatment of pregnant women for sexually transmitted diseases have kept the incidence of gonorrhea and syphilis in newborns relatively contained, however as mentioned above, there is now a new range of diseases which impact strongly, and often tragically, on newborns.

Cytomegalovirus, like herpes, is a chronic, recurring virus. It has only been within the past decade that sexual transmission of this virus was determined. The Study Group on Sexually Transmitted Diseases convened by NIAID in January, 1980 stated that "in the 1970s the data were accumulated to support the assertion that infantile CMV (cytomegalovirus) is the most common known cause of mental retardation, the most important cause of deafness, and contributes at least 6,000 children a year to the ranks of disabled/retarded citizens."

It has now been shown that group B streptococcal diseases can be sexually transmitted, producing infection which, although not dangerous for adults, is devastating for newborns. Dr. Carol Baker at Baylor College of Medicine estimates 5,000 infant deaths annually can be attributed to group B streptococcal disease. The NIAID Sexually Transmitted Disease panel stated "these data indicate that in the past few years more deaths annually could be attributed to group B streptococci than were reported during the polio epidemic era of the 1950s." Those babies who survive often suffer meningitis, hearing loss, blindness, cerebral palsy, mental retardation and/or epilepsy.

Dr. King K. Holmes of the University of Washington has developed the following chart showing the impact of the four sexually transmitted diseases we have discussed on infants and provides projections over the next five years:

ESTIMATED* ANNUAL INCIDENCE OF INFECTION AND DISEASE IN INFANTS IN THE U.S.
CAUSED BY CYTOMEGALOVIRUS (CMV), CHLAMYDIA TRACHOMATIS,
HERPES SIMPLEX VIRUS (HSV), AND GROUP B STREPTOCOCCUS

	Infants Infected			Infants Affected by Disease		
STD Agent	Percentage of Births	Total Per Year 1976	1986	Percentage of Those Infected	Total Per Year 1976	1986
CYTOMEGALOVIRUS	1.5 (Congenital)	46,500	60,000	15% cognitive defects	6,975	9,000
CHLAMYDIA TRACHOMATIS	5.0 (Perinatal)	155,000	200,000	50% Conjunctivitis 20% Pneumonia	77,500 31,000	100,000 40,000
HERPES SIMPLEX VIRUS	0.032 (Perinatal)	992	1,280	65% Mortality 50% Morbidity in survivors	645 124	832 224
GROUP B STREPTOCOCCUS	25.0	775,000	1,000,000	1% Early onset disease	7,750	10,000

*Estimates based upon 3,100,000 births in 1976 and approximately 4,000,000 births projected 10 years later.

Center for Disease Control - Venereal Disease Control Program

Until 1972 the federal program to control VD consisted solely of a syphilis program. Since 1972, syphilis has been fairly well contained and the program has focused almost exclusively on gonorrhea. Although the program has suffered historic neglect and a roller-coaster of funding levels, it is one federal program which can be proven cost-effective. When federal dollars are increased to the program, the incidence of venereal disease decreases.

During this past year the VD Program has made a major breakthrough in its efforts to control venereal disease by directing attention on the consequences of the diseases as well as the diseases themselves. The American Social Health Association believes CDC should be commended for taking this initiative. We believe that this new dimension in venereal disease control efforts is an essential one. CDC's new program aimed at detecting and treating pelvic inflammatory disease presents a valuable opportunity to prevent sterility and other serious complications.

We believe that CDC's VD program must be permitted to expand. Legislation which provided funds this year for the first time to programs of information and education will enable valuable new efforts in this area which must be strongly supported and expanded.

Even in light of current financial constraints, it is time to make a substantial and real national commitment to continue and strengthen these services. We recommend an additional $10 million over the President's Budget Request for this program. This figure will allow the program to keep pace with the ravages of inflation and begin to address the new problems of preventing chlamydial infections and their consequences, conducting operational research in the field of herpes virus disease, and beginning to develop methods to address the problems of group B streptococcal infection and cytomegalovirus.

NIH - National Institute of Allergy and Infectious Diseases

Without equivocation it can be said that research alone holds the long-term potential for solving the sexually transmitted disease problem. The ultimate solutions will come in the form of vaccines, but we are a very long way from that day. The massive gaps in our knowledge about these

diseases have hampered and hamstrung control efforts. Mass screening techniques exist for less than 6 of the 20 or more sexually transmitted diseases. Vaccines exist for none. Herpes has no effective or even palliative treatment.

Venereal disease is the most underserved, most under-researched disease area in medical science. The low priority ascribed these diseases can be evidenced no more clearly than by the fact that in fiscal year 1980 the National Institute of Allergy and Infectious Diseases, which has primary responsibility for sexually transmitted diseases, spent a paltry total of $7.4 million for all research in this area. (The $8.6 million figure in the budget request includes all research in which a sexually transmitted disease factor is part of the project.)

How can such a sum be justified against the magnitude and severity of these diseases? More people suffer from venereal diseases than suffer from such diseases as diabetes or arthritis, with severe medical consequences costing more than $1 billion in medical costs each year. Yet one has only to look at those programs against the sexually transmitted diseases program to see that a gross imbalance exists.

The President's budget request for fiscal year 1981 once again displays a total lack of enlightenment in this area and, in fact, deals a particularly severe blow to this field of research. Because there is already a great lack of researchers, clinicians and educators in this field, the Administration's decision to not provide new training money will have a severe impact on future venereal disease research. A corps of adequately trained qualified researchers must be ensured for the immediate future

In January, 1980 NIAID convened a Study Group of Sexually Transmitted Diseases made up of 65 scientists and specialists in this field, and chaired by Dr. King K. Holmes. This group was charged with assessing the progress made thus far in STD research, identifying and prioritizing the gaps in our knowledge, and needs for stronger commitments in research as well as new directions for pursuit. Training requirements to fulfill this responsibility were detailed by the Study Group as well as specific funding recommendations. The Study Group recommended to NIAID that the

STD research program needs an investment of $42 million to begin to address the critical needs of research.

These recommendations were presented to NIAID's Advisory Council in January. We strongly endorse and support the recommendations, and believe they represent the nation's best thinking in this area. The recommendations represent rational, thoughtful, and responsible funding levels as well as directions for investigation.

Venereal disease has never received the attention it so rightfully deserves in large part because it has had no vocal constituency. It is not that the severity of the diseases is not great enough to mobilize its victims, but myth and social stigma which has kept them suffering in silence.

Since May of 1979 alone the American Social Health Association has received approximately 100,000 inquiries for information and help from sufferers of herpes. NIAID currently spends $2.5 million in herpes research. The Study Group's recommendation of $8.6 for herpes research could be put to particularly valuable use immediately, not only in light of growing public awareness and demand for responsible action in this area, but in light of current opportunities for achievement in this area.

No Administration in recent history has been responsive to the epidemic of venereal disease or to the needs of its own venereal disease research or control programs. This Administration's budget shows no change in that familiar pattern. Every step forward in the federal role in venereal disease has been initiated by Congress.

Despite the fact that NIAID's own Study Group has unequivocably pointed out the drastic lack of necessary funding, the President's budget, thanks to inflation, will effectively cut back the sexually transmitted disease program. It therefore falls to Congress once again to initiate progress forward in the search for these answers. Let me stress that without some solutions from biomedical research, including such basic needs as effective diagnostic techniques, VD control and prevention efforts, essential as they are, can only continue to scratch the surface of the problem.

It falls to Congress to provide the leadership and direction in this area. Several other institutes, including the National Eye Institute, the Dental Institute, Child Health and Human Development among them, carry out

some small investment in research in this area. The Committee should encourage this research and its coordination throughout NIH. Most importantly, the Committee should direct NIAID to immediately implement the top priorities of its Study Group in the areas of herpes, chlamydia, gonorrhea and cytomegalovirus and this year provide $15 million to the sexually transmitted disease program and $4 million for training in STDs.

I request that a summary of the recommendation presented to the Advisory Council and a list of the highlights be included in the record for your information and guidance.

Mr. Chairman, the American Social Health Association believes that sexually transmitted diseases represent the most significant public health threat of our times, unparalelled in the annals of medical history, and richly and uniquely deserving of increased federal support.

We appreciate the opportunity to present our views.

SELECTED RECOMMENDATIONS
OF THE
NIAID STD STUDY GROUP

Subgroups	Recommended funding ($ in thousands)
• Training	10,472

Support to develop a pool of physicians and scientists to meet our national needs in STD.

• Genital Herpes	8,600

Support for research on the natural history of these infections, how they spread, and the causes of recurrent infections.

• Nongonococcal urethritis and Chlamydial Infections	3,150

Support for basic biology of these organisms as a prerequisite for improved diagnostic tests for NGU in men and epidemiologic studies to determine effects on infant and maternal health.

• Gonococcal Infections	4,615

Support to define specific gonococcal cell components that produce infection and disease and to determine how purified components can stimulate human immune response in an effective vaccine.

• Cytomegalovirus	4,500

Support to learn how this disease is transmitted and what mechanisms are responsible for latency and reactivation.

• Group B Strep Infections	3,450

Support for vaccine development.

• Syphilis	1,510

Support for research on the growth of the causative organism, its biology and immunology.

• Vaginitis	1,630

Support for basic studies of vaginal physiology and improved understanding of the vaginal ecosystem.

• Hepatitis	1,013

Support to study patterns of sexual behavior responsible for transmission, effectiveness of hepatitis B vaccine, and evaluation of education and counseling in reducing hepatitis B.

• Special Problems	2,225

Support to conduct epidemiologic investigations of enteric infections, improved diagnosis and treatment of chancroid, scabies and genital warts, and studies on the possible role of genital wart virus in cervical cancer.

Recommendations are ranked in order of priority set by the Study Group and recommended level of funding is in 1979 dollars for research in the 1980's.

SELECTED RECOMMENDATIONS OF THE NIAID STD STUDY GROUP

The members of the nine working subgroups of the STD Study Group developed an array of recommendations in each of their special areas of expertise. All subgroups concluded that an expanded program of research is needed on the basic biology and immunology of all the microorganisms (bacterial, viral, and parasitic) that are known to be or are suspected of being specific causes of STD. Further study is urgently required to develop better diagnostic tests and more effective therapeutic drugs for the STDs. Research leading to the development and testing of vaccines is crucial for the ultimate control of these STDs. The 10 major specific recommendations made by each of the subgroups are presented here in order of priority.

I. TRAINING--Because there is a great lack of researchers, educators, and clinicians serving the field of sexually transmitted diseases, the highest priority is given to development of a pool of physicians and scientists to meet our national needs in this area. Only 2 of 116 medical schools in the United States offer significant training in STD for their medical students, making this the most thoroughly neglected medical specialty in this country. Support is needed for training in STD of 200 Ph.D. and M.D. postdoctoral research fellows, 300 predoctoral microbiologists and 50 clinicians per year. Thirty STD faculty positions at schools of medicine and public health should be supported as renewable career development awards. Service in a STD clinic should be allowed to satisfy the requirements of National Health Service Corps physicians. Recommended level of funding: $10,472,000

II. HERPES SIMPLEX VIRUS (HSV) INFECTION--Genital HSV infection has emerged as the most prominent STD of the past decade, causing chronic recurrent infection with frequent complications in perhaps 20 percent of sexual active adults of all socioeconomic strata, and leading to a devastating, often fatal infection of infants. Impressive recent tech-

nologic advances in molecular biology and immunology provide a great many opportunities for attacking this problem and warrant increase support of research at all levels, ranging from basic biology to antiviral therapy and prevention of HSV infections. Greatest emphasis should be given now to the following:

A. Prospective studies of the natural history of gential infections. including definitions of factors that influence spread of infections to sex partners and to the newborn.

B. Studies of the causes of recurrent genital infection that may lead to development of methods to prevent recurrences.

Recommended level of funding: $8,600,000

III. CHLAMYDIA TRACHOMATIS INFECTIONS--Chlamydia infection is several times more common than gonorrhea and within the past 5 years has been linked with approximately 20 medical conditions that were previously of unknown cause. These include infection of the fallopian tubes in women (salpingitis), the major cause of ectopic (tubal) pregnancy and involuntary infertility in women. Chlamydia is the commonest cause of infant eye infection and of infant pneumonia. In the United States, more than 100,000 infants per year develop chlamydia infections, and this number is expected to increase. Although chlamydia infection can be easily treated with antibiotics, the majority of infections go without proper treatment because present diagnostic tests are expensive and generally not available. Research on the basic biology, immunology, and pathogenesis of chlamydia should therefore be emphasized, since basic studies will be a prerequisite for development of improved diagnostic tests and future vaccine development for this infection. Clinical epidemiologic studies should focus on the role of chlamydia in salpingitis and on the effect of chlamydia on the outcome of pregnancy and on infant and maternal complications. A sizeable increase in funding of chlamydial research is indicated now with further increased funding provided as more scientists with experience in chlamydial research become available.

Recommended level of funding: $3,150,000

IV. GONORRHEA--About 2 million cases of gonorrhea occur each year in the United States. The total cost of gonorrhea and its complications is approximately $1 billion annually. Although gonorrhea rates have stabilized as a result of concerted control efforts, further control of the disease will require deployment of an effective vaccine. A remarkable surge of new information about gonococcal infections during the past decade has partially defined the complex mechanisms by which the gonococcus causes diseases and have led to development of several vaccine candidates. Further progress in vaccine development will depend upon defining the specific components of the gonococcal cell that enable the organism to produce infection and disease, understanding how these components cause disease, and determining how the human immune response can best be stimulated by vaccines prepare from purified gonococcal components.

Recommended level of funding: $4,615,000

V. CYTOMEGALOVIRUS VIRUS (CMV)--CMV is the commonest known cause of infections of the fetus, the leading known cause of deafness, and contributes at least 6,000 children a year to the ranks of retarded disabled citizens. As with herpes simplex virus infection, the following research is particularly important with CMV:

A. Definition of the importance of genital infections in transmission to sex partners and in transmission to the fetus or to the infant during birth.

B. Investigation of the pathogenesis and immunology of CMV infection, particularly of the mechanisms responsible for sustained latency of infection, reactivation, and reinfection.

Recommended level of funding: $4,500,000

VI. GROUP B STREPTOCOCCAL INFECTION--Approximately 5,000 infant deaths annually are caused by Group B streptococcal infections--the single most common cause of fatal bacterial infections during the first 2 months of life. Up to 2,000 survivors annually are left with deafness, blindness, cerebral palsy, mental retardation, and/or epilepsy. The

first priority for research in the coming decade in this area should be the development of immunologic methods for preventing Group B streptococcal infection of infants. Well characterized and purified vaccines made from the outer capsule of the organism are available and must be assessed for efficacy in well controlled trails. Such studies will require collaborative efforts among several institutions to assess efficacy and side effects in the shortest period of time.

Recommended level of funding: $3,450,000

VII. SYPHILLIS--The major obstacle to research on syphilis has been the inability to grow the causative organism, Treponema pallidum, except in living experimental animals. However, the advent of new techniques in applied molecular biology, particularly in recombinant DNA technology, now makes possible more innovative avenues of approach. Such methods should be applied to studies of the biology and immunology of T. pallidum, and to development of improved methods for diagnosis of tools for study of pathogenesis of syphilis, development of and treponemal components for vaccine research.

Recommended level of funding: $1,510,000

VIII. VAGINITIS--Vaginitis is one of the 10 commonest disorders in medical practice and the commonest condition diagnosed in female STD clinic patients. Trichomonal vaginitis is the commonest protozoan infestation and candida vaginitis the most frequently acquired human fungal infection. Candidal vaginitis and nonspecific vaginitis are highly resistant to standard methods of therapy. Only one study of nonspecific vaginitis, one of trichomonal vaginitis, and no studies of candida vaginitis are currently funded by NIAID. Certain important questions are common to all causes of vaginitis. Thus, in addition to substantially increased support at all levels of research on each of the common forms of vaginitis, basic studies of vaginal physiology and improved understanding of the vaginal ecosystem should be given high priority.

Recommended level of funding: $1,630,000

IX. HEPATITIS--It is likely that at least 500,000 persons are afflicted with hepatitis each year in the United States. The most important

viruses responsible for the disease are hepatitis A, hepatitis B, and hepatitis non-A non-B viruses. Homosexual and heterosexual transmission and vertical trasmission (from infected mother to newborn infant) appear to be the most important natural modes of transmission of hepatitis B virus. Basic research on hepatitis B has been exceptionally productive, and a vaccine is now undergoing field trials. Additional research should be conducted to indicate specific patterns of sexual behavior that may be responsible for transmission of each of these hepatitits viruses, to evaluate post-exposure prophylactic use of hepatitis B vaccine, and to evaluate education and counseling to reduce further transmission of hepatitis B virus by chronic carriers.

Recommended level of funding: $1,012,500

X. SPECIAL PROBLEMS--Considered as special problems are those STDs that currently receive no research support from NIAID. However, they are very common and sometimes serious. Four special problems were considered.

A. Enteric infectious agents (Shigella, Entamoeba histolytica, and Giardia lamblia) cause an increasing proportion of infections in the U.S. and yet the epidemiology of these infections as STDs is not currently not being studied.

B. Chancroid on a worldwide basis may be more prevalent than syphilis. It is caused by Hemophilus ducreyi, recently found to carry plasmids (genetic material) responsible for resistance to a variety of antimicrobials.

C. Genital warts, caused by a sexually transmitted papilloma virus, affects at least a half a million persons each year.

D. Ectoparasites (Phthirus pubis or crabs, a well known sexually transmitted disease, and scabies) are pandemic and account for about 2 to 4 percent of new patients seen in a dermatologist's office.

Research is long overdue on the epidemiology of all these infections as sexually transmitted diseases, on improved methods for diagnosis of

chancroid and scabies, and on improved treatment particularly for the protozoal diseases, chancroid, warts, and scabies. The possible role of genital warts virus in cervical cancer also needs definition.

Recommended level of funding: $2,225,000

STATEMENT OF CLYDE E. SHOREY, JR., VICE PRESIDENT, MARCH OF DIMES BIRTH DEFECTS FOUNDATION

THE MARCH OF DIMES URGES FUNDING FOR FY 1981 OF THE APPROPRIATION KNOWN AS "GENETIC INFORMATION AND COUNSELING" AT $21 MILLION WITH $18 MILLION EARMARKED FOR GENETIC SERVICES AND SICKLE CELL CENTERS AND $3 MILLION FOR HEMOPHILIA PROGRAMS.

For FY 1980 the funding for genetic services was increased to $8 million from $4 million in 1979. To this must also be added $3.5 million for sickle cell centers, the funding of which has now been joined as part of the total appropriation for genetic services. Therefore, the appropriation for FY 1980 comes to $11.5 million.

Under the 1979 funding of $4 million for genetic services and $3.5 million for sickle cell centers, 21 genetic grants were able to be funded along with 20 sickle cell centers. Most of these centers are now linked in some fashion to the genetic service grants. In anticipation of the increased funding for 1980, 7 additional grants were approved but unfunded. This means that those 7 grants, unless substantially modified, will not have to go through the approval process again for 1980 funding but will have to take part in the ranking along with all other approved grant applications to determine the allocation of funds. Six applications were turned down in 1979.

Because of the requirement of the National Genetic Diseases Act to provide supporting services including technical assistance, education programs, laboratory facilities and planning and demonstration grants and also to evaluate the entire program, it is possible that the total number of genetic service grants could be expanded from 21 in 1979 to slightly over 30 in 1980. This means that close to 20 states still would not receive any funding in 1980.

Under the proposed appropriation for FY 1981 of $18 million for genetic services and sickle cell centers, grants to States would be increased to approximately $14.75 million and the supporting services required by the Genetic Diseases Act would total $3.25 million. This would allow 45 states to participate in the program at a level of funding just able, in most instances, to create mobile and satellite clinics as an outreach facility for the existing genetic service centers. In addition, it will continue the funding of the sickle cell centers which will now be linked to the State genetic services plan.

The funding of Hemophilia programs has been joined for appropriation purposes to genetic services. Hemophilia programs have been funded at $3 million.

The Administration has requested $14.945 million for "Genetic Information and Counseling" for 1981, with $11.945 million for genetics and sickle cell and $3 million for Hemophilia, substantially the same amount as the appropriation for FY 1980. The March of Dimes, therefore, seeks to increase the appropriation for "Genetic Information and Counseling" by $6 million over the budget figure proposed by the Administration.

States With 1979 Grants	States with Grants Approved but Unfunded	States with Grants Rejected in 1979
Connecticut	New Hampshire	Massachusetts (2nd grant application)
Maine	Massachusetts	Rhode Island (2nd grant application)
Rhode Island	Indiana	Louisiana
Vermont	North Carolina	Minnesota
New Jersey	South Carolina	California
New York	Utah	North Dakota
Pennsylvania	Oregon	
Virginia		
West Virginia		
Alabama		
Georgia		
Tennessee		
Florida		
Ohio		
Michigan		
Wisconsin		
Texas		
Iowa		
Nebraska		
Colorado		
Washington		

STATEMENT OF COOLEY'S ANEMIA FOUNDATION, INC.

For the past three years, the Cooley's Anemia Foundation has come before you seeking improvements in research and care programs in the Cooley's Anemia field. Each time you have been most courteous, and we want to tell you that we believe that your interest has already greatly benefitted the victims of the disease, their families, and the public greatly.

To refresh your memory on the nature and extent of Cooley's Anemia, I have attached to my testimony a copy of an explanation, and ask that that be made a part of the hearing record.

Two years ago, after you heard our testimony, language was inserted in the bill report which called for an extensive study on research, care, and the epidemiology of the disease. This had never been done before, extensively and scientifically, and that report has formed the basis for research and care planning. The National Heart, Lung, and Blood Institute was the chief agency to develop this report, and they did a superb job.

Last year, the bill report language carried instructions to develop an education program for patients, families, and the public at large. This is now moving forward, with the NHLBI again the lead institute. That Institute was also instructed to work with the CDC on information programs, for professional medical people and lay persons, detailing the possible screening tests and pre-natal diagnostic tests.

Finally, the Department of HEW was instructed to convene a meeting to determine whether a program of Federal aid could be developed within present authorities for patient care for the victims of the disease.

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The Health Services Agency was designated to lead this effort, and they presented a part of this study to the Congress just three weeks ago. Again, we are deeply grateful to this committee for calling for that report, because the report is very thorough in indicating just what opportunities are available within Federal programs for patient care with patients with Cooley's Anemia.

To quote from that report: "The consensus was that sections 503 (2) and 504 (2) of Tital V of the Social Security Act provide the most feasible and appropriate administrative and legislative vehicles through which aid to States could be provided for Cooley's Anemia patient care."

Further, the report outlines specifically what can be accomplished.

First, there is available a project grant funding mechanism under the so-called RB funds for the Maternal and Child Health Program and the Crippled Childrens Services Program, which permits up to 25% of the so-called B funds in those programs to be reserved for grants to States and institutions of higher learning for special projects of regional or national significance which may contribute to the health of mothers and children or to services for crippled children.

As the report says in this regard, the "project grant funding mechanism under RB funds could be used effectively for providing treatment services for Cooley's Anemia patients. Funds could be granted to States which have a high incidence of the diseases and which include care for this condition under their CCS programs; or funds could be granted to designated regionalized centers which could provide the necessary comprehensive services and assist with the costs of care, as needed, even if the child and family lived in an adjacent State which does not provide coverage for this condition. This approach would make it possible to utilize administrative structures for delivery of health care on a state-wide basis, and at the same time, would allow utilization of sophisticated medical centers for specialized services."

We are very hopeful that this Committee will instruct the Maternal and Child Health Program to proceed forward on the matter of providing a program for such a regionalized centers concept in regard to Cooley's Anemia, and also provide funding for such programs out of a portion of the increases that the Congress grants this year to the Maternal and Child Health program. We have examined the question of this concept of regionalized care. We endorse it, and would like to indicate that it seems to fit particularly well with the epidemiology of the disease. That is, given the nature of the cultural patterns involved (those of Mediterranean ancestry are most affected--largely those of Italian and Greek

ancestry), and the historical settlement patterns of those coming from those areas, we find that by far the largest numbers are concentrated in the cities of the Northeast, and far West, and major medical centers which have been doing research on Cooley's Anemia matters, and which have been doing some patient care, are already well situated to take on this additional responsiblity.

Second, it was indicated in the report, that the funding grant mechanism, states are permitted, under present law, to determine what specific handicapping conditions will be included in its State plan for crippled childrens' services. In most states, the report indicates "Cooley's Anemia would be covered by the Crippled Children Services program." We are anxious to move forward to see that as many states cover the care as possible, within the regulations, and would urge that the Committee request in report language that the Maternal and Child Health program work with Cooley's Anemia groups to identify the states and programs wherein coverage now exists, and under what regulations and constraints, and to identify those states who do not have such coverage, and how such coverage can be obtained.

Mr. Chairman, if these two objectives are obtained in this appropriations bill, a truly major advance will have been made in the care of patients.

The Foundation would also like to comment on the levels of funding for the two institutes of the NIH which have most to do with research on Cooley's Anemia, and NHLBI and the NIAMDD. We have examined the budgets of both institutes, and the President's proposed budgets for each.

In regard to the NHLBI, we would ask you to take note of the fact that last year, because of a serious misunderstanding of research scores determined differently among the institutes, the NHLBI budget suffered severely, so that the increase for that institute was extremely small, far below even the inflation level. We hope that the Committee will see fit to redress that problem, and to increase the institute at least 15% above the President's proposed budget and the add-on necessitated by the last year's misunderstanding. It would be difficult to tell you how very fine the support of the NHLBI in regard to Cooley's Anemia has been. The leadership of that institute, and the intramural program concerned with the disease, have truly been marvelous. Their work has been unstinting. Just recently, an article appeared in the Washington Post (a copy is appended to this testimony) which tells of the new research technique which shows great promise for our patients. Without going into detail, you should know that a research technique has been developed to transfuse only young blood cells, which will have a long life, rather than young and old blood cells that would naturally occur in a transfusion.

Because patients suffer severely from iron overload from transfusions (all transfused blood carries iron, which is deposited in patients' vital organs) the longer the cell life, the less transfusion, and the less transfusion, the less iron to damage the patients.

This is a major advance in the treatment of our patients, but more than that will be effective in other disease catagories as well. This institute has become a major force in the change and improvement of patient care because of the breakthroughs that have been occurring. Please support this institute strongly, it deserves it.

The NIAMDD, where a great deal of basic research on blood is going forward, also should have its budget increased above the President's proposal. You no doubt know that this institute has a major number of disease catagories in it, and all because of the nature of biomedical science, are exploding in terms of opportunity for research. Certainly this institute should receive at least 15%, and if possible more increases over last year's funding.

Mr. Chairman, we have been very pleased over the last several years with the assistance you have given to us. We are in your debt. We pledge to work as hard as we can, as a Foundation, to raise funds to pay for research projects that cannot be funded by the institutes because of shortages of funds there, but which have excellent scientific progress. We intend to work closely with all those Federal agencies which may in some way help our children.

Thank you very much.

Statement of the American Hospital Association

The American Hospital Association represents over 6,100 member institutions (including most of the hospitals in the country, extended and long-term care institutions, mental health facilities, and hospital schools of nursing) and about 30,000 personal members. We welcome the opportunity to present our views on HEW health program appropriations for Fiscal Year 1981.

In reviewing the federal health budget for FY 1981, we have identified key program areas which are of primary concern to our membership. Following is our assessment of funding needs for these priority programs.

NURSING AND HEALTH PROFESSIONS EDUCATION

Recognizing the significant contribution by the federal government to the development and enhancement of nursing and health professions education, the AHA strongly supports continued funding for these programs. We are convinced that the cessation of federal support in this area or a precipitous decline in such aid would have an adverse impact on the ability of hospitals to meet the health care needs of their communities, and would exacerbate the problems of manpower shortages and maldistributions.

While we are aware of aggregate increases in the total supply of health professionals, we would like to point out that, in certain fields, such as nursing and the allied health professions, hospitals are experiencing severe and chronic shortages. We take strong exception to the position of the Administration that federal financial assistance to medical and other health professions schools should be dramatically reduced or terminated. The loss of these federal funds would place many educational institutions in financial jeopardy, price such education out of the reach of most Americans, and adversely affect the quality and accessibility of health care services.

The AHA is deeply concerned by the Administration's proposed $77 million reduction for FY 1981 in nursing education funds below the FY 1980 appropriation level of $106 million. Contrary to Administration statements that most programs of nursing education no longer require federal support because there are sufficient numbers of nurses, hospitals across the country are reporting critical shortages of nursing personnel. AHA member hospitals indicate that they have between 90,000 and 100,000 vacancies, and a recent article in Nursing '79 stated that 80 percent of the nation's hospitals currently have nursing vacancies.

Moreover, according to the Department of Labor's Bureau of Labor Statistics, of job openings in the health care field in the 1980s, up to 50 percent will be for nurses—approximately 83,000 annual openings for registered nurses. The American Nurses' Association cites higher figures, predicting that, by 1982, there will be a nationwide shortage of 100,000 nurses. Therefore, we strongly urge that the Subcommittee continue support for nursing education at the current level of $106 million.

We are also distressed to note that the Administration's FY 1981 budget includes no funds for capitation grants to health professions schools. Moreover, the

President is expected to continue to propose rescissions of approximately $88 million from this program from current appropriations for FY 1980.

The Administration has stated that, because such schools have been anticipating the loss of such funds, they therefore should be able to make up for the loss through other revenue sources. This position is unrealistic, in our view, and could lead to significant cutbacks in opportunities for enrollment in these educational institutions. Schools for the health professions depend upon the capitation program as a means of keeping tuition costs at affordable levels. Any precipitous withdrawal of capitation monies from health professions schools would place many of these institutions in a state of financial crisis. Therefore, we recommend that, at a minimum, the present funding level be maintained.

Our Association also is disturbed that the Administration would propose to eliminate in FY 1981 the funds available for allied health education--a drastic proposal which, in our view, is unwarranted. We do not concur with the Administration's claim that there is now a pending oversupply of allied health professionals--a claim that is inconsistent with a preliminary HEW report on allied health personnel which reflects widespread shortages and cites programs in some states that are having problems in recruiting students. Such recruitment problems are bound to increase, particularly if predictions materialize that the 18 to 24 age group in our population will decline in number substantially in the coming years, so that there will be a smaller pool of potential students from which to draw. Hospitals rely heavily on allied health personnel for efficient and cost-effective delivery of health services. Moreover, many institutions provide clinical facilities for allied health education programs, and the costs of training these personnel cannot be completely offset by payments for the health services rendered. We would suggest that allied health funds be held to at least the 1980 level of $10 million.

There is, however, one positive aspect of the Administration's FY 1981 proposed budget for health professions education. The funding level for primary care/family medicine grants has been increased significantly. We are pleased that present initiatives to resolve shortages in family medicine will be continued, and we wholeheartedly support this aspect of the budget proposal.

HEALTH FACILITIES

Our Association continues to be concerned about the failure of the Administration to request meaningful funding for Title XVI of the Public Health Service Act, which authorizes federal funds for construction and modernization of health facilities. The Administration appears to be pursuing a systematic policy of limiting hospital access to capital financing, at a time when lack of access to capital for the maintenance of facilities and the incorporation of needed advancements in medical care delivery is a serious problem facing many urban hospitals. Such institutions not only are in precarious financial condition, but also are experiencing a decline in philanthropic resources, which make it increasingly difficult for them to obtain necessary capital, a problem compounded by the recent rise in interest rates, greatly increasing the costs of capital. Apart from the issue of deficits in urban hospitals, on which we testified recently before the House Ways and Means Committee, we believe serious attention should be given to such hospitals' capital needs, through more adequate funding of existing programs intended for this purpose.

We are especially concerned by the lack of support for Section 1610 of the Public Health Service Act, which authorizes project grants for construction and modernization of public and voluntary hospitals so that safety hazards can be eliminated and licensure and accreditation requirements met. The program is directed at upgrading institutions which serve principally medically indigent populations which rely on such hospitals for all of their medical care. The AHA believes that a commitment to this program is consistent with other federal initiatives aimed at meeting the needs of the medically indigent. Therefore, we urge the Subcommittee to include an appropriation at the authorized level of $65 million for FY 1981.

HEALTH CARE DELIVERY TO THE UNDERSERVED

The AHA continues to be committed to improving health care delivery for all Americans, and we place a high priority on supporting programs of the federal government which better enable hospitals and other health care institutions to meet the needs of medically underserved populations. Accordingly, we endorse funding for several important health services delivery programs: hospital-affiliated primary care centers, community health centers, the National Health Service Corps (NHSC), migrant health services, home health programs, and emergency medical services (EMS) assistance.

In the 95th Congress, the AHA supported the enactment of legislation providing for two hospital-related ambulatory care programs in medically underserved areas: a new program for hospital-affiliated primary care centers (Section 328, Public Health Service Act), and a revised community health center program to provide assistance to hospital-linked centers (Section 330, Public Health Service Act).

In our view, these initiatives are a necessary step cowards improving access to quality health care services in underserved areas, through appropriate use of hospital outpatient facilities in conjunction with other ambulatory services. Close affiliation with hospitals will contribute to the financial and operational stability of these centers, and will enhance the continuity of care in the community. Progress in establishing the centers is particularly vital in meeting health care needs in urban areas, where hospitals are often the only resources for primary care services in certain neighborhoods.

We believe an increase in funds for FY 1981 is warranted for the primary care and community health center programs. HEW has been reluctant to fund hospital-based ambulatory care programs, despite recent studies, including one by New York State, which show that there is no significant difference in program costs between hospital-based and free-standing ambulatory care centers. While we support the Administration's request of $361 million for community health centers, we are disappointed that less than $10 million has been requested for hospital-affiliated primary care centers, and we recommend that the Subcommittee include the full $30 million authorized for FY 1981.

We also recommend expansion of HEW's Bureau of Community Health Services' (BCHS) urban and rural health initiatives, to enable hospitals to play a stronger role in an integrated health delivery system. The AHA's Centers for Urban Hospitals, Small or Rural Hospitals, and Ambulatory Care have been working with BCHS to meet this objective.

Further, the AHA supports two related programs which we view as significant in meeting the needs of medically underserved populations: the NHSC and the migrant health program. We strongly support the NHSC, and have been working with HEW to have additional NHSC personnel assigned to primary care in urban and rural hospitals. However, as with other hospital-based ambulatory care programs, HEW has been reluctant to assign NHSC members to hospital-based programs. We endorse

the Administration's request of approximately $134 million for operation of the NHSC in FY 1981, and recommend that the NHSC scholarship assistance program be increased by at least the $8 million recommended by the Administration.

Similarly, we strongly endorse the $5 million increase requested for the migrant health program, which utilizes NHSC personnel in many instances to provide services to migrant populations. We are pleased to note that the Administration's request would provide health care services to an additional 10,000 migrant persons, with particular focus on the delivery of needed hospitalization services to migrant mothers and infants.

Two health services programs for which the Administration has recommended reductions--home health care and EMS--continue to be priority Association interests, and we urge funding of these programs in FY 1981 at no less than current levels. The AHA's Center for Ambulatory Care, which serves as a focal point for hospital activity related to these programs, is concerned about the proposed elimination of support for BCHS's home health service program. In 1979, 9 million people in some 650 counties lacked the services of Medicare-certified home health agencies, demonstrating the continuing need for this program. The AHA believes that, by providing linkages to acute inpatient health care resources, high-quality home health services can play an important role in our health care delivery system, ensuring that patients receive appropriate care in an economical manner.

The proposed $13 million reduction in EMS funds similarly is unwarranted, in view of the need for initiation of EMS systems in 98 areas of the country in order to complete the service network mandated by Congress. The AHA has supported a three-year extension of the EMS program to provide the time and federal support needed for more complete integration of public and private EMS and related communications systems.

HEALTH PROMOTION AND DISEASE PREVENTION

The AHA strongly endorses health promotion and disease prevention activities, and has increased its own support to these areas. In 1978, the AHA established a Center for Health Promotion, with a primary mission to encourage and assist hospitals in expanding their programs in patient education, community health education, and employee health programs. The Association's Policy and Statement

on the Hospital's Responsibility for Health Promotion, issued in 1979, states that "hospitals have a responsibility to take a leadership role in helping ensure the good health of their communities."

Therefore, we join the Administration in the view that federal funds spent on health promotion and disease prevention are cost-effective investments. Specifically, we endorse the Center for Disease Control's (CDC) $17 million request for risk reduction/health education activities, an increase of $3 million over the appropriation level for FY 1980. During the past five years, the AHA has worked closely with CDC to improve the quality and quantity of education programs provided by both hospitals and voluntary service agencies for patients and their families, and, at the present time, we are working with CDC and more than 60 other organizations to stimulate the development and evaluation of patient education programs for use in ambulatory care settings. CDC is to be commended for supporting activities that foster national and local cooperation among groups with similar health education goals.

The AHA also supports the $10 million allocated to prevention formula grants, and we endorse the authorization for funding of the disease prevention activities of public and private organizations; we look forward to expansion of hospitals' participation in these efforts to develop community health promotion programs.

Similarly, we endorse the $3 million increase in funding for health promotion programs under the Office of the Assistant Secretary for Health. A major health promotion goal of this office is the development of a cohesive national policy for health promotion and disease prevention, a policy that is vitally needed if interested organizations, including the AHA, are to work together effectively and have a significant impact on efforts to improve the health status of the American people.

We must note, however, our disappointment that federal funds for health promotion and disease prevention programs have not been made available to hospitals, which are committed to these activities and are interested in participating directly as grant recipients. We would hope that the Administration would broaden its definition of appropriate organizations to receive assistance under these programs, to recognize such commitment and interest.

HEALTH PLANNING

The AHA has long been committed to the development of an effective, locally-based health planning process, and has supported the enactment, implementation, and extension of the Health Planning and Resources Development Act (Titles XV and XVI, Public Health Service Act). An effective health planning process is consistent with our dual objective of improving access to quality health care services while reducing the rate of increase in health care costs. We wish to point out that the health planning program could become a futile and wasteful exercise if it lacks the resources to be properly-implemented and administered. In view of our commitment to a locally-based planning process, we are pleased that the Administration's proposed $3 million increase for FY 1981 will support local planning agencies.

PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS (PSRO)

The AHA supports the basic utilization review and medical audit objectives embodied in the PSRO program, which was established to help assure that medical care for Medicare and Medicaid beneficiaries is of high quality and is rendered in an appropriate setting. Under the program, review activities are "delegated" to approximately 3,270 hospitals, about 70 percent of all hospitals currently involved in the program. HEW is to compensate these institutions for the costs incurred in carrying out the review functions according to federal standards.

However, HEW has made substantial changes in the method of calculating the federal payment to hospitals for PSRO-related costs, in an effort to reduce the outlays under this program. Unfortunately, these changes have caused difficulty for many hospitals in discharging their responsibilities to conduct review programs, resulting in decisions by some institutions to relinquish "delegated review" status, thereby decreasing the effectiveness of the program. Other hospitals have been forced to subsidize losses incurred because of inadequate federal payments through additional charges to patients.

The AHA supports the Administration's request for an increase in PSRO appropriations, so that the program can more adequately meet the costs of hospitals and others in carrying out the functions required by law.

* * * * *

In conclusion, we wish to emphasize that other federal health programs, on which we have not commented specifically, also merit continued budgetary support. Our statement focuses on those aspects of the FY 1981 health budget which we believe deserve priority attention by the Subcommittee. We appreciate this opportunity to present our recommendations, and we stand ready to respond to any questions or provide such assistance as the Subcommittee may request.

Statement of the American Nurses' Association

The American Nurses' Association appreciates the opportunity to present its views on the fiscal year 1981 budget requests by the Administration.

The President's proposed budget offers a few increases for health services and research. The majority of the increases serve to maintain existing programs with some expansion of services. In the areas of aid to nursing education and research, a cutback of nearly $78 million is proposed.

The Administration continues to assert that there is an adequate supply of nurses. As clear evidence of a serious and severe shortage of registered nurses continues to mount, the Administration offers no evidence to the contrary and maintains, without any supporting data, that the supply of nurses is in balance with need.

Congress extended authorization for the Nurse Training Act last year necessitating action again this year to authorize the programs through fiscal 1981.

Bills to authorize continued federal support to nursing school and students are under consideration. We are very discouraged by the fact that this is the third year in a row that we have had to go through the reauthorizing process.

During the past year, reports of nursing shortages have poured in from the entire nation. The shortages exist in urban as well as rural areas and in every type of health care setting although it is particularly severe in long-term care and acute care settings.

In an American Hospital Association 1979 survey of state hospital associations, nine out of ten states reported shortages of registered nurses ranging from spotty to critical. Reports of budgeted, unfilled hospital positions ranged from 600 in Utah to 1,500 in Arkansas. Some states reported a need for nurses in addition to those for which positions were budgeted. California, for example, reported a 17 percent vacancy rate plus a need for an additional 8,300. Texas reported a vacancy rate of 12 percent plus a need for an additional 9,000.

A National League for Nursing survey of Community Health Agencies[1] reported a position vacancy rate for the years 1977 and 1978 of 31.% and 34.8% respectively. And yet, the largest increases in professional nursing employment has occurred in community health settings. The number of nurses in public health agencies and other community health settings is more than 77,000, an increase of 36,000 or nearly double the 1972 figures.

The Administration contends that although there are vacancies, the supply is still adequate because many nurses simply are not practicing nursing, and that federal intervention should be directed at bringing those inactive nurses into the work force. An examination of this "potential" supply reveals the fallacy in the Administration's reasoning.

The ANA 1977 Sample Survey of Registered Nurses[2] indicates there are 1,401,000 registered nurses in the U.S. who hold current licenses. Of this aggregate, over 70 percent are employed in nursing which is considered a very high proportion. This is much higher than the labor force participation rate for all work-eligble women which is about 56 percent overall, and 61 percent for women college graduates. For example, a recent survey of women educationally prepared in the field of science and engineering found that 25 percent were employed in science and engineering related positions.

Of the approximately 30 percent of nurses not employed in nursing, about 62,000 were working in another field, 42,430 had children under six years of age, 42,000 were seeking employment and about 104,000 were over 60 years of age. This last group forms the largest cadre of nurses not actively participating in the work force.

Although the total number of licensed registered nurses has risen substantially over the past five years and the total number of nurses in the work force has increased, there are still reports of severe shortages. The outlook for even maintaining the current supply of nurses does not look promising.

The Department of Labor Occupation Outlook Handbook[3] states that average annual openings for registered nurses will be 85,000 through 1990.

The National League for Nursing, which conducts an annual survey of nursing schools, predicts that final 1979 figures will show a two percent drop in nursing graduates, the first such drop since the mid-1960s. Admissions showed a five percent drop in 1978-79. Applications to RN programs decreased 16 percent between 1977 and 1978 along with a 13 percent drop in the number of applicants on waiting lists.

Over the past ten years the demand for registered nurses in acute care hospitals has risen dramatically. As of 1977, 601,000 nurses worked in hospitals,

an increase of nearly 16 percent since 1972. The real demand for nursing services in hospitals has come from the expansion of intensive and special care units. In addition, utilization review has brought about shorter hospitalization stays meaning that patients in the hospitals are sicker and require a higher degree of complex nursing care.

Nurse Practitioner

Of all categories of nursing, only nurse practitioner programs would receive support under the President's proposed budget. The budget proposes $17 million for FY 81 for grants and contracts to public and non-profit hospitals and schools of nursing, medicine and public health to develop and operate programs to train nurse practitioners in primary health care. The program also provides for traineeships to students who reside and agree to practice in health manpower shortage areas.

We agree with the President's recognition and continuing support of nurse practitioners. We cannot, however, agree with the President's apparent and continued belief that these programs can be expected to flourish independent of the rest of nursing education. Qualified candidates, instructors, staff and facilities must exist to support nurse practitioner programs.

Nursing Student Loans and Scholarships

The Administration has requested zero funding for nursing student loans and scholarships. It is the contention of the administration that eligible nursing students could receive financial assistance through other student assistance programs financed by the Department of Education. Congress does not support this contention, as nursing student loans and scholarships and similar programs for the health professions were retained in Health Resources Administration by House amendment to the Department of Education Bill, and was accepted by both the Senate and House when the bill passed in 1979.

There is a significant demand for loan and scholarship funds. In FY 1978 and FY 1979 over $84 million in loans were requested by schools of nursing for eligible students but only $22.5 million was made available in FY 78 and only $13.5 million in FY 1979. In a recent survey by the National Student Nurses Association the association reported: 51 percent of students responding indicated that they received federal financial assistance of some kind for their nursing education, and 81 percent of these students stated that they could not have attended school without this assistance. Fifty-one percent came from families with incomes below $15,000.

The majority of students receiving loans and scholarships are from minority and disadvantaged backgrounds. A CBO study says that in 1974, 79% of scholar-

ships went to students from families with incomes of less than $10,000. The percentages of blacks and minorities were about the same for loans, and the CBO study suggests that "the availability of NTA loans and scholarships may have been a major reason for minority enrollment increases in nursing schools." The report points out that the number of blacks enrolled in RN programs began to increase dramatically after enactment of the Nurse Training Act of 1964, which first provided loans and scholarships.

The percent of payback for the Nurse Training Act loans is 87-98% which is very high especially when compared to 80-88% repayment in other federally-sponsored programs. We believe these programs to be highly successful and one of the most cost effective methods of federal assistance to students.

Advanced Training

The CBO report also indicates heavy reliance on NTA funds by RNs enrolled in graduate programs. In 1980, $12 million was available to support 3,000 students over 30 percent of all full-time students in master's, doctoral, nurse practitioner programs. In many instances, these trainees received only tuition assistance, as funding was too low to include the usual stipend.

The greateat need today in nursing is for nurses with advanced training, but at present less than four percent of all nurses are prepared at the masters or doctoral level, and only 14,000 are enrolled in such programs. It is projected that over 130,000 nurses with advanced training will be needed in the early 1980's. At the present time, less than 50,000 are prepared.

In view of the Administration's emphasis on need for containment of health care costs, improved distribution of health care providers, and increased use of nurse practitioners, it seems extremely short-sighted not to request funding in the areas of advanced nurse training. To attain these goals, qualified nursing leadership is needed in such areas as the administration of millions of dollars of institutional nursing budgets (much of which is federal money); to prepare other nurses for expanded responsibility; and to conduct research into the behavioral and psychosocial aspects of health care.

Capitation

We believe capitation grants should continue for the present in order to maintain the spply of qualified registered nurses. To be eligible for capitation, schools must increase enrollment or carry out two of four program options: (1) nurse practitioner training; (2) clinical training for students in facilities remote from the school location; (3) continuing education; and (4) recruitment of students from disadvantaged background. The capitation grant program has already been phased down significantly. In FY 1978, 1,082 schools received

$30 million as opposed to 990 schools who received $24 million in FY 1979. This is a reduction of 20 percent in funds. Alternatives to replace these funds are increases in state legislative appropriations for state supported schools or increases in tuition. Neither of these mechanisms is too viable in the present inflation squeeze.

Capitation grants also have had a direct impact on the national health goals of primary care and improved geographic distribution. For example, in 1978:

- o 22 of the collegiate schools of nursing have elected to operate programs for the training of nurse practitioners in such primary care fields as pediatrics, geriatrics, family health, nurse midwifery, community health, and emergency care.
- o 213 schools planned programs of remote site training.
- o 173 schools provided continuing education course in which approximately 40,000 professional nurses participated.
- o 170 schools submitted plans to enroll and retain students from disadvanctaged backgrounds.

These funds are critical for 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.

Special Projects

The Special Project program has provided institutions with support to develop innovative nursing methods emphasizing primary care and prevention to help meet the needs of high risk groups such as the elderly, children, and pregnant women.

This program is effectively targeted because it addresses specific areas where there is a great need, such as increasing the educational opportunities of the disadvantaged, increasing the supply of nurses in underserved areas, and employing preventative health techniques among high risk groups. The program also addresses crucial issues in the nursing profession such as providing retraining opportunities for inactive nurses wishing to reenter practice and providing continuing education for active nurses.

The President's budget request would result in a decrease of 66 projects from FY 1980, or a reduction of 42.5 percent. This is in contradiction to the stated goals of increasing availability of primary health care services and correcting maldistribution.

Construction Grants

Prior to the $3.5 million appropriation in FY'78, 1975 was the last year that a new construction award was made, although $20 million was authorized from 1967-78.

This moratorium on construction support may already have had a serious and adverse effect on the geographic distribution of nurse supply. We believe that geographic need should be a prime consideration, as should construction assistance for graduate schools. Many schools with approved applications over the years have had to lose matching funds and delay building or renovation judged essential to the maintenance of a high quality nursing education programs.

Nurse Anesthetists

We were pleased to see funding recommended for the nurse anethetists program. The projected need for nurse anethetists in 1980 is between 22,000 and 25,000 compared to a supply of 15,000. The program will help alleviate the present shortage.

Over two-thirds of the current nurse anesthetists supply are delivering quality anesthesia services in small hospitals located in medically underserved areas. They provide the great bulk of anethesia services for people residing in rural, sparsely populated and low income areas.

Anesthesia, administered by anethetists, is cost effective, especially in the 40 percent of U.S. hospitals where only nurse anesthetists are on staff and no anesthesiologists are available.

Nursing Research

Nursing reseach has major significance and potential for reducing health care costs. This program authorized under Section 301 and 472 of the Public Health Service Act provides for research project grants and research training. Funding for nursing research has been static sine 1976. With inflation, the program has had to reduce the number of approved and funded grants and awards anually.

Although the National Academy of Sciences has given funding for nursing research a high priority since 1977, and recommended that the research capability of nursing be increased through the 1980's the Administration has not been supportive. The President's budget again recommends zero funding and indicates nursing research should be housed under appropriate institutes of NIH. Given the current basic research focus of NIH, the significant contribution of nursing research would be lost.

Program Support Division of Nursing - Bureau Health Manpower

In anticipation of drastic cuts in all nursing programs except nurse practitioners, special projects and nurse anethetists, and cuts in other health manpower areas, the President's FY 81 budget contains a recommended deletion of 130 budgeted positions from the Bureau of Health Manpower, with 52 positions to be cut from nursing program support funds. It is essential that there be

adequate funding of the support programs for nurse training and research. We urge the committee to specify a level of program support congruent with the appropriations for nursing education and research.

Home Health

The President's FY 81 budget includes increases for anticipated liberalization of Medicare/Medicaid home health benefits currently under consideration by Congress.

Increasingly in demand, home health care offers a cost-effective alternative to rising hospital and other health-care costs. The development of adequate home health care programs could prevent or postpone the institutionalization of as many as 2.5 million elderly people. 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.

The Home Health Services program under the Health Services Administration has provided grants to existing home health agencies for expansion of services and for the development of new agencies. It also provides training grants for home health agency personnel. Many communities still lack access to home health services, and existing agencies need to improve service delivery. The President's FY 81 budget requests zero funding for this valuable program. In light of pending legislation which will liberalize home health benefits, we believe funding should continue to be available for the program.

Mental Health

Psychiatric and mental health nurses are recognized by the President's Commission on Mental Health to be one of the core mental health professionals. The disproportinate amount of funding for clinical training programs belies the significance of the practice of the psychiatric and mental health nurse. We suggest that the level of funding for educational programs in nursing be increased so the need for clinical specialists, teachers, and administrators in psychiatric and mental health nursing can be met.

Maternal Child Health

There is a critical need for adequate maternal-child health services. The Maternal and Child and Crippled Children's Programs provide for the extension and improvement of services to children and pregnant women. The services include preventative services, improved pregnancy outcome programs, and health maintenance services.

Funding for this vital program has provided only for inflationary increases. The demand for the services is beyond the capacity of the current program.

In addition, the Maternal-Child Health Program provides for service-related research and training. Funding for research and training has remained static and

the President's FY 81 budget recommends a reduction in funding for research and training.

There has been increased demand for specialists in prenatal nursing, adolescent nursing, school health (for handicapped children), nurse midwives and nurse clinicians to work with the handicapped and retarded children.

With the increased service demand and the current inadequate supply of nurses with graduate degrees in the area of maternal child health, we suggest funding should be increased significantly for the MCH programs.

NOTES

1. National League for Nursing, Community Home Health Agencies/Community Health Services.
2. 1977 Sample Survey of Registered Nurses, American Nurses' Association under contract from the Division of Nursing, Bureau of Health Manpower, U.S. Public Health Service, Department of HEW.
3. Occupation Outlook Handbook, U.S. Department of Labor, Bureau of Labor Statistics

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Statement of the National Association of Social Workers

This testimony is submitted by the National Association of Social Workers, a professional organization representing 80,000 social workers across the nation. We wish to express our strong support for an increase in funding levels over those proposed by President Carter in his budget for family planning services and research under Title X of the Public Health Service Act.

The two major objectives of the Title X program are: (1) the prevention of unwanted pregnancies among low- and marginal-income women and adolescents through voluntary family planning services; and (2) the promotion of research to monitor the safety of existing contraceptive methods, while developing safer, more effective and more acceptable ones. Although substantial progress has been made since the program was initiated nine years ago, much work remains to be done toward achievement of these objectives.

In 1979, an estimated 4.4 million women received contraceptive services from organized family planning programs in the United States. Approximately one-third of those women were adolescents. Yet at least that many more low- and marginal-income women and sexually active teenagers are still unable to obtain subsidized family planning services because of the program's limited capacity. Likewise, current contracep-

tive methods, however sophisticated, still have considerable failure rates in actual use and side-effects that make them unacceptable to many women and teenagers.

The President's request for services ($176.9 million) is well below what is necessary to compensate for inflation, requiring cutbacks in either patient caseload or types of services offered. The research budget as a whole ($76.8 million) also lags far behind inflation. Most damaging, however, are the proposed reductions (not even counting inflation) of perhaps the two most vital areas of human reproductive research: contraceptive development and contraceptive safety.

The National Association of Social Workers believes that it is in the best interest of society at large as well as individual women and families to increase Title X funding levels for both services and research in real dollars. In this way, availability of voluntary family planning services may be expanded to all those in need, and research may be promoted in contraceptive development, safety, and effectiveness for the benefit of all men and women of reproductive age. We therefore are in strong support of the funding levels recommended by the Planned Parenthood Federation of America:

TITLE X BUDGET

Services:	$210.0 million	Allowing for a real increase of about 25% for program growth of approximately 500,000 to 700,000 patients.
Research:	$102.0 million	About a 25% increase in real dollars, providing support for previously approved but unfunded projects ($15 million) and allowing funds for some new grants and contracts.

BACKGROUND AND BASIS FOR CONCERN

The unique importance of the family in the development and maintenance of the physical, mental, and emotional health of its members underpins the determination of social workers to support social institutions and welfare programs that enhance and buttress effective family functioning. Our respect for the dignity and worth of each individual human being commits us to work toward the fulfillment of the highest potential in every person. Although society has the responsibility to facilitate

the well-being of each person, the individual must in turn assume some responsibility for the welfare of the community.

Within this philosophical framework, we direct attention to the individual and social consequences of unplanned and unwanted pregnancies. We believe that potential parents should be free to decide for themselves, without duress and according to their personal belief and convictions, whether they want to become parents, how many children they are willing and able to nurture, and the opportune time for them to have children. These decisions are crucial not only for the parents but also for the unborn child, the community, the nation, and the world. For the parents, unwanted children may present economic, social, physical, or emotional problems. If the birth occurs out of wedlock, the problems are compounded for everyone. The tragedy of the unwanted child born out of wedlock is often dramatized by cases of abuse and abandonment.

Advances in the United States in the standard of living, urbanization, medical technology, and understanding of both family and individual needs have produced a corresponding demand for family planning services. Many married persons and engaged couples using private physicians have had fairly ready access to medically approved methods of contraception. Until recently, many medically indigent persons have been able to obtain similar help in family planning only from limited voluntary programs. This discrimination was the result of their low socioeconomic status.

Growing public pressure for governmental support of family planning services as a public health measure comes from several sources: young married couples who want financial and emotional security before venturing into parenthood, parents of large families who are overburdened and unable to break out of the poverty cycle, parents who want to give the children they already have every advantage from their limited resources, and those concerned about the quality of family life. Along with other professions responsible for enhancing family life, social work includes the provision and expansion of birth control services as part of its overall task.

FAMILY PLANNING SERVICES

Since the Title X program was initiated less than a decade ago, great strides have been made toward voluntary, individual fertility regulation among low-income American women and teenagers:

- In 1979, 1.5 million teenagers and 2.9 million poor women received contraceptive services at some 5,000 clinic sites.

- A NICHD-supported study has shown that between FY 1970 and FY 1975, an estimated 1.4 million unwanted births were averted as a direct result of the federally-subsidized family planning program.

- In recent years, there has been a marked increase in the use of the most effective methods of contraception among low-income groups, thus eliminating the historic differences in use and choice of method between the poor and the affluent. In addition, between 1971 and 1976, the proportion of unmarried teenage women who use the most effective methods more than doubled.

- Aside from the benefits derived by individuals from being able to plan their families, the NICHD study documented that the cost/benefit ratio for family planning services is 1/1.8; that is, each dollar invested in family planning by the government in Year 1 yields a government saving of $1.80 in Year 2 in health and welfare costs alone. This cost/benefit ratio is unmatched in any other federal health program.

Despite the remarkable achievements that have been made as a result of the Title X program, there is evidence that a substantial amount of work remains to be done:

- An estimated 2 million sexually active teenagers and 3.5 million poor women are currently unable to obtain family planning services either from clinics or private physicians.

- Approximately 1.4 million abortions were performed in 1978, reflecting a high incidence of unwanted pregnancies that could possibly have been avoided had preventive services been more readily available.

- About 300,000 married women each year have unwanted births, a disproportionate number being poor and women over age 35.

- One out of every seven births - 447,000 in 1975 - occurs out of wedlock.

- Approximately 250,000 babies each year are born with congenital defects, occurring largely to very young and older mothers who have the highest incidence of unintended and unwanted pregnancies.

Greater support for Title X is the best way for the federal government to continue the momentum toward reducing the vast and urgent need for reproductive health services:

- Title X comprises the core support of the organized family planning program. In FY 1980, about 50% of the funds from all sources for services is drawn from Title X. (Other sources included Titles V, XIX, and XX of the Social Security Act, state and local government funds and private fees.)

- Since 1973, new federal policies have sought to shift federal support to state-administered Medicaid and social services programs, which vary widely in scope and coverage from state to state. Federally-administered Title X assures more uniformity in service delivery as well as greater accountability.

- Support through Title X is the only way many women can afford family planning services at all. For adults, those who are "not poor enough" or otherwise ineligible for Medicaid or Title XX but whose incomes are close to the poverty level depend on the subsidization of Title X clinics so that fees can be significantly lowered or waived entirely. Teenagers face a variety of barriers in obtaining family planning services; the existence of a clinic in close proximity to their home where they can receive confidential services at a minimal cost could make all the difference.

POPULATION AND HUMAN REPRODUCTION RESEARCH

When Title X legislation was drafted, it was recognized that efforts to expand family planning service programs must be accompanied by an expansion of efforts to acquire new basic knowledge in the processes of human reproduction and to apply this knowledge to produce new and usable technologies. Since the inception of the research component of the Title X program, much has been learned:

- In 1977, two NICHD-supported scientists won the Nobel prize for their work on the brain hormone (LHRH) which could supplant today's birth control pills for women and provide the first such pill for men.

- Studies in the area of contraceptive safety have demonstrated that women under 50 who take the birth control pill have increased risk of heart attack - especially for those women who smoke.

- A reassuring study was completed which showed little long-term health risk to men who have had vasectomies.

Although these findings are significant, much progress is yet to be made in the field of contraceptive research:

- The FY 1981 Administration budget calls for a 16.5% decrease below last year's appropriation for contraceptive development and a 17% decrease in funds for research in contraceptive safety. This is approximately a $3 million cut in these two important research areas even without taking into account the inflation rate. As a result of this cutback, many projects will have to be cancelled or compromised including further testing of the brain hormone (LHRH).

- Present birth control methods are imperfect and inadequate. The birth control pill and IUD, used by an estimated 13 million American women, are often accompanied by serious health risks. For this reason and in order to reduce the need for abortion, it is essential to increase research in the development of new contraceptive methods. Examples of programs in this area which will be jeopardized without additional funding include: clinical and use-effectiveness tests of new barrier methods of contraception for men and women and studies of new oral contraceptives which would be safer for women.

- In the area of contraceptive safety, increased funds are needed in order to study the safety and effectiveness of birth control for adolescents including the protective effects of spermicides against venereal disease; and a definitive study of the relationship between birth control pills and cancer of the breast, endometrium and ovary.

Increased support for research under Title X is the only way these vital projects will be completed because:

- The bulk of the national and international research effort in population and human reproduction is conducted and administered by the Center for Population Research (CPR) of the National Institute of Child Health and Human Development (NICHD).

- According to the Public Health Service Act, research money for CPR can only come from Title X appropriations.

- A recent Ford Foundation review of reproductive research throughout the world concluded that the field urgently needs at least three times the current level of support to exploit the existing leads to improved and safer contraceptive technologies as well as for a solution to many problems of infertility.

CONCLUSION

The National Association of Social Workers believes that the federal government should actively support the development of community and statewide public voluntary health services for all methods of family planning. Indeed, the government should take a vigorous and full-partnership role with other institutions of society in the broad study, planning, and programming needed to assure that the right of all children to be born into a family and a world that can care for them adequately will be realized. Through its various channels, the government should provide the financial incentive and official support to public and voluntary facilities for the wide dissemination of family planning services. Such governmental support should include the financing of research to evaluate the effectiveness of these family planning services and to develop improved methods of preventing, postponing, or promoting contraception.

With this in mind, we urge an increase in funding levels under Title X over those proposed by the Administration. Specifically, we support an appropriation of $210 million for family planning services. This figure would allow approximately 500,000 to 700,000 additional patients to enter the program. Further, it would enable the program to continue to serve "near poor" women who cannot pay for services themselves but do not qualify for reimbursement from the other government sources of family planning money; to reduce the need for abortion; and to reach out and serve more teenagers. In addition, we support an appropriation of $102 million for human reproduction and population research. This figure would provide funds for the high priority studies already approved by the Center for Population Research. Further, it would allow for some expansion of efforts to fill the remaining gaps in scientific knowledge of reproductive physiology and contraceptive technology.

While we appreciate the concern to limit government spending, we wish to stress that because of its cost-saving method of operation and the short- and long-term health and social benefits of voluntary family planning, this country cannot afford not to support program growth. The National Association of Social Workers urges the Committee not to sacrifice the health and social well-being of women and their families in the United States, and indeed worldwide, for the sake of an uncertain, short-term solution to curb inflation by slashing spending for family planning services and research.

STATEMENT OF SUELLEN LOWRY, NATIONAL ABORTION RIGHTS ACTION LEAGUE

The National Abortion Rights Action League (NARAL) was founded in 1969 to lead the struggle for repeal of restrictive state abortion laws. Since the 1973 Supreme Court decisions which ruled that abortion is a constitutionally guaranteed right, NARAL has worked to keep abortion legal, safe, and available regardless of socioeconomic level.

The National Abortion Rights Action League has a rapidly growing membership which currently totals over 75,000 dues-paying individuals. NARAL also has affiliates in nearly every state with their own memberships. NARAL is dedicated to the elimination of all laws and practices that would compel any woman to bear a child against her will. We would like to express our appreciation for the opportunity to make this statement.

In working to maintain free choice with regard to abortion, NARAL represents the majority in this nation, for numerous public opinion polls (conducted by Harris Survey, Gallup Poll, CBS News, and others) indicate that most Americans are pro-choice. A recent poll of registered voters conducted for the National Abortion Rights Action League by the New York based firm of Dresner and Tortorello Research shows that more than three times as many registered voters are pro-choice as are anti-abortion. This telephone survey reveals that 88 percent of registered voters believe abortion should remain legal in all or some circumstances. Most voters do not think of abortion as something they are simply "for" or "against" but rather are moved to support abortion when they consider the specific circumstances surrounding the decision. Perhaps one of the most significant findings of our poll is that WHEN INFORMED THAT THE GOVERNMENT PAYS FOR CHILDBIRTH, OVER TWO-THIRDS (69 PERCENT) OF THOSE WHO THINK ABORTION SHOULD BE LEGAL IN ALL OR SOME CIRCUMSTANCES ALSO FAVOR THE USE OF GOVERNMENT FUNDS FOR ABORTIONS.

For years, anti-abortion amendments proposed to Labor-HEW appropriations legislation have resulted in lengthy, emotional, often deadlocked debate which threatens Labor-HEW programs and consumes countless hours of Congressional time. A number of threatened Labor-HEW programs -- medical research and care, for example -- are important and perhaps necessary for the continuation of life itself

for many Americans of all socioeconomic levels. Also, health and welfare problems for which we still must find solutions take a "back seat" to the continual abortion debate as anti-abortion rhetoric impedes development of effective measures to promote and enhance the health, education, and welfare of the American public. The United States Congress is enveloped in consideration of an issue which is appropriately a matter of personal choice, individual conscience, and serious deliberation -- deliberation which should take place between a woman, her family, and her physician rather than between Senators and Members of Congress. The anti-abortion amendments have, indeed, become an albatross for Congress and the public which relies on Congress for innovation and thoughtful deliberations.

The right of a woman in consultation with her physician to make the abortion decision (as part of the fundamental right of privacy) was upheld in the 1973 Supreme Court rulings. Some would maintain that the unavailability of Medicaid funds for abortion services has not impacted this right. However, a right without access is no right at all. Therefore, denial of federal funds for Medicaid abortions does, indeed, deny this constitutional guarantee.

In his January 15, 1980, McRae v Harris ruling, Judge John F. Dooling, U.S. District Court, Eastern District of New York, ruled unconstitutional the denial of Medicaid funding for medically necessary abortions. Judge Dooling noted that "The statutory purpose of Medicaid is to provide medical assistance to the needy . . . The need for health care during pregnancy is basic, and, in the case of complicated or problem pregnancy, is indispensable. To exclude from the physicians' battery of procedures legal abortion when it is medically necessary is repugnant to the scheme of the entire Medicaid program."

The Dooling decision holds that excluding abortion from the otherwise comprehensive Medicaid program violates First Amendment rights of freedom of conscience and Fifth Amendment rights of privacy, due process, and equal protection. With respect to the First Amendment, Dooling said, "A woman's conscientious decision, in consultation with her physician, to terminate her pregnancy because that is medically necessary to her health, is an exercise of the most fundamental of rights, nearly allied to her right to be, surely part of the liberty protected by the Fifth Amednment, double protected

when the liberty is exercised in conformity with religious belief and teaching protected by the First Amendment . . . The irreconcilable conflict of deeply and widely held views on this issue of individual conscience exclude any legislative intervention except that which protects each individual's freedom of conscientious decision and conscientious nonparticipation." The abortion decision has a conscientious nature which can be and often is religiously based and which merits the same protection accorded to religiously mandated conduct. It is unconstitutional to impose religious teachings, particularly in the absence of a broad-based social concensus. In situations concerning private moral conduct about which religions strongly disagree, the conscious liberty of women to decide must be protected.

With respect to the Fifth Amendment, Dooling said, "Abortion is medically necessary to safeguard the pregnant woman's health, and her basic statutory entitlement is to appropriate medical assistance, the disentitlement to Medicaid assistance impinges directly on the woman's right to decide, in consultation with her physician . . . to terminate her pregnancy in order to preserve her health."

Who is impacted by restrictions on federal funding of Medicaid abortions? The typical female Medicaid eligible is a recipient of Aid to Families with Dependent Children (AFDC), is receiving welfare assistance for the first time, and has been impelled to seek public assistance because of family crisis: dealth, illness or injury, job layoff, or desertion by the father.. If receiving assistance as the mother of dependent children, she usually has two or fewer children and heads the household. Most AFDC families have children under school age, yet 3 in 10 AFDC mothers are working, seeking work, training for work, or awaiting recall from a layoff.

While some states have assumed coverage of medically necessary abortions for low-income women through state funding, there has been a tendency by most state legislatures to emulate the federal 99 percent elimination of funds. As noted in McRae v Harris, "The relevance of the woman's poverty is that Medicaid is her health care reliance, and when she is excluded from receiving under Medicaid the therapeutic abortion that is to her a medical necessity, THERE CAN BE

NO ASSURANCE THAT SHE WILL RECEIVE THE MEDICALLY NECESSARY ABORTION ELSEWHERE. She is effectively denied assurance of a basic necessity of life because of her medically advised decision." While repercussions of the federal funding restrictions have not all been measured at this time, there is evidence that women are waiting longer before they make the decision to abort -- yet each week of delay signi icantly increases risks to the woman's health.

This year federal funds are being provided for Medicaid abortions only in cases of life endangerment and rape and incest, which has reduced federal funding over 99 percent -- from 297,000 federally funded Medicaid abortions in 1977 to less than 2,000 federally funded Medicaid abortions which will probably be perfomed this year. Of the 1,000 plus Medicaid abortions that will be performed this year, nearly all will be performed in cases of life endangerment.

An AFDC mother or child who will not die if she carries a pregnancy to term and who has not conceived as a result of rape or incest, or who has conceived as a result of rape or incest but who is afraid to report the crime or unaware that she can go some place for help, must bear an unwanted child, resort to illegal or self-induced abortion, or find personal funds to pay for the abortion herself. It must be noted that the average monthly AFDC payment for a mother and two children is $241 a month ($2,892 per year). The average estimated cost of an abortion is $285. Translated more graphically into the basic necessities for life, the cost of one abortion equals an average welfare family's (mother and two children) budget allocation for food for three months or for clothing for nine months. Therefore, denial of funding for Medicaid abortions detrimentally impacts the health and well-being not only of low-income women themselves but also of their children or brothers and sisters.

Only a handful of Medicaid abortions will be funded due to reported cases of rape or incest. This is not because there are decreasing incidents of rape and incest in this country, but rather because rape and incest are infrequently reported crimes and because the sixty-day Medicaid reporting requirement has often passed before a woman realizes she is pregnant or before she can decide whether or not to shoulder the repercussions of reporting. The National Center for Child Abuse and Neglect estimates that there may be as many as 100,000 cases of incest per year. Yet victims of

incest are usually young and ignorant of how to seek help or terrified of retribution. Pregnancy also often occurs in cases of incest because the victims are usually not practicing birth control and because the crime generally occurs repeatedly. FBI statistics show that a forcible rape occurs every 9 minutes -- 276,000 women are raped each year. Fifty percent of these rape victims are under the age of eighteen and 25 percent are under age twelve. If we look at the increasing frequency of rape and incest and then note how few abortions Medicaid funds which were the result of rape or incest, we can quickly see how inadequate the rape and incest exceptions are.

Last year federal funding for Medicaid abortions was allowed in cases of life endangerment, rape or incest, and severe and long-lasting physical health damage. As noted above, the rape or incest exceptions are totally inadequate. The severe and long-lasting physical health damage exception also has been the grounds for only a handful of Medicaid abortions in the past. Besides ignoring instances of irreparable mental harm if a pregnancy is carried to term, severe, perhaps fatal, fetal deformity, situations in which the pregnant woman is a little girl or well beyond the normal child-bearing years, conditions of horrible poverty where a family does not know how it can support another child, and so on, the severe and long-lasting physical health damage exception has been inadequate because Medicaid women have been required to have certification from two doctors who do not practice together that such health damage would result. As noted in McRae v Harris, " . . . the medical profession will interpret and has interpreted the Hyde-Conte amendment and its successors narrowly rather than attempt to demonstrate to DHEW the basis of their medical judgments in cases in which they are satisfied that abortions are medically necessary for the pregnant woman's health." Therefore, it has been extremely difficult for Medicaid recipients to find certification that will make them eligible for funds. The severe and long-lasting physical health damage exception has also been inadequate because, as Judge Dooling states, "There is a very large number of specifically pathological conditions that at some level of intensity and under some circumstances of treatment will jeopardize the health or life of a pregnant woman and indicate termination of pregnancy as the medically more appropriate procedure.

However, except for a few classic conditions, they are not characterized by that certainty of predictability that the Hyde-Conte amendment and its successors appear to require."

NARAL feels that the restrictions which have been placed on federal funding of Medicaid abortions in the past and which have drastically reduced this funding 99 percent, deny access to, and thus the right of, low-income women to freely decide whether to carry a pregnancy to term. The impact on the health and lives of these women and their families, as they bear an unwanted child, are forced to seek a self-induced abortion, or take food from their mouths to pay for the abortion themselves, can be devastating. We urge the Subcommittee on Labor-HEW Appropriations to hold firm against the injustices which have occurred in the past and to work for a Labor-HEW appropriations bill free of all anti-abortion restrictions. We thank the Subcommittee for its efforts in the past and for the opportunity to present this statement.

STATEMENT OF MARY JANE PATTERSON, CHAIRPERSON, RELIGIOUS COALITION FOR ABORTION RIGHTS

The Religious Coalition for Abortion Rights is a coalition of twenty-seven national Protestant, Jewish, Catholic and other religious groups whose denominational constituencies total approximately 27 million. My own denomination, the United Presbyterian Church, which has a nationwide membership of approximately 2.5 million, was a founding member of RCAR, which was organized in 1973 to maintain the option of safe and legal abortion for all women who choose it, consistent with sound medical practice and their own moral and religious beliefs. My statement is presented on behalf of the Coalition, whose members you will find listed at the end of this testimony.

We deeply regret that the abortion issue, which has become so divisive among well-intentioned individuals in this nation, has been used to subvert the legislative process and to hold important government programs hostage to the demands of a very vocal minority nationwide. Since 1976, despite the fact that it is contrary to both House and Senate rules, Appropriations bills have been used as vehicles to establish de facto a Federal policy on abortion which we believe to be inconsistent with the guarantees of separation of church and state and equal protection as established by the Constitution. We continue to hold out hope that the Senate will reject this futile process and will withstand efforts to perpetuate it into FY 1981, particularly in light of recent Federal court rulings in New York and Illinois declaring the so-called "Hyde Amendment" unconstitutional, and the imminent consideration of these cases by the U. S. Supreme Court.

We believe that the decisions of the Federal courts in Zbaraz v. Quern and McRae v. Harris present a new factor in the deliberations over Medicaid abortions for FY 1981. We are particularly gratified by these decisions, since one RCAR member organization (The Women's Division of the Board of Global Ministries of the United Methodist Church) was a plaintiff in the McRae case, and a number of others entered the case as amici curiae. The Supreme Court has agreed to hear these important cases on expedited appeal and to issue its ruling this session. We are confident that Judge John Doolings's decision will be upheld by the high court, thereby obviating the annual confrontations associated with this issue.

It has consistently been our contention that the restrictions on abortion embodied in the Hyde Amendment constitute an infringement upon the right of individuals to follow the teachings of their faith on the matter of abortion, and also deny equal protection under the law to indigent women who seek medically necessary abortions. This has been established to the satisfaction of the court.

The court determined that the purpose and effect of the abortion restrictions on Medicaid funds was not to promote the health of the woman or to protect a compelling state interest in normal childbirth; nor does the state have a significant financial interest in prohibiting abortions. To the contrary, testimony before the court conclusively revealed that the restriction disregarded the woman's health except in the direst of circumstances when determining the availability of coverage, and that the language used in the law was vague and essentially non-medical. Also, on the basis of previous Supreme Court action, the Dooling court determined that any state interest in the fetus and in normal childbirth may not override the woman's interest in her own health. Finally, it is part of the record that the cost of financing abortions for women who choose them is many times less than that associated with childbirth and subsequent services which must by law be made available to an indigent family, thus negating the argument that the amendment was enacted as a measure of fiscal restraint.

It was established that the actual purpose and effect of the Hyde Amendment is to reduce the number of abortions and to frustrate a woman's making an abortion decision in consultation with her physician and for medical reasons. It was also established that the amendment itself stems from a religious bias against abortion that is not shared by all American citizens and not taught by all religious faiths.

In anticipation, however, that efforts to restrict funds available for abortion will continue to be made, and since the Hyde Amendment is already included in the President's budget request, the Religious Coalition for Abortion Rights wishes to go on record once again in opposition to any abortion funding restriction which may be proposed for inclusion in the FY 1981 Labor/HEW Appropriations bill. We believe that poor women dependent upon the Medicaid program for their medical care should receive the same level of conscientious and comprehensive health protection that is available to others in our society. It is our conviction that the medical procedure of

abortion must therefore be among the health services made available to all women, without regard to economic circumstances.

We believe that excluding abortion from the services available through Medicaid contravenes the intention of the Medicaid statute, which seeks to make a full range of health, rehabilitation, and education services accessible to all our citizens regardless of their own ability to meet the costs of such programs, "to help such families and individuals attain or retain capability for independence or self-care." Without this assistance and this equilization of services, lower and marginal income Americans have no means of securing these important services. Thus a prohibition in the Labor/HEW bill of a particular service such as abortion effectively denies to poor women the same kind of health care available to others in society with higher incomes, thereby promoting and perpetuating discrimination.

The stated goal of the legislation is significantly distorted by the abortion restrictions, since doctors treating poor women are forced by the prohibition to resort to a different (and less adequate) standard of care than they provide for other women in society. Rather than allowing a medical doctor the latitude he/she needs to determine the need for an abortion, doctors treating poor women may now, according to law, recommend abortions only when the woman's life is endangered by pregnancy or for victims of rape and incest who promptly report the crime to a law enforcement or health agency.

This language, which was adopted in the Continuing Appropriations resolutions of Oct. 12 and Nov. 16, 1979 after protracted debate and confrontation between House and Senate, presumed to represent a compromise between the position of the two bodies. However it demonstrates an even further erosion of the principle of equal health care, since it eliminates even the minor health considerations permitted by the FY '78 and '79 Appropriations laws. We do not believe that true compromise has taken place when the result is a 99% decrease in the abortions available to poor women. This figure, based on HEW statistics for FY '78 must certainly belie the fears of some Members of Congress that the '78 language created tremendous loopholes which would allow hundreds of thousands of women to obtain abortions at government expense.

Furthermore, the "compromise" language adopted is so restrictive that it does not allow for compassionate treatment of the poor woman who has been in and out of mental hospitals for years, whose hope for recovery is completely destroyed by a pregnancy she neither planned nor understands. It provides no options to the woman who has six children already and simply cannot support another. It offers no humane alternative to parents who know from medical tests that the child they expect will be severely deformed at birth with little chance for survival. And for the woman whose own precarious health is even further jeopardized by an unplanned pregnancy, it withdraws the means to secure adequate medical care.

As religious organizations concerned for the health and welfare of all people, we oppose any legislation which would impose on any segment of society a standard of

care which is clearly inadequate. We have a deep concern for the women who are compelled to carry problem pregnancies to term, risking their health and in some cases their lives, as well as for those women who will be forced by their circumstances to resort to self-induced or back alley abortion.

And as religious organizations committed to equal and civil rights, we cannot support legislation which would discriminate against the poor by denying to them access to a service which has been ruled, by no less than the highest court in the land, to be a right for all American women.

In addition to our concern for the health and well-being of poor women and our commitment to the principal of equal access to quality health care for all, regardless of income level RCAR has an even more basic and compelling reason for objecting to abortion restrictions in the Labor/HEW Appropriations bill. We believe that these restrictions deny religious liberty to poor women by preventing them from following their own conscience and religious convictions on abortion. Within the religious community, there are widely differing views on abortion. There are some religions that object to abortion under all circumstances. This view is based on the belief that a separate, equal human life exists from the moment of conception and that abortion represents murder. However, there are also those faiths which teach that separate, equal human life begins sometime between viability and birth. While these religions have a deep respect for the human potential of a fetus, they do not consider it a full human person with rights equal to those of existing individuals. Therefore, many of these religions agree that when a problem pregnancy would result in tragic circumstances, abortion should be considered a moral alternative and one which may be the most loving and responsible solution.

My own denomination clearly teaches that "God has given persons the responsibility of caring for creation as well as the ability to share in it, and has shown his concern for the quality and value of human life." We recognize that there are times when "the natural ability to create life and the moral and spiritual ability to sustain it are not in harmony", and therefore moral and ethical decisions about abortion are incumbent upon individuals of faith (Resolution of the 184th General Assembly of the United Presbyterian Church, USA, May, 1972).

The United Methodist Church counsels that, "When, through contraceptive or human failure, an unacceptable pregnancy occurs, we believe that a profound regard for unborn human life must be weighed alongside an equally profound regard for fully formed personhood, particularly when the physical, mental and emotional health of the pregnant woman and her family show reason to be seriously threatened." (Resolution on Responsible Parenthood, adopted by the 1976 General Conference of the United Methodist Church.)

In Judaism, a fetus is not considered a full human being and for this reason has no "juridical personality" of its own. According to Jewish law, the fetus in the womb is not a person (lav nefesh hu) until it is born (Rashi, Yad Ramah, and Me'iri,

all to Sanhedrin 72b). According to Scripture, while the fetus clearly has value, its loss is to be atoned for by monetary compensation, but there is no capital liability for foeticide as there is for the loss of human life. By this reckoning, abortion cannot be considered murder.

While Jewish law teaches a reverent and responsible attitude to the question of life and thus views abortion with great concern, resons affecting basic life and health may sanction or even require therapeutic abortion. For example, Jews are particularly subject to Tay-Sachs disease - a genetic disease fatal to infants. No Tay-Sachs child has ever lived beyond 5 years of age, and each dies an agonizing death. Tay-Sachs disease cannot be detected until the second trimester, and thus no therapeutic action can be taken until that time. Were the beliefs of another religion concerning abortion to be enacted into law, the right of Jews to follow their religious convictions would be denied.

RCAR remains profoundly sensitive to those individuals who feel compelled, on the basis of religious beliefs, to reject abortion as an alternative to a problem pregnancy. However, because there is no agreement on this subject within the religious (or medical or legal) community, government policy on this matter must allow people of all faiths to freely practice their <u>own</u> belief. It is paramount that there be no law embodying the views or bias of any religious group; otherwise, the rights of others to follow their own religious teachings and conscience on this matter are abrogated.

Finally, we would stress that no member of RCAR advocates abortion or considers it an easy solution to a problem pregnancy. Certainly none consider it a desirable means of family planning. We are hopeful that in the future, the need for abortion will be reduced. Within the programs funded by the Labor/HEW Appropriations bill, there are a broad range of services for family planning and contraceptive research which we hope will increasingly meet the needs of the poor and alleviate the problems which lead women to seek abortions. We strongly believe, however, that complete abortion services, including referral and counselling, must be among the services available to the poor through these publicly funded programs. We would hope that the House and Senate will see fit to appropriate sums of money to insure the success of these programs.

For these reasons, we urge the committee to reject all abortion restrictions in the FY 1980 Labor/HEW Appropriations bill, and to restore to lower income women their right to obtain safe abortion services.

MEMBERS OF THE RELIGIOUS COALITION FOR ABORTION RIGHTS

National Ministries
American Baptist Churches

American Ethical Union

National Women's Conference
American Ethical Union

American Humanist Association

American Jewish Congress

Women's Division
American Jewish Congress

B'nai B'rith Women

Catholics for a Free Choice

Division of Homeland Ministries
Christian Church (Disciples of Christ)

Episcopal Women's Caucus

National Council of Jewish Women

National Federation of Temple Sisterhoods

General Assembly Mission Board
Presbyterian Church in the U.S.

Committee on Women's Concerns
Presbyterian Church in the U.S.

Union of American Hebrew Congregations

Unitarian Universalist Association

Unitarian Universalist Women's Federation

Board of Homeland Ministries
United Church of Christ

Office for Church in Society
United Church of Christ

Board of Church and Society
United Methodist Church

Women's Division,
Board of Global Ministries
United Methodist Church

Church and Society Unit
United Presbyterian Church in the U.S.A.

Washington Office
United Presbyterian Church in the U.S.A.

Women's Program Unit
United Presbyterian Church in the U.S.A.

United Synagogue of America

Women's League for Conservative Judaism

Young Women's Christian Association

CENTER FOR DISEASE CONTROL

STATEMENT OF LORIN E. KERR, M.D., M.S.P.H., DIRECTOR, DEPARTMENT OF OCCUPATIONAL HEALTH, UNITED MINE WORKERS OF AMERICA

I am Dr. Kerr, Director, Department of Occupational Health, United Mine Workers of America. Thank you for the opportunity to testify before this Subcommittee.

Passing laws and implementing programs to protect the health and safety of miners took a long time to accomplish. Looking back it is hard to believe that it was not until 1968, when 78 miners lost their lives in a major coal mine disaster, that Congress and the nation were spurred to begin passing comprehensive occupational laws. I am speaking of the Coal Mine Health and Safety Act of 1969 which preceded the Occupational Safety and Health Act of 1970. The coal mine act was finally strengthened with enactment of black lung amendments in 1972 and 1978 and finally with the Federal Mine Safety and Health Amendments Act.

But simply passing laws is not enough--fiscal resources must also be committed to insure proper implementation and enforcement. In 1972 the President estimated that occupational diseases caused the death of 100,000 workers per year. Hundreds of thousands of new illnesses each year are thought to be occupationally related.

It is thought by some that today about 300,000 workers die each year from job-related diseases. In fact a former director of the National Cancer Institute (NCI) publicly stated on several occasions that nearly 90 percent of all cancers originate in the environment. Occupational carcinogens, the most neglected area of environmental cancer research, are the probable cause of the vast majority of these cancers. In 1947, the world-renowned Wilhelm C. Hueper, M.D. stated that, "Environmental (occupational) carcinogenesis is the newest and one of the most ominous of the end-products of our industrial environment".

Dr. Hueper at that time was a commissioned officer in the U.S. Public Health Service assigned to the NCI to conduct cancer epidemiology. In 1952 his studies on occupational cancer were "forcefully and abruptly brought to a halt--by an order of the Surgeon General". This order which was never rescinded followed a protest to the USPHS by the medical advisor to the chromate-producing industry on behalf of his clients. Dr. Hueper had just reported an alarming amount of cancer among workers in the chromate industry.

Today we have no accurate accounting of any occupational disease although some diseases such as silicosis and plumbism were reported more than 2,000 years ago. The enactment of the federal coal mine act in 1969 has begun to provide some specific figures in that industry. Congress for the first time reached into a major industry and mandated that the disease characteristically occurring in that industry must be eliminated. It is now safe to conclude that the death each year of more than 4,000 miners can be attributed to black lung. In addition, about 15 percent of the working coal miners exhibit some x-ray changes ascribed to coal workers' pneumoconiosis. The federal government in the ten years since enactment of the coal mine act has paid a cumulative total of somewhat more than $8 billion in black lung benefits.

All of this misery and costs could have been prevented by the application of preventive measures that have been well known for several decades. Congress mandated their implementation but as with all occupational diseases it will be a number of years before the results can be reported.

Coal workers' pneumoconiosis like all occupational diseases is man-made and can be prevented. However, it will take at least one generation to eliminate it from the coal mining industry.

These figures emphasize the enormity of the problem which miners and other workers face. But they are especially frightening when we realize they represent people and families who undergo hardships and suffering. Let me repeat, these human tragedies are avoidable. I am here today to emphasize the seriousness of this problem and describe the fundamental role the National Institute for Occupational Safety and Health (NIOSH) has in protecting miners and other workers, and why it is so critical that NIOSH receives the resources it needs to protect our nation's miners and other workers from job hazards.

The Federal Mine Safety and Health Amendments Act of 1977 gave NIOSH responsibility for mining research and training programs, and recommending mine health standards to the Mining Safety Health Administration (MSHA). Mining safety research remains with MSHA. To fulfill this mandate, the Institute has established programs in eight major areas:

--Surveillance

--Health Hazard Evaluation

--Standards and Criteria Development

--Laboratory Based Research

--Control Technology Assessment

--Industrywide Studies

--Monitoring and Measurement Research Development and Support

--Training

The following is a summary of what NIOSH is doing in these eight important areas, and what yet needs to be done.

Surveillance: Under the Federal Mine Safety and Health Act, NIOSH is directed to determine the toxicity of harmful physical agents found in mines.

Towards this end, NIOSH has established the National Coal Workers Surveillance Program, which has conducted over 270,000 radiographic examinations of working miners in two rounds of study.

However, almost no other health surveillance has been done in mines and NIOSH needs to conduct additional research in this area. As mandated by the Federal Mine Safety and Health Act of 1977, NIOSH prepared an initial surveillance report, which has been transmitted to the Secretary of Labor, listing exposures which were known to be toxic at concentrations found in coal and noncoal mines.

This report was supposed to be based upon first-hand data, and used to help establish new mine health standards. However, the quality of this important document was compromised due to a lack of funds and insufficient staff personnel requested in FY 80. Much of the data in this report was obtained from literature searches and other secondary sources, rather than current on-site analyses conducted by trained personnel.

Accurate, first-hand surveillance information on the presence of hazardous substances in the mines, and corresponding worker exposure, is essential for setting research priorities and developing health standards. The establishment of well supported standards is essential to protect the health of miners.

Since many more potentially toxic agents than were reported in this first survey are found in mines, NIOSH is planning a National Occupational Hazard Survey for Mining. This survey of 5 percent of all mines, coal, metal, and non-metal will include an extensive inventory of exposures, measurement of as many exposures as feasible, and identification of those miners who have a high risk exposure to hazards. Miners and regulatory agencies must be directly informed about the results of the NIOSH mining surveillance program.

In FY 80 this surveillance program was supported with $250,000 and 10 positions. The new mining surveillance objectives will require an additional $3.0 million and 25 new positions for FY 1981. With this level of funding a survey of all mines could be conducted in two years.

Health Hazard Evaluations: Under this program, NIOSH responds to requests from miners or mine owners to determine the toxic effects on miners from agents found in the mines. The HHE fulfills an essential role in providing

a "quick response" mechanism for investigating often elusive, potential workplace health hazards.

As this program becomes better known, requests for HHE's from miners is expected to strain NIOSH's ability to respond with the quickness and thoroughness the act requires. In FY 80 this program is just beginning. NIOSH will need $1.5 million and 15 new positions if this program is to operate effectively in 1981. With this level of funding approximately 60 HHE's could be completed each year.

Standards and Criteria Development: Protecting the health of our nation's miners depends upon the development, implementation, and enforcement of well documented health standards. Under the Federal Mine Safety and Health Amendments act, NIOSH is responsible for the development of criteria for health standards in mining.

While recommended standards have been developed for over 100 hazards found in general industry, only a few have been completed for mines. Recommended standards are being developed to protect miners from exposure to hazards such as diesel exhaust emissions, oxygen deficient environments and radon daughters. However, this does not even begin to deal with the hazardous substances to which miners are exposed. In FY 80, $1.9 million was allocated for standards development. If the Institute is to tackle its Congressionally mandated responsibilities to protect miners, it must develop at least a dozen new recommended standards, which will require an additional $2.5 million and 21 new positions.

Laboratory Based Research: Laboratory based research in NIOSH includes animal toxicology studies, particle identification and other laboratory work.

Scanning and transmission electron microscopy capabilities for identification of harmful pesticides should be upgraded to support field studies, mining hazard evaluations, surveillance activities, as well as the National Coal Workers Autopsy Study.

Methods to detect toxicity at the cell level must be given emphasis to characterize fibrous minerals and other respirable dusts to which miners are exposed.

Research emphasis should be given to reproductive, and carcinogenic effects of substances to which miners are exposed.

Studies of animals exposed to combinations of hazardous substances similar to those found in actual mining conditions should be undertaken to forecast toxic effects in miners.

In FY 80 $1.0 million was allocated to laboratory research with no increase in positions. For NIOSH to meet its laboratory research demands in FY 81 it will need an additional $1 million and 20 new positions.

Industrywide Studies: NIOSH conducts long-term epidemiologic and environmental studies to evaluate occupational diseases of miners. Respiratory disease studies and occupational cancer research comprise two important segments of the NIOSH program. NIOSH also has a strong research effort in ergonomics and occupational skin disorders.

In anticipation of the Federal Mine Safety and Health Act of 1977, NIOSH began a number of industrywide studies in the metal and non-metal sector. These included a recently completed study of miners exposed to silica and diesel emissions, and morbidity and mortality studies of talc workers, crushed stone workers, gold miners exposed to asbestiform minerals, and cement workers. In all of these studies, respiratory disease was the focus of the morbidity studies, while carcinogenesis was examined in the mortality studies. Several other studies focused principally on carcinogenesis, including those dealing with exposures to uranium, potash mining (diesel and radon daughters), selenium, and phosphate.

Studies should emphazize the mutagenic and carcinogenic effects of various substances, including metals, radiation, diesel emissions, and fibrous minerals found in coal and non-coal mining. These studies should also examine potential interactions between these toxins that could increase cancer risk.

Field work to discover the extent of exposure to mutagens is needed. This will also require developing and testing new methods to determine exposure.

A comprehensive assessment of the potential hazards associated with new processes and equipment should be undertaken.

Further investigation of such physical agents such as heat, noise, vibration--all prevalent in mining--should be undertaken.

Studies of such factors as stress, fatigue, shift work that may contribute to the high accident rate in mines are needed.

The FY 80 budget allocated $3.1 million for mining industrywide studies. These studies are of critical importance to the future health of thousands of miners, and the Institute will need $4 million and 15 positions to start 3 new field studies in FY 81.

Training: NIOSH's Division of Respiratory Disease Studies has been unsuccessful in attracting well qualified mining experts from the field because of NIOSH salary restrictions. As an alternative, NIOSH needs to develop a training program, generating this expertise in staff.

Those NIOSH Educational Resource Centers (ERC) with access to mining schools should be asked to develop specific mining training courses and perhaps programs. One new ERC concentrating its efforts on mining and energy should be developed for funding in FY 81.

Interactions between NIOSH and the National Mine Health and Safety Academy in Beckley, West Virginia should be strengthened to train NIOSH staff in mining and provide the Academy's staff with more health training.

$1.5 million and 2 new positions will be necessary for NIOSH to start one new ERC and to support 2 existing ERC's in mining health activity.

Control Technology: While the Bureau of Mines has developed expertise in mining safety control technology through long experience, it lacks expertise in health protection. NIOSH should make a special effort to work with the Bureau of Mines to identify control technology issues for protecting the health of miners and to assess Bureau of Mine's research programs for developing new health protection controls.

It may be possible to affect their future control technology development program in areas that need additional research effort, especially in support of criteria being developed with NIOSH.

Internally, NIOSH control technology assessments in mining should be coordinated with field research and health hazard evaluations. NIOSH control technology research should also be closely coordinated with MSHA field enforcement personnel. Also UMWA personnel, trade associations, and manufacturers of mining equipment should be kept informed of progress in this area.

NIOSH currently has 5 staff positions and $0.5 million allocated to control technology in mines. For NIOSH to conduct 5 new control technology studies in conjunction with BOM it will need $1.5 million and 5 additional positions in FY 1981.

Monitoring and Research Development and Support: Health problems in mines often require special sampling techniques, field equipment, and analytical procedures. In FY 80, NIOSH has several such projects underway, such as analytical support for diesel studies and development of aerosol monitoring methods.

Much more research is needed to develop direct reading instruments and methods for multiple agents. Sampling/analytical instrument packages need to be developed that have greater potential for acceptance by miners.

Further research and coordination to better define "respirable" dusts for MSHA standards are needed. Different definitions have been proposed by various agencies.

Special effort should be directed toward developing sampling and analytical methods for specific substances as well as methods that will work in humid conditions frequently encountered in mines. The ability of internal and contract analytical testing to accommodate increased field studies needs to be expanded.

In FY 80 $1.0 million was allocated for sampling and analytical support related to mining. NIOSH will need $2.5 million and 8 new positions to carry out these duties in FY 1981.

Contract Problems: Because necessary positions have not been authorized to implement the Mine Safety and Health Act, more and more of NIOSH's work is being done by contractors. However, there are a number of problems involved with using contractors to conduct occupational safety and health research. Contract field researchers have difficulty gaining entrance to workplaces in spite of regulations which were intended to facilitate this process. Management zealously guards confidential information fearing misuse by contractors, and contractors research findings may at times be influenced by their over-riding business interests.

Moreover, NIOSH researchers must divert energies from their own research activities to monitor contracts. It is a serious misconception

to believe that it is a good use of taxpayers' money to force an agency to contract out vital functions involved in protecting the health and safety of American workers.

The President's FY 1981 budget includes no increase in either dollars positions for mining. In the FY 80 budget, an additional $8 million was provided to finance the mine health activity and only 10 positions were allocated for mining surveillance.

We are concerned that the responsibilities for NIOSH have increased substantially, but the proposed increase in funding for NIOSH for FY 1981 in the President's Budget Request is only 2 percent (1.7 million) and in personnel is less than 1 percent. For example, on February 26, 1980 the President issued an Executive Order concerning occupational safety and health for Federal employees. This Executive Order extends the right to request health hazard evaluations to 2.7 million federal civilian employees. We fully support extending the protection of the Occupational Safety and Health Act to all workers, including federal employees. However, NIOSH has no new resources to meet this demand. We are concerned that if Congress does not rectify this situation, NIOSH will be forced to divert resources from mining, the most hazardous industry, to meet some of this new demand.

Turning specifically to coal mining I must reiterate three of our long standing recommendations:

1. NIOSH must have the total responsibility to make the chest radiographs of the working miners. This can be accomplished by examining 25 percent of the miners each year. The examinations must be made while the miners are on shift. If not the number of examinations will be so low that statistical analysis will be meaningless. The coal mining operators would continue to pay the costs as mandated by Congress by reimbursing NIOSH. For the first time comparable films will be available to assess the miners' health and adequacy of the dust suppression program.

Both the 1976 and 1979 UMWA conventions unanimously approved a resolution recommending this program.

I must alert you and all other Members of Congress that if this program is not implemented in the immediate future the medical surveillance aspects of the NIOSH program will become a nonentity.

2. Asbestos must be eliminated from the coal miningiindustry. Until recently the UMWA has fought a rear guard action attempting to get asbestos out of strip mining. Since the first of the year, we have learned of a heretofor unknown exposure of construction workers to an unusually heavy dose of asbestos at the construction of preparation plants in Illinois.

Again the last two UMWA Conventions demanded elimination of asbestos from the coal mining industry.

MSHA and NIOSH must take immediate action on this.

3. Funds must be available from MSHA, such as those currently allocated by OSHA under the caption of New Directions Programs. This would enable the UMWA to add sorely needed industrial hygienists to its staff.

Summary: In summary, NIOSH is responsible for conducting the research and providing the technical support necessary for the development, implementation, and enforcement of the nation's occupational safety and health standards. NIOSH's daily activities profoundly affect the welfare of 100,000,000 workers--half a million of which are miners. Few new mine health standards have been developed. While resources for mining health research have grown over the years, few additional positions have been provided.

This is intolerable, especially in view of NIOSH's need to implement its new responsibilities to protect the health of miners. For this NIOSH will need an additional $17.5 million and 102 new positions in the 1981 FY.

There is a lot of time to make up for--and many miners will pay dearly for further delay. The problems associated with minimizing workplace health hazards are complex--and in many cases, cannot be addressed cheaply. If Congress is serious about protecting this nation's miners it must go farther than passing legislation. It must provide NIOSH with funding and positions commensurate to the enormous task at hand.

NATIONAL INSTITUTE ON AGING

STATEMENT OF EWALD W. BUSSE, M.D., DEAN, DUKE UNIVERSITY MEDICAL CENTER, DURHAM, N.C.

I am Ewald W. Busse, M. D., Professor of Psychiatry and Associate Provost and Dean, Duke University Medical Center, Durham, North Carolina. I would like to submit a statement on behalf of the appropriation for the National Institute on Aging (NIA) of the National Institutes of Health.

For approximately twenty-six years I have been engaged in research on aging at Duke University Medical Center. I have also served as President of the Gerontological Society (1967-68), the American Geriatrics Society (1975-76), and the American Psychiatric Association (1971-72).

The NIA, and the fields of gerontology and geriatrics, are still in their early infancy, the Institute having been effectively established at NIH only approximately five years ago. Gerontology and geriatrics date back approximately thirty years but the fields remain underdeveloped for a wide variety of reasons, the most important one being underfunding during the Post World War II period when much of the medical research in the United States enjoyed a period of rapid growth and maturation. Recognizing that the present population over age sixty-five now totals approximately twenty-three million will more than double during the next thirty to forty years, while the overall population in the U. S. is projected to remain relatively constant, means that by the year 2020 perhaps one in five of our population will be over age sixty-five. It is estimated that young men and women in medical school today will spend perhaps seventy percent of their patient care time caring for older citizens, yet very few of our medical schools have well-developed programs in geriatrics and gerontology at either the pre- or postdoctoral levels and there is currently a critical shortage of trained faculty for positions in these fields.

A second major area of concern has to do with the lack of adequate research resources such as aged experimental animals for research on aging. Unfortunately, such animals are costly because they must be maintained in a controlled environment until they reach an age when they can be used for investigational purposes. Currently, only aged mice and

rats are avilable and these only on a very limited basis. Other animal resources must be developed and made available for investigational purposes if aging research is to progress and if the needs and demands of the field are to be met.

Thirdly, I want to speak to the subject of specialized centers for research on aging. Research on aging, by its very nature, is a multi-disciplinary effort encompassing most disciplines in the biomedical sciences as well as those from the social and behavioral sciences. The Institute currently supports only one center in the biomedical sciences - its own Gerontology Research Center in Baltimore. Additionally, only two or three centers in the social and behavioral sciences are supported, although these are really supported by a variety of grants rather than as centers per se. As I am sure members of this committee are aware, most of the categorical Institutes at NIH provide support for centers of various kinds, in some instances continuing for nearly two decades. As noted above, it is essential that this need be recognized and that funding for specialized centers in aging be available without delay.

Fourthly, I would like to speak to the matter of staff positions for the Institute. Since I currently serve on the Advisory Council and I have had a prior familiarity with the Institute and the biomedical research enterprise in this country dating back many years, I do feel justified in addressing this issue. As indicated above, the Institute was established only about five years ago and has developed during a period of relative austerity, not only in terms of funds for its programs, but also in its staffing. A major effort has been directed to the development of a program in the neurosciences which will offer promise for benefiting large numbers of older people who now are confined to nursing homes because of senile dementia. We now know that senile dementia is not an inevitable consequence of old age yet perhaps fifty percent of the U. S. nursing home population areinstitutionalized because of it. The Institute added women to its Baltimore Longitudinal Study beginning in January of 1978; however, if the full cohort of approximately six to seven hundred women are to be added in a timely fashion, additional positions will be required.

Extramurally the Institute has experienced considerable growth

thanks to the foresightedness of this committee. The number of approved grant applications has increased some four-fold since 1976 and several new program areas such as pharmacology, endocrinology, immunology, nutrition, geriatric medicine, and the social and behavioral aspects of aging are being actively developed. However, additional staff is required if these efforts are to develop their full potential.

A more detailed rationale for additional appropriations for the National Institute on Aging is provided below:

Development of Trained Manpower for Geriatrics and Gerontology. The Institute is currently (FY 1980) providing support for the training of approximately 164 trainees, almost all of whom are non-M. D. trainees. This is a decrease of some thirteen trainees from the number supported during 1979. I understand that the projected number to be supported at the level of the Administration budget during FY 1981 will be about 125, a further decrease of some 39 trainees. The urgent need for trained scientists and physician investigators can hardly be met by this decrease in support for training programs. I am recommending an appropriation for the support of 177 trainees be provided for FY 1981, the same number supported in 1979. This will necessitate an increase in the appropriation for training of $1.0 million.

Geriatric Medicine and Dentistry Academic Awards. This program is designed to strengthen medical and dental school curricula in the area of geriatrics and to further the development of role models in geriatrics and gerontology. The program will help meet an urgent need for future faculty members. At the level of the Administration budget, approximately twenty-six such awards will be supported. I recommend that an additional appropriation sufficient for twenty-five additional awards be appropriated during FY 1981 at an additional cost of $1.6 million.

Research Resources and Animal Models. The Institute is currently spending approximately $2.5 million extramurally for the development of cellular and genetic resources and rodents for use in research on aging. However, as noted above, the availability of these resources is extremely limited. I am recommending an additional appropriation of $3 million to expand the current inventory of mice and rats and to develop other colonies, such as cats, for research on aging.

Specialized Centers. As noted above, the Institute does not currently support any specialized centers of research. These centers would provide a rich environment for stimulating research in a number of important areas in which a multidisciplinary approach would be most profitable. Examples include senile dementia, pharmacology, immunology, and a number of social and behavioral areas such as work and retirement, and the special problems of the older women (women tend to outlive men by approximately seven years, and the proportion of women in our very old population outnumber men by perhaps four or five). These centers would provide a setting for training future researchers in the field of aging. I am recommending an additional appropriation of $3 million for this purpose. These additional funds will provide support for approximately six to eight centers.

Investigator Initiated Research Grants. In addition to the special areas of emphasis identified above, additional attention must be given to the investigator-initiated grants, which, as this committee is well aware, represent the basic fabric on which the biomedical research enterprise is based. The Institute has experienced a dramatic increase in the number of grant applications since 1976. Clearly, if the opportunities for research on aging are to be expanded, the most meritorious of these research grants must be funded. Therefore, I am recommending an additional $8.5 million for the support of new and competing investigator-initiated research grants.

Positions. I am also recommending that the Institute's position allocation be increased from the present 303 to 353 positions. This increase is well-justified for the reasons noted above, and is still perhaps as many as 100 positions below what would be regarded as the optimal number needed to fully exploit opportunities available to the Institute. I estimate that these additional positions would require an additional appropriation of $1.3 million.

NATIONAL LIBRARY OF MEDICINE

LETTER FROM SAMUEL HITT, PRESIDENT, ASSOCIATION OF ACADEMIC HEALTH SCIENCES LIBRARY DIRECTORS

February 26, 1980

FEB 28 1980

The Honorable Warren G. Magnuson
Chairman, Committee on Appropriations
U.S. Senate
127 Russell Senate Office Building
Washington, DC 20510

Dear Senator Magnuson:

I am writing on behalf of the appropriations for the National Library of Medicine, and I would like to request that this letter be made a part of the hearings record. I write both as director of an academic library serving the health sciences at the University of North Carolina at Chapel Hill and as President of the Association of Academic Health Sciences Library Directors, an organization whose purpose is to enhance the advancement of science and medicine through increased access to the scholarly literature. I also write as a member and former President of the Medical Library Association, an organization representing the interests of all medical librarians, whose role in the delivery of health care is a very important one.

I have received copies of two excellent letters in support of increasing the National Library of Medicine appropriations for FY 1981, which I understand will be made a part of the hearings record, and I strongly endorse their contents. Mrs. Nina Matheson, Director of the Himmelfarb Library at the George Washington University Medical Center, wrote on February 7 to Senator Eagleton. On February 6 Gerald Oppenheimer, Director of the Health Sciences Library at the University of Washington, wrote to you.

There is no point in repeating the remarks of Mrs. Matheson and Mr. Oppenheimer. I would like, however, to emphasize the current concern of medical librarians over two crucial problems: (1) Fiscal problems for libraries nationally and (2) The effect of National Library of Medicine budget structures and manpower losses on libraries nationally.

I would like to add two illustrations of the fiscal plight of libraries. In the five-year period between 1974 and 1979 the expenditures of academic health sciences libraries nationally rose 67%, but the average number of journal subscriptions dropped 11%. At the same time service demands have increased dramatically. In my library at Chapel Hill, loans to other libraries have increased 265% in this period; on-line database searches for faculty, researchers, and students have increased by 95%.

The health libraries are further weakened in their ability to contribute to the delivery of health care when the services of the National Library of Medicine are weakened. The innovations such as MEDLARS from the greatest medical library in the world would be impossible for any academic library to achieve. Dr. Martin Cummings, Director of the National Library of Medicine, has made a telling point in stating that the 1980 NLM personnel ceiling has 68 fewer positions than it had in 1968. It is inconceivable that in the face of a 110% increase in the last ten years in the volume of the literature, the NLM staff available to manage this information has been reduced by 14% during this same period.

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Further evidence of the increasing need to control and retrieve information is the data recently released by the National Science Board, as pointed out by Mr. Oppenheimer. 48% of all scientific and technical articles published by U.S. scientists in 1977 were in the fields of biomedicine and clinical medicine--72% if the fields of biology, chemistry, and psychology are added. The depth of the problem with which the NLM and health libraries must contend is all too apparent.

If you have any questions whatsoever, I will be more than pleased to answer them.

Sincerely,

Samuel Hitt

Samuel Hitt
President

LETTER FROM NINA W. MATHESON, DIRECTOR, GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER

February 7, 1980

The Honorable Thomas F. Eagleton
Senate Office Bldg, Rm 1209
Washington, DC 20510

Dear Senator Eagleton:

I am very pleased to have been invited to provide some information relevant to the NIH Appropriations Hearings, with particular regard to the budget of the National Library of Medicine. While a resident in St. Louis from 1962-1970, I supported your work, and since coming to Washington have followed your career with admiration. I know you are knowledgeable about libraries and have been a longtime defender and supporter of our aims and purposes, which are to make the scholarly record available and useful in advancing the public welfare.

I speak personnaly as a director of a medium sized health science library in a private school. The sector I represent is an increasingly beleagered one. I also wish to speak as a Board Member of the Association of Academic Health Sciences Library Directors. Our concerns are specifically to enhance the advancement of science and medicine through increased access to the scholarly literature. Finally, I speak from my experience on the NIH Biomedical Library Review Committee which has afforded me additional insight into the needs expressed by the health care community.

I would like to forward an expanded commentary at a later date. Here I wish to highlight a few crucial points: 1) Fiscal problems for libraries nationally; 2) the impact of NLM budget strictures and manpower losses on libraries nationally; 3) recommendations and needs.

Fiscal problems for libraries nationally:

Libraries are loosing the battle against inflation. The enclosed study by H.S. White gives data up to 1975. From 1975 to 1978 average budgets for book and journal expenditures rose 35%, but the increase in journal subscriptions have steadily declined. Libraries are having to spend more for fewer and fewer journals and books. See enclosed Table 1.

Service demands have increased dramatically. In my library alone, inter-library loans have increased 79% in this period; on-line database searches have increased by 53%.

To deal with the combination of inflation and increased service demands with minimal staff growth, (nationally, staff numbers increased by 10%) libraries are banding into consortia and networks. While this is useful resource sharing, the penalty to be paid may be high: There is loss of timeliness of information delivery and increased manpower costs to manage acquisition and use of a shared pool. Without technological methods of linking libraries together in an on-line mode this is at best only a temporary staunching of the wound.

The need for computer controls of health science library collections is stymied by lack of software development and scarcity of trained personnel to handle computers in medical libraries.

The nation's health science libraries are inextricably linked to the NLM, to what it can & can not do, what it does & does not do. Whatever weakens the NLM has serious implications for the entire medical library system.

The Impact of NLM program development on health sciences libraries nationally:

Technology transfer: It is critically important to computerize labor-intensive manual processes in libraries. The Senate has honored one of its senior colleagues with a fitting memorial - the Lister Hill Center for Biomedical Communications. It would be a hollow thing, however, if the building were to stand but approprate manpower and program funding denied. The Lister-Hill programs of research and development promise rapid improvement in the cost/productivity ratio of libraries through such efforts as the mini-computer based INTEGRATED LIBRARY SYSTEM, which will allow low cost bibliographic controls for larger hospital libraries and medium sized academic libraries such as mine. Highly trained manpower in concentration is needed over the next year to capitalize on current work.

The need for this system is urgent, but it is only one of several similar efforts. For example, development of knowledge/fact data bases is of great importance in taking clinical information to the patient's bedside for use by the medical team. This is pioneering work of international significance which could radically alter the information delivery flow processes in patient care. Another example is the MEDLARS III project which has the potential to tie all health science library collections together on-line. The Computers in Medicine program supported by the Medical Library Assistance Act, (MLAA) is dealing with the critical national problem of training a new breed of computer/clinicians in academic medical centers. Highly successful so far, (one program is at the University of Missouri-Columbia under the brilliant and highly effective leadership of Dr. Donald Lindberg) it needs to include other types of personnel. Librarians must be trained to work with the health systems teams to integrate these new methodologies into the total information flow.

Resources maintenance and management:

The NLM is a back-up resource to the nation's health sciences libraries. All medical school libraries are struggling with diminishing resources, but the NLM collection should be the last to suffer deprivations. A library-of-last-resort must collect in depth. It is distressing to note a 1975 study which found that 23% of the requests located in the Midwest Medical Union Catalog were not owned by the NLM.3
Table 2 shows that average health science library budgets, (measured in thousands) increased by 34-35% between 1975 and 1978.5 The number of the subscriptions dropped by 3%, and costs went up 49%.2,4,5
In this same period NLM's budget, (measured in millions) rose only 30%, (the NIH R&D budget rose 40%)! While the 5% difference between average medical school libraries & NLM may seem small, the latter is measured in millions not thousands so that the total amount is of enormous significance to the national information resource base. Although collecting is critical, materials are entirely useless unless they are known to the medical library community at large through cataloging access tools such as CATLINE. Cataloging backlogs at the NLM now equal one full year's acquisitions - an alarming number. This demonstrates one of the severe manpower needs at the NLM.

Extramural Programs:

It is now unthinkable that health workers be unable to access the medical literature through on-line bibliographic data base searches. Yet only 1200 of the 5000+ health libraries in this country have such access, and recently the NLM placed a moratorium on additional users because of limited computer capacity. These 1200 libraries generated over 1.4 million searches in 1979 at an annual growth rate of 16%. We know that such searches generate information requests and thus make greater demands on individual libraries for more resources. A 1973 survey revealed only 2893 health libraries could meet at least 2 of these three criteria: 500 bound volumes, 25 current subscriptions and some personnel. Yet there are more than 5,000 health care facilities. There is an urgent need to help develop minimal collections in nearly 3,000 such facilities. The MLAA program has supported more than 600 collections through small seeding grants, but at least another $1 million is needed to bring minimum health information into hospital libraries for the health care teams to support quality care and developing licensure requirements.

Continued dependence upon the NLM's collection for primary materials dilutes the effectiveness of the NLM's limited manpower resources. There is an accumulating body of evidence that suggests all libraries will need assistance in the near future if we are to avoid the state of affairs revealed in 1965 when Sputnik awakened American scientists to the inadequacy of their information resources. We know that the US continues to hold scientific and technological leadership internationally, but the distance between us and competing countries is rapidly diminishing. Access to the world's research literature is crucial to maintaining our leadership. But the fact is that while the rate of scientific publication accelerates, the number of articles indexed in the MEDLINE database is not increasing but actually has decreased since 1976. NLM annual reports show 266,765 items were indexed in 1976 as compared to 230,427 items in 1979.

I do not mean to overstate the case, but we should all be deeply concerned that the NLM as the most significant health sciences library in the world receive no less than it needs in human and fiscal resources to carry out its mission and responsibilities to science. There is a momentum now in computer technology in the health sciences that should not be stayed. There is an opportunity with the Lister Hill Center for Biomedical Communications to provide a critical surge of intellectual energy that will help carry health information management systems into a new decade.

Some recommendations:

1. Restore budgeted position levels to a 1979 comparable level, plus 10%.
2. Increase the total NLM budget to a meaningful ratio (4%) of the NIH Research and Development budget, and to a percentage that compensates for the unequal budget increases over the past 5 years (+20%).
3. Provide additional extramural program support for library resource development and research into better methods of disseminating health care information through our libraries ($3 million).
4. Provide funding for the computer-in-medicine program to include training of health science library personnel to work with health care computer teams ($1 million).
5. Provide funds to strengthen automation in health sciences libraries especially through network configurations ($2 million).

Please feel free to enter this letter into the hearing record and to call on me if I can provide further information.

Sincerely,

N. W. Matheson

Nina W. Matheson
Director

TABLE 1. ACADEMIC HEALTH SCIENCES LIBRARIES EXPENDITURES

A. Mean value expenditures (in thousands)	1974/75	1975/76	1976/77	1977/78	1978/79
1. Total expenditures	$ 473.	$ 524.	$ 553.	$637.	$ 710.
2. Book & Journal expenditures	$ 146.	$ 158.	$ 163.	$198.	$ 213.
3. Number of journal subscriptions	2186	2206	1944	2116	1964
B. Annual percentage change over previous year					
1. Total expenditures		+ 11 %	+ 5.6 %	+ 15 %	+ 11 %
2. Book & Journal expenditures		+ 8 %	+ 3 %	+ 21.4 %	+ 7.5 %
3. Number of journal subscriptions		+ 9 %	- 12 %	+ 8.8 %	- 7.2 %
C. Annual percentage increases in medical journal prices	+ 19.5%	+ 12 %	+ 8 %	+ 11 %	+ 11 %

TABLE 2. A COMPARISON OF LIBRARY BUDGETS AND COSTS

U.S. Medical School Libraries	1975	1978	Percentage Change
Average Annual Total Expenditures (in thousands)	$ 473.	$ 637.	+ 34.6 %
Average Book & Journal Expenditures (in thousands)	$ 146.	$ 198.	+ 35.6 %
Average Number of Journal Subscriptions	2186	2116	- 3 %
Average Cost per Journal	$ 42.38	$ 63.31	+ 49 %
Total National Support for Research & Development (in Millions)	$ 4,587	$ 6,161	+ 34.3 %
NIH Research & Development (in millions)	$ 1,846	$ 2,581	+ 39.8 %
National Library of Medicine Budget (in millions)	$ 28.8	$ 37.6	+ 30 %

Library Management in the Tight Budget Seventies

Problems, Challenges, and Opportunities*

By Herbert S. White, *Director*

Research Center for Library and Information Science
Professor, Graduate Library School
Indiana University
Bloomington, Indiana

ABSTRACT

This paper examines changes in the management of university, special, and medical libraries brought about by the budget curtailments that followed the more affluent funding period of the mid-1960s. Based on a study conducted for the National Science Foundation by the Indiana University Graduate Library School, this paper deals with misconceptions that have arisen in the relationship between publishers and librarians, and differentiates between the priority perceptions of academic and of special librarians in the allocation of progressively scarcer resources. It concludes that libraries must make strong efforts to reduce the growing erosion of materials acquisitions budgets because of growing labor costs as a percentage of all library expenditures; that they must make a working reality of the resource-sharing mechanisms established through consortia and networks; and that they must use advanced evaluative techniques in the determination of which services and programs to implement, expand, and retain, and which to curtail and abandon.

It was Francis Bacon who said, "He knows not his own strength that hath not met adversity." Much earlier, Seneca stated, "Fire is the test of gold, adversity of strong men." Do these sages from the past really provide present-day library managers with any consolation in their present predicaments? Or are we perhaps more inclined to agree with Sholom Alcichem's Tevya, in *Fiddler on the Roof*, that "Poverty may not be a sin, but it's no great honor, either"?

There can remain no doubt that the cuts in budgets of these 1970s, coupled with rapidly rising inflationary costs for both library materials and salaries, and finally the incessant pressures for more and more diverse services, have forced library managers into the kinds of relative evaluations and justifications for which many may have been ill prepared and ill suited. Much has been said and written about the fact that individuals choosing the profession of librarianship are rarely guided by the motivations and value systems that tend to make successful profit center managers. To be now confronted, after years of dedication to scholarship and knowledge as self-evident goods best served through thorough collection building, with the need to develop program budgets, performance budgets, and objectives through participative management techniques through which cost-effective selection of alternatives may now be made, must seem to many librarians to be a dirty trick.

*Presented June 15, 1976, at the Seventy-fifth Annual Meeting of the Medical Library Association, Minneapolis, Minnesota.

Library Budget Changes Since the 1960s

This is not to suggest that the librarians of the 1960s had unlimited resources at their disposal. Far from it. Even during what we now know in retrospect to have been the lush days of the Johnson administration library programs (although then we didn't know they were lush days), library managers complained of insufficient funds and of impoverishment. But it was a poverty of not being able to buy all of the additional materials they wanted to buy, of not being able to start all of the new programs they felt needed starting, of not being able to open all of the new branches and bookmobile services that they felt needed developing. It was not, as it tends to be now, decisions of which materials to retain and which to cancel, which programs to maintain and which to curtail or abandon, of which branches to keep open and which to close. Those are management decisions in a far grimmer environment.

I have just finished teaching a course in personnel management for libraries and information centers at the Indiana University Graduate Library School, and I find case studies, written between five and ten years ago, that stress the need of the library administrator to keep his

professional staff content, because librarians are in short supply, and if they leave he may not be able to replace them. This is a sort of gallows humor for today's library school students, who find themselves competing with 80 to 100 of their compatriots for the same junior professional position.

Along the same lines, in teaching a course in literature of science and technology, I decided last fall to go beyond the traditional approach of covering selection tools and selection criteria, and emphasized also selection alternatives and criteria for collection reduction. When the publication *The De-Acquisitions Librarian* first came out, some of us may have thought it a rather humorous and catchy title. It is humorous no longer. De-acquisition, the determination of what to remove without doing violent damage to the ability to perform library services is, for many collections, more important than the traditionally prized ability to locate sources for obscure scholarly acquisitions.

NSF Study by Indiana University Library School

To an even greater and perhaps more dramatic extent, the financial dilemma confronting American libraries, including medical libraries, since the lavish days of the mid-sixties was brought into focus by a study just completed by the Indiana University Graduate Library School Research Center for the National Science Foundation [1]. This study examined the economics and interaction of the publisher-library relationship in the production and use of scholarly and research journals. There has been considerable concern about the health of the overall economic model. With publisher production costs rising, in large part because of inflationary cost increases in labor, paper, and postage; with sources of other potential income through subsidies, page charges, and advertising remaining a relatively insignificant percentage, publishers are forced to turn to subscription income for what, with many publisher groups, amounts to almost 90% of their revenue. To complicate the problem even further, publishers of scholarly and research publications have learned that, whatever the financial constraints of their *library* customers, the financial pressures on *individual* subscribers have been even greater, and increases in cancellation rates because of price increases for personal subscriptions have far outweighed the reaction even in financially pressed libraries.

With only an increase in foreign customers to help offset this gloomy economic news, publishers have turned increasingly and repeatedly to their library customers for the dollars needed to offset both their rising costs and their declining individual subscriber bases. Libraries, of course, beset in this decade by budgets which have certainly not risen in keeping with cost increases, and which in many cases have not risen at all, or have even decreased, have been able to provide little solace to the publishers in their economic troubles. The resulting frustration, further fueled by the copyright controversy, has led to a series of wildly exaggerated charges through which publishers are characterized as rapacious robber-barons making wildly exorbitant profits at the expense of libraries. Librarians, in their turn, are characterized as Machiavellian schemers who spin webs of cooperative purchases, boycotts, and unlimited orgies of photocopying, all designed to drive the publisher to the poorhouse.

Let me state quickly that neither description holds. In fact, if there is one characteristic that publishers and librarians tend to share it is their inability to cope with this increasingly strangulatory financial vise. The problem may, in fact, be insoluble without substantial and continuous subsidy, a solution not wildly embraced by the government sponsors of our study. At the same time, it is only judicious to recognize that this economic model has at least some of the symptoms of the death spiral that grips the public transportation sector—as fewer people ride public transit, revenues decrease, fares are increased, fewer people ride, revenues decrease, fares are increased, fewer people ride, and so on, ad infinitum.

Librarian and Publisher: Misconceptions

There are a number of misconceptions which this study may serve to correct, and I would like to address these for a moment before moving on to the financial implications for libraries, and for medical libraries in particular.

1. It is simply not true that increasing periodical prices result from inflated profits of publishers. Our study divided publishers into four groupings—the for-profit sector, professional societies, university presses, and the remaining, generally small and miscellaneous, nonprofit sector.

Only one of these groups, commercial publishers, as might be expected, reports any kind of operating surplus. I say "as might be expected" not only because return on investment is clearly

one of the prime motivators impelling a commercial organization to invest its own capital in the publication of journals. Profitability of the commercial sector can also be expected because this group of publishers, unlike any others, operates under a self-purging mechanism under which financially unsuccessful publishers disappear and only those that in fact do operate profitably remain. Commercial publishers report operating profits that grew from 11% in 1969 to 14% in 1973. While some reviewers and critics have pointed to this figure as an indication of profiteering, such comments show an ignorance of business accounting practices. Gross or operating profit is further reduced by a number of factors before distributions can be made to owners and stockholders. These factors include funds for capital expansion, risk investment for start-up costs, and interest payments on outstanding loans. These calculations result in a net profit before taxes, to which a combination of federal, state, and local taxes usually well exceeding 50% are applied. The remaining net profit after taxes, perhaps 5% or 6%, can hardly be considered an attractive return on investment, a conclusion which is also reflected in the low esteem in which publishing stocks are held on the various stock exchanges. This return rate must be compared with the fact that anyone with money to invest can get a 10% or better return from absolutely gilt-edged or government securities, and without any risk or work. The one factor that must be watched, and that should be examined closely in follow-on studies, is the profit trend within the publishing industry. The 14% operating profit in 1973 is not disturbing, but the fact that this represents a 27% rise over a four-year period warrants attention, to see if it indicates any sort of ongoing or continuing trend.

2. It has been charged that much of the financial pressure for libraries has been brought about by continued rapid and uncontrolled growth of the published literature. In fact, there have been suggestions that boycotts be imposed on new publications, to force a halt to this proliferation [2]. There has historically been a lack of firm data on this question, and estimates have ranged from zero growth [3] to an annual growth rate of 8% [4], which would result in a doubling every nine years. While our survey cannot be considered definitive, either, it indicates an annual birth rate of about 4%, offset by a death rate of 2%, for a net growth of 2%. If this is accurate, then literature proliferation cannot be held to be the cause for budgetary pressures. A 2% net growth rate compares favorably in this context with the rate of growth of research and researchers and the number of academicians in general. It is rather more likely that this growth rate, when added to other economic pressures, aids in creating the economic imbalance that both libraries and publishers are feeling so acutely. There will be further comments on this later, but for the moment let me address the third and last of the major misconceptions that the NSF study has identified.

3. There is no indication from our survey data that the growth of interlibrary loan and of photocopying has adversely affected the total budget that libraries expend on periodicals. This is not to say that the sharp increase in interlibrary lending, and the upsurge in copying (we were never able to obtain a satisfactory differentiation between the two but I doubt that it really matters—the lender's decision on whether to supply the original or a copy depends largely on his own copying equipment, delivery service, or packaging operations—and the borrower still can and frequently does make a copy before returning original material) have not occurred—libraries in all categories reported sharp increases in both borrowing and lending. Nor is it to suggest that individual journals and individual publishers have not been adversely affected by a library's decision to forego a subscription and depend on interlibrary loan, perhaps through network or consortium services. Undoubtedly this has occurred, although we have no measurement of specific impact on specific publishers. What our study does indicate, however, is a heavy shift of funds from the book to the periodical budget to try to protect the ongoing adequacy of the periodical collection, so that there is no evidence that any restriction on interlibrary borrowing would add to the total sum spent on periodical subscriptions. Such restrictions would most certainly force further evaluations and curtailments, from which some publications and some publishers would undoubtedly gain and others suffer. The question of how these decisions are made will be discussed later. However, with regard to the total dollar amount now being spent for the purchase of scholarly and research periodicals, there is no evidence that the imposition of restrictions on loan or copying, or even the imposition of copying royalty charges that cannot be passed along as a cost allocation outside the library budget, would increase the total amount of

money distributed to the publishers of scholarly and research journals. It would only affect its distribution.

I've talked at some length about overall perceptions of the study, and it is time I related this to the main thrust of my topic—the management of libraries, particularly medical libraries, under the tight budget constraints of the 1970s.

It was important to find out what sort of problems libraries faced in the allocation of their resources, and how they attacked these problems. We also anticipated differences between types of libraries, and therefore broke our library responses into academic, public, and special libraries, with each group further subdivided by size. Medical and hospital libraries, even those on academic campuses, were classified as special libraries if their funds came from separate allocations rather than from the general university library budget as a whole, and virtually all medical libraries fell into this category. While no attempt was made to segregate the specific responses of medical libraries from those of other special libraries, there is also no indication that these responses differed markedly. Thirty-eight percent of the special library responses came from libraries classified as medical, hospital, medical school, or other health science libraries, so that the interests of the Medical Library Association were strongly represented in the survey.

Price Increases of Periodicals

An immediate indication of the problem in terms of funding adequacy can be seen in the price increases for periodicals reported by American publishers and by the libraries responding to the survey. The price increases reported during the four-year period 1969 to 1973 by American publishers averaged 42.5%, for an annual rate of increase of 9.3%. The rate for commercial publishers was slightly higher, an annual 9.85%, with society publishers at 9.4% and university presses at 8.65%, and only the small and scattered other nonprofit sector was significantly lower at 7.5%. However, sharper differentiations arise between subject disciplines, with humanities publishers increasing their prices at the lowest annual rate, 7.9%. This is of little consolation to medical libraries, since the pure sciences happened to increase at the greatest rate, an annual 10.5%, while prices of applied science and technology journals grew at 8.5%.

These reported price increases do not agree with price increases reported by libraries, which consistently report higher figures. The difference can be postulated to come from two primary sources: (1) the greater impact of price increases for journals published outside the United States, since these journals bore the brunt during 1969 to 1973 both of even greater inflation rates in the country of publication and of deterioration of the U.S. dollar in relation to most major world currencies; (2) the second potential source of differentiation comes from the impact of subscription agency service charges. While this must be a topic for further study, it is known that these service charges generally increased during the period, both because of the need to meet higher operating costs by the subscription agents themselves, and because publishers substantially decreased the discount offered to subscription agents, a decrease that became a de facto price increase for the ultimate customer.

Large academic libraries and special libraries report the largest price increases (as well as the largest average prices). The median price of the academic library subscription increased at an annual rate of 11.25%. For special libraries the rate was even higher, 12.4%. If this 12.4% is combined with the 2% net growth reported earlier, it appears that an annual budget increase of 14.5% would have been required in the medical libraries represented in the special library response sample just to stay even, in terms of equivalent coverage of the literature.

These figures are compared to budget reports for the period 1969 to 1973. In 1974 things got a lot worse, in terms of both the budget increases (or lack of them) for American libraries, and of a much higher rate of inflation, which in turn served to increase publisher labor and materials costs, postage rates, and interest rates on money they owed to banks and other lending institutions. The dollar did not do well on international monetary exchanges in 1974, either.

Budget Growth and Allocation

Regardless of how much worse our later studies will show the situation to be, things were already bad enough during 1969 to 1973. No library budget grew by anything approaching 14.5%. The annual rate of budget increase for academic libraries ranged from 5% to 8.5%, with larger academic libraries faring better than smaller ones. A similar pattern appeared for special libraries, although all of them fared better overall. Small

special libraries increased their budgets at an annual 10%, large special libraries at rates up to 13%. This is perhaps a better rate than might have been anticipated, although, as stressed earlier, the period 1969 to 1973 was still much better than what followed. In any case, however, the rate of budget increase was insufficient to keep pace with price increases, even if the objective was only to maintain the same relative position in terms of the completeness of the collection.

All the above statements assume a direct one-to-one relationship between library budgets and periodical subscription budgets. Such an assumption is, of course, both simplistic and incorrect.

Library Budgets

The greatest source of library costs, in any type of library, is salaries. This cost factor exceeds all other costs combined in every type of library, with ranges from 59% of the total budget in academic libraries, to 60% in large and 65% in small special libraries, and finally to 68% in public library systems. In determining the increase in salary expenditures between 1969 and 1973, the survey did not differentiate between raises for existing staff members and changes in the number of library employees. Such information, while critical for salary surveys, was really not significant in terms of our own endeavor.

The survey for 1969–73 indicated that salary budgets for academic libraries increased at a more rapid rate than the budget itself, and this in turn forced academic libraries to divert funds from the already beleaguered materials budget to pay salaries. Special libraries, at least for the period 1969–73, did not face this additional problem. Salary budgets (these are salary budget increase percentages, not individual salary increases) increased by 8.5% for small and 12% for large special libraries, so that most special libraries were spared at least part of the budget crunch that academic libraries experienced.

Budget Crunch: Strategies

However, both academic and special libraries felt some degree of pressure, and the alternatives chosen in responding to this pressure indicate sufficiently significant differences in style and priorities to be worth noting.

It would be nice to be able to say that, in response to financial pressures, librarians throughout the United States responded with imaginative and innovative improvements and efficiencies, resulting in a maintenance of acceptable levels of service even at reduced funding levels. It would be nice to be able to say it, but unfortunately we can't, any more than we can state that publishers, also caught in an economic vise, thought of significant alternatives to simply raising prices. Librarians report, in the period 1969 to 1973, some steps toward a consolidation and sharing of technical processing, particularly through shared cataloging services, but while these are claimed as benefits, the financial implications are unclear. Similarly, while many libraries agreed that benefits could be obtained from cooperative acquisitions and collection sharing, there is little tangible evidence as to how much these commitments actually affected specific selection and purchasing decisions. Perhaps the greatest evidence of the lack of clarity in this area comes from the frequent singling out of automation as the area affording a large potential benefit in improved efficiency and reduced costs. Unfortunately, analysis discloses that some of the respondents claim budgetary benefits from automation, while others base their cost reduction on the elimination of automation.

Confronted with the need to reevaluate priorities, academic and special librarians reacted differently. Some of these differences are described in the following section.

Academic Library Strategies

The academic librarian's approach to the problem of insufficient funds for periodicals acquisitions has largely consisted of the following:

1. Transferring funds from the book to the periodicals budget. During the period of the survey, this transfer can be termed as massive. In only four years large academic libraries moved from spending $2.00 on books for every dollar spent on serials in 1969, to a drop to $1.16 spent on books for every dollar spent on serials in 1973. I suspect that, by now, the lines have crossed, and that these academic libraries are in fact spending more for serials than for books. It is not likely that this sort of fund transfer can be shown to have been maintained, and by the last few years academic libraries were probably in fact slashing at their periodicals budget expenditures. In 1973, however, they were still doing everything possible to maintain the periodicals budget as a prime priority, and it is this knowledge which caused us to conclude that the prevalence of photocopying could really have little impact on the overall amount of money spent on periodicals.

2. Academic libraries have tended to forego adding new subscriptions instead of making room for these by cancelling existing ones. In 1969, academic libraries were cancelling existing subscriptions at a trivial rate of 0.2% of their periodical collection, indicating that titles once placed tended to be renewed automatically without evaluation. By 1973, the cancellation rate had in fact tripled, but even the 0.7% rate of cancellation indicates little in the way of evaluation or analysis. By contrast, the impact on the ordering of new titles was far more severe. In 1969 the percentage of new titles as related to the collection as a whole was 9.4%; by 1973 this had dropped to 5.1%. Comparing cancellation rate and new subscription rate changes in a perhaps more meaningful way, the data indicate that these large academic libraries, confronted by the choice of cancelling an existing subscription or foregoing a new one, chose to forego a new subscription forty-three times for every five times they decided to cancel an existing one, a ratio of better than eight to one.

3. The price of the subscription in question was not a particularly significant factor in a retention/cancellation decision. The mean price of cancelled titles exceeded that of retained titles, in large academic libraries, by 13.6%, a noteworthy but certainly not dominant distinction. Publishers who insist that quality journals tend to survive in libraries, at least in academic libraries, whether or not they have increased their price, may be correct. In fact, it can be surmised that periodicals that have not increased in price at all may end up being cancelled to provide funds for the price increase of publications considered more worthy of retention.

Special and Medical Library Strategies

Special libraries, including medical libraries, show some significant differences.

1. They are already far more oriented to the purchase of serials as large percentages of their overall materials budgets. In 1969 large special and medical libraries spent $2.40 on serials for each dollar spent on books, and for small libraries the figure of $1.95 is still a ratio much larger (by a factor of four) than that reported for academic libraries in the same period. While serials expenditures rose between 1969 and 1973 as they did in academic libraries, special libraries were far more successful in attempts to keep this activity from unbalancing their acquisitions budget. They were able to do this in part by the ability, reported earlier, to secure larger budget increases, and by the fact that they were able to keep labor costs from taking an increasing slice of their overall budgets. As a result, these libraries, while they did increase their periodicals expenditures, were able to do this without the drastic book budget amputations experienced by academic libraries.

2. In contrast to academic libraries, special and medical libraries were able to maintain, and in some cases to increase, their placement of new titles as a percentage of the collection, and by 1973 were doing so at a greater rate than large academic libraries. This was accomplished in large part because cancellation rates ran at between two and three times the academic library rate, despite the fact that special libraries were not as sharply affected by budgetary constraints. Evaluation is obviously more severe and ongoing.

3. Special and medical libraries were as prone to cancel duplicates in preference to sole remaining copies as were academic libraries, causing at least some puzzlement as to whether or not anyone pays much attention to Bradford's Law [5]. Of course, these libraries, which usually serve smaller and geographically closer communities, may be able to exercise better control over the one remaining heavily-used copy. Special libraries were even more prone to cancel foreign language titles in preference to domestic ones, and were more sensitive to price as a factor in cancellation decisions. In the pure sciences, for which virtually no difference in the price of retained and cancelled titles appeared in academic libraries, a sharp difference emerged in special libraries, with cancelled pure science journals that were 68.5% more expensive than retained ones in large libraries, 123.6% in small ones.

For applied science and technology no such tendency to cancel based on price appears for large libraries, but for small libraries the price of cancelled titles was 35.6% higher than that of retained titles. As with academic libraries, there is no particular indication that, at least through 1973, availability from another library was an important factor in retention or cancellation decisions. All kinds of libraries were still buying or keeping the things they thought they ought to have, and then worrying about obtaining the things they didn't have.

Conclusions and Recommendations

What general conclusions are possible from the mass of data only superficially reported in this

paper? Most obviously, there is great need to update the acquired information for the years 1974, 1975, and beyond. There is clear evidence that the problems that emerged during the years covered by the study have worsened, and worsened at an accelerated rate. For this reason, library preferences and actions in coping with this problem take on even greater significance, and it is hoped that some of the things that now appear to be clearly necessary are already being done.

1. In the face of level or even decreasing budgets, libraries must take action to reduce the budgetary impact of labor costs. I have already reported on the large chunk of the budget dollar spent on salaries. As budget dollars shrink or fail to rise, increasing labor costs, frequently mandated by organization-wide increases or union negotiations, will take an even larger and constantly growing percentage of the library's budget, and will ultimately create an instability so great as to warrant precipitous management action. The problem is not that librarians are paid too much. Nor do I think a case can be made for decreasing public services in reference, bibliography, or user assistance in computer-assisted searches. The economy must come, I think, in the technical processing area, through fuller utilization of centralized and cooperative processing systems which will, in turn, allow the library to do more with the same processing staff or to do the same with fewer people.

2. Within the constraints of copyright legislation now being written, libraries must make regional resource sharing a fact and not just an applauded ideal. To do this, we must break away from the entrapment of collection building as its own value system, and away from the pride of ownership under which we measure our own collection against perceived standards and then against some other collection to see who comes out ahead. Regional access requires more than the formation of a consortium and a committee that meets semiannually. It requires discipline in the acceptance of group decisions concerning prime areas of responsibility. It requires major improvements in bibliographic access (both computer and printed) and major improvements in document delivery systems, so that the difference between obtaining for a user something that is physically in your library or something that is in another library in your region becomes a matter of hours and not of weeks. We must take the favor out of interlibrary loan transactions, under which they remain the task of lowest priority, by making it worthwhile, and perhaps even advantageous, for resource centers to lend. When libraries compete for the privilege of lending, service will improve.

3. Finally, we must take increasingly hard looks at the tasks we perform, the services we provide, the materials we acquire, the formats in which we acquire them, and the formats by which we discard or retain them in permanent or temporary form, using advanced techniques of measurement and cost-effectiveness evaluation. The 1976 presidential election, regardless of its outcome, will provide no escape from the reality that libraries will be able to physically own and control less and less of what they would like to have and of what they occasionally need. A large number of recently evolving use studies reassure us, as the early devotees of Bradford did, that a large collection, carefully winnowed, can become a much smaller collection without seriously affecting the quality of service. If we combine this concept with truly coordinated acquisitions programs, and if our coordinated access consists of more than sharing published lists of journal holdings and honoring one another's borrower's cards, even much of this risk can be safely avoided.

The tight budgets that libraries are now experiencing, and that they can expect to live with for much of the foreseeable future, certainly create pressures and cause problems and difficulties. However, they also create opportunities in providing an environment that requires strong management, intense critical examination, coordination, and cooperation—all of them things very much necessary and perhaps long overdue—and all the other kinds of things we are not very likely to do until we have to.

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SUBCOMMITTEE RECESS

Senator HOLLINGS. This concludes the public witness testimony for today. The subcommittee will stand in recess until 10 a.m. Tuesday morning.

[Whereupon, at 3:49 p.m., Monday, March 10, the subcommittee was recessed, to reconvene at 10 a.m., Tuesday, March 11.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1981

TUESDAY, MARCH 11, 1980

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

The subcommittee met at 10:10 a.m. in room S–128, the Capitol, Hon. Quentin N. Burdick presiding.

PUBLIC WITNESSES

NATIONAL INSTITUTES OF HEALTH AND RELATED AGENCIES

STATEMENTS OF:

JACK MILLAR, PRESIDENT AND CHAIRMAN OF THE BOARD, GORGAS MEMORIAL INSTITUTE OF TROPICAL AND PREVENTIVE MEDICINE, INC.

DR. PEYTON WEARY, AMERICAL ACADEMY OF DERMATOLOGY

DR. ALVIN TARLOV, ASSOCIATION OF PROFESSORS OF MEDICINE, AMERICAN FEDERATION FOR CLINICAL RESEARCH

MR. CHRISTOPHER SCHATTE, FEDERATION OF AMERICAN SOCIETIES FOR EXPERIMENTAL BIOLOGY AND AMERICAN PHYSIOLOGICAL SOCIETY

GORGAS MEMORIAL INSTITUTE BUDGET REQUEST

Senator BURDICK. The subcommittee will come to order. There are just two groups this morning. Each group has been allotted 15 minutes. Please watch the time. Introduce yourselves. All statements will be made a part of the record as if read.

Dr. MILLAR. Thank you, Mr. Chairman. The Gorgas Memorial Institute is requesting an increase of $100,000 for a total of $1.8 million to continue the work of the Gorgas Memorial Laboratory. This amount is well below Gorgas' authorized ceiling. Level funding was provided in fiscal years 1979 and 1980 and has been again recommended for fiscal year 1981. No level-cost-plus-inflation budget proposed for Federal programs is recommended for Gorgas. The $100,000 increase here requested would only partially restore our purchasing power in the face of everincreasing inflationary rates but it insures having a laboratory. It is from the base of facilities, maintenance, operating support, and the staff that the laboratory can then compete for grants and contracts for

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targeted research and it can perform its teaching and service mission. The Government of Panama for the first time has made a cash contribution, giving $5,000 for operation and maintenance of the Gorgas Memorial Laboratory. This amount may not sound like much, but considering it within the total Panamanian budget, it is as if the U.S. Congress would give $3 million to Gorgas. The laboratory with its nucleus of scientists had been able to increase grant and contract support from $400,000 to $800,000 in the past 3 years. We would appreciate very much to have our request acted on favorably. We thank you very much for your continued support and encouragement. Thank you sir. I would appreciate submitting my full presentation for the record.

Senator BURDICK. It will be received.

[The statement follows:]

STATEMENT OF DR. JACK MILLAR

Thank you, Mr. Chairman, for the opportunity to appear before this Subcommittee on behalf of the Gorgas Memorial Institute of Tropical and Preventive Medicine, (GMI) and the Gorgas Memorial Laboratory (GML).

I am here today to describe how we used the Congressional appropriation of $1,700,000 and to ask you for an increase of $100,000 to continue the work at the Gorgas Memorial Laboratory.

The Laboratory opened in Panama City in 1929 and has been the major tropical disease research, service and teaching institution in Central America for half a century. It has always received a Congressional appropriation for partial support of its programs. We are a part of a collaborative network that includes U. S. and foreign universities, international health organizations, national health ministries, and U. S. federal agencies.

The Gorgas Memorial Laboratory is also associated with Louisiana State University and the University of Texas in graduate student education. It has trained technicians and health officials from Panama, Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, Haiti, Dominican Republic, Colombia, and Mexico in laboratory techniques; medical students from Panama in epidemiology; and physicians from Gorgas Hospital in virology. It has a collaborative program in virology with the Walter Reed Army Institute of Research, which has now assigned an officer to the Laboratory to work in the program.

The Gorgas Laboratory physicians are consultants at the Santo Tomás, Children's, Social Security and Gorgas Hospitals; the Gorgas Laboratory scientists are advisors and consultants to the World Health and the Pan-American Health Organizations, the U. S. Armed Forces Epidemiology Board and the Ministry of Health of Panama.

The Institute and Laboratory are not restricted to Panama. This year we had scientists working in Honduras and Nicaragua. In each case, we were invited in by the national Ministry of Health and in each case we were able to be of significant help in solving their problem.

We are managed by a Board of Directors all of whom are distinguished members of universities, the U. S. Public Health Service and the military, international organizations, government agencies and the private sector, from both the United States and Panama. All are volunteers, many give freely and copiously of their time - and not one is paid anything at all. We work closely with the Director and staff of the Fogarty International Center; the latter make site visits every three years - the next one to be in May 1980. We are audited by the General Accounting Office and have always received a clean bill of fiscal integrity.

Does the Government of Panama care about and support the Laboratory? The answer is an unequivocal yes! They have provided the building and the land, now worth over half a million dollars; have provided relief from taxes and import restrictions and duties, special legal status for the U. S. and other foreign scientists, and permission for our physicians to work in their hospitals, and for our scientists to work throughout the Republic of Panama. This year, for the first time, the Government appropriated $5,000 as a line-item for general support of the Laboratory. That may not sound like much, but in comparison to their total budget, it is as if the Congress were to contribute $3 million.

The Laboratory has the major modern medical library in Panama City for physicians, scientists, and medical students. In fact, so useful is this library that the Government has provided support in order that it can be open nights and weekends. We do the sophisticated laboratory diagnosis for patients hospitalized at the Santo Tomás and Social Security Hospitals in Panama City and at the Gorgas Hospital in the Canal area. We have teaching and training programs for technicians and physicians from Central and South America, as well as from the United States.

I think it is worth mentioning that whatever the temperature of U. S. and Panamanian diplomatic relationships, or whatever demonstrations have occurred in Panama - not once has the Laboratory been molested nor has the government ever changed its friendly attitude.

General Gorgas is remembered for his preventive medicine work which made it possible to build the Panama Canal. We should not forget that he was also the Surgeon General of the Army in World War I. The Gorgas Memorial Laboratory, in totally open, unclassified medical studies, makes significant contributions to Department of Defense research, educational and training requirements.

For 20 years, the U. S. Navy has continuously assigned an officer to the Laboratory and since 1971 has contracted with us to run four 6-week courses for 24 Navy doctors a year. These courses give Navy physicians practical and clinical experience in tropical diseases which they may have to be responsible for in contingency circumstances. This year, the Uniformed Services University of the Health Sciences sent two senior medical students who took one course and had additional training in field experiences. The relationship with USUHS will continue and we are pleased to be a part of the military medical education of these future career military physicians.

The Gorgas Memorial Laboratory sits at one of the great crossroads of the world. It has not only the responsibility for disease surveillance and early warning, but also has a responsibility to be the consultant reference laboratory for the region. It is that for dengue fever, for yellow fever, for influenza, for hepatitis, for

leishmaniasis and for Venezuelan Equine Encephalitis. The Laboratory has the scientists, the protected specialized containment laboratories and the equipment to do this important job.

I have outlined our teaching, service and patient care programs. Let me very briefly highlight our research programs. Our complete Annual Report is due to the Congress on April 1st and, of course, contains the detailed information.

Malaria research, partly funded by the Army, is directed toward establishing human malaria in monkeys so that new Army anti-malarial drugs can be tested. Part of the problem is the world-wide shortage of monkeys for research and the increasing reluctance of many nations to permit increased export. The Laboratory has now established a human malaria in the Panamanian Aotus monkey; we can now support Army research on a most critical military medical problem. In collaboration with the Agency for International Development (AID) we are undertaking basic studies in the in vitro cultivation of malaria parasites.

This same monkey, the Aotus, also appears to be an excellent animal model for a very common parasitic disease of the tropics - leishmaniasis. This disease is transmitted by sandflies and can cause everything from a persistent skin ulcer to death. Our present drugs do not always work, nor do we know very much about the mechanisms of action of the parasite. It is worth noting that leishmaniasis is quite common in a belt that extends from Kenya through Egypt and the Middle East, up through Pakistan and Afghanistan into Southeastern Asiatic Russia.

In some programs we combine the search for new information with a surveillance program. In bacterial diseases, we have shown that diarrhea is not due to toxin-producing organisms common elsewhere; rather, viruses are the most common cause in Panama, among children and adults and in tourists. This is important information because it means that antibiotics - widely used elsewhere - are not the proper treatment. Our work was done in collaboration with the Johns Hopkins University. In cases of meningitis, we provide diagnostic studies to determine the type; this then guides decisions at the Ministry of Health about the use of vaccines.

Our yellow fever work monitors the spread of the disease, north from Colombia, by going deeply into the jungles and testing monkeys, who are the natural host for the disease. In this role, Gorgas is a distant early warning system for outbreaks of the disease, for mosquito and quarantine control, and for emergency immunization programs. I need not remind the members of this Committee that we had yellow fever in the United States until 1905, that we have the vector mosquito, and that air travel could bring in an early case, with a consequent outbreak in our own non-immune population. This program will be enhanced this year by a new colloborative effort with Yale University.

Not all our research is on tropical infectious diseases. Because we are in Panama, we can seize opportunities often not available elsewhere. There is a part of Panama in which the women have an abnormally high incidence of cervical cancer. With additional support from a National Cancer Institute grant, we are studying these patients and seeking answers about relationships to the environment, life style, and other infectious diseases. This new program has considerable potential for answering questions about a common cancer in American women.

Now: Let me talk about money. A detailed table is attached for the record (enclosure 1). I will discuss the highlights of our financial position.

In 1974 the Congress established a $2,000,000 ceiling for its contribution to the Gorgas Memorial Institute and Laboratory. The Congress appropriated $1,700,000 in Fiscal Year 1979 and again in Fiscal Year 1980; the same amount has been recommended for Fiscal Year 1981. This is level funding for three years. The Members of the Congress are acutely aware of the impact of inflation in recent years. For Fiscal Year 1981, $1,700,000 has a real value of $1,300,000 - or a $400,000 cut in funds. We have not been recommended to you for the "level cost plus inflation" budget proposed for other Fogarty programs. It is obvious that an increase of $100,000 will only partially restore our purchasing power. We face, for example, a 47% increase in utility costs which will add over $50,000 to our Fiscal Year 1981 costs.

What do you get for $1,800,000? These core funds make it possible to have a laboratory. A non-profit research or teaching institution cannot exist without enough stable funding to keep its doors open. It is from the base of facilities, maintenance, operating support and staff that a faculty and scientific staff can then compete for the grants and contracts for targeted research and can perform its teaching and service missions.

Because Congress has provided the essential floor for establishing and maintaining the Laboratory, we have been able to compete internationally for grants and contracts. We are proud that in the last four years we have gone from $400,000 a year in grants and contracts to a projected $800,000 in Fiscal Year 1980.

What are we doing to make every dollar count? We have increased our charges to some of our support and service work. We have restricted salary increases to the percent used by the U. S. Government. We have aggressively competed for contracts. For example, we have just secured an environmental impact study contract with IRHE, Panama's Institute of Hydraulic Resources and Electrification. The Annual Report will detail for you the work we have done for the Agency for International Development, the World Health Organization, the Pan-American Health Organization, and other

institutions whom we serve as a unique resource for our region. We have essentially stopped technician recruitment and will be reducing salary costs by attrition.

But unless inflation slows down, none of this will even keep at constant funding. We are going to have some increased support, like that we seek from you and which we will also be seeking from Panama, the international organizations and private donors. Or, we will have to stop certain programs.

We do not want to stop programs. The Gorgas Memorial Laboratory works because it is an integrated critical mass of people, skills and tools. Cancel programs and we lose irreplaceable people whose interdisciplinary capabilities are lost to the remaining research.

We in the United States do not suffer from the tropical diseases, although we did until just after World War II. We travel, trade and have fought in the tropics (and we could again). Air travel can reimport tropical disease to this country. But since World War II we have lost the cadre of trained tropical disease specialists; the Congress has properly provided funds to study and treat those diseases from which U. S. citizens now suffer.

In my view we cannot, as a nation, afford to become totally innocent in tropical medicine. One must now go to the tropical countries to study these diseases. The emerging nations often cannot afford modern research laboratories, even though it is their citizens who endure malaria, trypanosomiasis, leishmaniasis, onchocerciasis, schistosomiasis and a host of other diseases. There are few of the old colonial laboratories left. The Department of Defense has maintained seven overseas laboratories - but now the Office of Management and Budget wants to close them. If - unwisely - this is done, the Gorgas Memorial Laboratory will be one of the very, very few institutions left to maintain any national competence in the diseases of the tropics.

The Gorgas Memorial Laboratory, chartered by Congress in 1928, is the creature of Congress. I state boldly that we are important to international health and to a favorable view of our country abroad. I ask your continued support and encouragement.

GORGAS MEMORIAL INSTITUTE OF TROPICAL
AND PREVENTIVE MEDICINE, INCORPORATED

Support Fiscal Years 1975 - 1979

	FY 1975	FY 1976	FY 1977	FY 1978	FY 1979
U.S.Appropriation (thru Fogarty International Center)	$ 707,500	$1,360,000	$1,400,000	$1,400,000	$1,700,000
Other National Institutes of Health	929,085	174,803	228,119	248,417	333,301
HEW-Office of International Health	--	--	--	--	4,414
U.S.Army Medical R&D Command	223,368	203,512	111,728	130,219	145,208
U.S.Navy	34,994	33,756	25,000	25,000	30,000
Agency for International Development	120,027	5,481	--	--	8,064
Subtotal Federal Government Support	$2,014,974	$1,777,552	$1,764,847	$1,803,636	$2,220,987
Johns Hopkins University	$ --	--	--	--	55,014
Other U.S. organizations	7,340	4,346	2,738	--	3,240
Total U.S. Support	$2,022,314	$1,781,898	$1,767,585	$1,803,636	$2,279,241
Government of Panamá	$ --	$ 59,331	$ 17,180	$ 37,087	$ 968
WHO/PAHO	7,650	4,350	15,999	36,850	118,247
World Bank	--	--	--	6,836	--
The Wellcome Research Laboratories	--	--	--	45	1,000
Total Non-U.S. Support	$ 7,650	$ 63,681	$ 33,179	$ 80,818	$ 120,215
Total Support	$2,029,964	$1,845,579	$1,800,764	$1,884,454	$2,399,456

Dr. WEARY. In addition to being chairman of the department of dermatology, I am also chairman of the American Academy of Dermatology. I am submitting in testimony on behalf of the American Academy, which represents over 90 percent of the dermatologists practicing in the United States and on behalf of the society, research organization for scientists interested in skin disease research.

We are pleased to report that the analysis mandated by the Congress in 1976 has been completed and published as a special supplement to the Journal of Investigative Dermatology in November of 1979.

All members of this subcommittee have or will soon have in hand this report as well as a summary document which outlines the findings. The congressionally mandated report on research needs and priorities in dermatology emphasizes the following:

One, significant skin disease at some time afflicts one-third of our population at an annual cost estimated to exceed $2.65 billion.

Two, skilled skin research scientists are in serious short supply. The funding for skin disease research is not commensurate with the burden of illness nor adequate to take advantage of many significant opportunities in high priority areas to improve disease treatment through acquisition of new knowledge.

Three, skin disease research is broad in scope and is a shared responsibility of a number of institutes—among which are NIAMDD, NIAID, NIA, NCI, NIEHS, and NIOSH.

Our recommendations are the following:

One, we believe there should be restoration of the training support funds, deleted by the President. This is essential for the orderly conduct of all research particularly for skin disease research. Because of our acute research manpower shortage we request the Congress to specify that special emphasis be placed on increasing the support level for skin disease research training by a factor of 20 percent per year for 5 years.

Two, there is a need for better inter-institute coordination and unified planning for skin disease research. We request that the Congress appropriate funds for the NIH to create a skin disease coordinating committee with designated representatives from NIAMDD, NIAID, NIA, NCI, NIEHS, and NIOSH, and stipulate that the committee report back to the Congress within 1 year about the possibilities of creating additional intramural components for skin disease research within institutes other than the National Cancer Institute.

We feel these intramural programs will provide a very good opportunity for training additional skin disease research oriented scientists.

Three, there should be a 5-year phased increase in funding for skin disease research in each of the appropriate institutes of the NIH by a factor of 10 percent per year over, and above the amount necessary to maintain parity. For fiscal year 1981 we would propose a 25-percent increase in funding for skin disease research in each appropriate NIH Institute above current levels and we ask the Congress to specify such an increase.

Four, we believe the President's proposed fiscal year 1981 health research budget is inadequate and would result in a reduction in new initiatives and a major reduction in the priority score cutoffs for approved competitive grants for NIAMDD, NIAID, NIA, NCI, NIEHS, and NIOSH. We recommend the budgets proposed by the Coalition for Health Funding for these Institutes, to create stability and promote modest growth.

Thank you for the opportunity to present this testimony, Mr. Chairman.

PREPARED STATEMENT

Senator BURDICK. The statement of the American Academy of Dermatology and the Society for Investigative Dermatology regarding fiscal year 1981 appropriations will be inserted in the record at this point.

[The statement follows:]

STATEMENT OF THE AMERICAN ACADEMY OF DERMATOLOGY AND THE SOCIETY FOR INVESTIGATIVE DERMATOLOGY

We would direct your attention to the Journal of Investigative Dermatology of November of 1979, and in particular to our report on research needs and priorities in dermatology. Specific important observations are as follows:

One, significant skin disease afflicts one-third of our population at some time in their life.

Two, there are a number of high-priority areas for research in skin diseases which provide significant immediate opportunities to acquire new information which can improve the capacity to treat and prevent many common disabling skin diseases and reduce the burden of illness and the costs of illness which are currently thought to exceed $2.65 billion in the United States.

Three, to accomplish this it will be necessary to secure substantially increased support, not only for investigator-initiated research but of even more urgency, for training of competent young investigators, of which there is a serious shortage at the present time.

Four, the responsibility for research support and training lies not in any single institute but, because of the very scope of skin disease, encompasses the research interests of a number of institutes. It is for this reason that we have repeatedely testified for increased efforts by a number of institutes which we feel share in the responsibility to upgrade the neglected areas of skin disease research. As an example, we submitted testimony for the last 2 years on occupational skin disease and as a result we are pleased to report that NIOSH has responded in a most appropriate fashion to commit major funding to occupational skin disease research and training. We hope that this subcommittee will continue to support these new initiatives by providing the necessary additional funds to NIOSH to insure their ability to maintain this momentum.

Mr. Chairman, we are very much aware of the fact that, were investigator-initiated research funds for skin disease research to be doubled for fiscal year 1981, we could not utilize the money wisely or well nor would we want to make extravagant claims about our ability to quickly eradicate or ameliorate any of the disorders we have established in this report as high-priority items. We believe there is a high probability of developing substantial increments of improved knowledge and improved care through research in all of these areas with a sustained and phased incremental increase in support over a 5-year period, and it is on this premise that we submit the following requests and suggestions:

One, as noted above, it will be clear from the report that our greatest shortage at this time is of skilled research scientists motivated to working in the area of skin disease research. For this reason we were most disheartened to learn that the President's proposed budget for fiscal year 1981 has eliminated funds for new training positions. We would strongly urge the Congress to restore those funds because the development of talented individuals is the only effective method to insure an orderly growth of new information. We would furthermore request that, in restoring these

funds, the Congress specify that special emphasis be placed upon increasing the level of training support for individuals interested in skin disease research by a factor of 20 percent per year over a period of 5 years.

Two, because the scope of skin disease is so broad that it encompasses the research interests of at least six institutes, five within the NIH and NIOSH as well, there is a significant need to develop better inter-institute coordination and planning for a unified approach to the problems of skin disease. We believe the time is at hand to develop a mechanism to insure this coordination by creating a skin disease coordinating committee within the NIH with designated representatives from the following institutes: NIAMDD, NIAID, NCI, NIA, NIEHS, and NIOSH. We would ask the Congress to stipulate that funds be made available to the Director of the NIH to establish such a committee. We would also propose that one of the first items of business for this committee would be to examine the possibility of creating additional intramural skin disease research components within institutes other than the National Cancer Institute during the next 5 years. If this can be accomplished, it could provide a significant opportunity for onsite training of young investigators in skin disease research. We would suggest the coordinating committee submit its recommendations on this matter to the Congress within a year after its establishment.

Three, to provide appropriate stability in funding for skin disease research and an orderly growth in this relatively neglected area to a level where the research effort is commensurate with the burden of illness and the economic loss to society of skin disease in comparison with that in other disciplines, we would propose a 5-year phased increase in funding for skin disease research conducted in each of the appropriate Institutes of the National Institutes of Health by a factor of 10 percent per year over and above the amount necessary to maintain parity using the biomedical R. & D. deflator index to establish each year of level of parity. At the present rate of inflation we would estimate that for fiscal year 1981 this would mandate a 25-percent increase in funding for skin disease research in each Institute above the current levels and we would request the Congress to specify this level for fiscal year 1981.

Four, we believe the levels of funding proposed in the President's budget for the NIAMDD, NIAID, NIA, NCI, NIEHS, and NIOSH are woefully inadequate and would produce, not just a no-growth pattern, but actually a substantial reduction in new initiatives already underway and a major decrease in the priority score cutoffs for approved competitive grants. To create this degree of instability can only serve to undermine the morale of the scientific community, permanently displaced skilled scientists and retard the acquisition of new knowledge. We believe the budgets proposed by the coalition for health funding are far more appropriate to insure stability and modest growth, and we would urge your endorsement of these levels.

Thank you for the opportunity to present our recommendations.

AMERICAN PHYSIOLOGICAL SOCIETY

Senator BURDICK. Continue please.

Dr. SCHATTE. Mr. Chairman, the American Physiological Society represents over 5,000 M.D. and Ph. D. scientists doing basic and clinical biomedical research. We are dedicated to the implementation of a national biomedical research policy which provides for training of research scientists and long-term funding sufficient for those scientists to confront difficult and enduring research problems.

Our interests in the proposed fiscal year 1981 budget for the National Institutes of Health and our recommendations are:

One, we support the move to cap new grants at 5,000. We believe $139 million is probably reasonable given the various considerations the Congress has in setting the budget.

Two, new training starts should not be completely eliminated. We seek a $29 million increase over fiscal year 1980.

Three, biomedical research support funds should be increased beyond the level proposed by the President.

Four, intramural research will suffer, we believe, if the President's recommended level of funding is maintained. We believe this is a very important part of the program and should receive a funding increase of approximately $35 million for fiscal year 1980.

Senator BURDICK. Fiscal year 1980?

Dr. SCHATTE. Over fiscal year 1980. I am sorry.

PREPARED STATEMENT

Senator Burdick. Dr. Schatte, your prepared statement will be inserted in the record at this point.

[The statement follows:]

STATEMENT OF DR. CHRISTOPHER SCHATTE

Mr. Chairman, The American Physiological Society is composed of over 5000 M.D. and Ph.D. research scientists who engage in basic and clinical research at universities, in industry and in government. It sponsors annual scientific meetings and publishes several scholarly journals. Our members and activities are accordingly in the mainstream of biomedical research in the United States.

We are dedicated to the proposition that achievement of the Nation's health research goals requires a consistent, long-range plan backed by stable and sufficient financial support. The Federal commitment to this proposition necessitates a policy which 1) provides training of research scientists in appropriate numbers and specialties and 2) supports those trained scientists in a manner commensurate with the enduring task of solving difficult and complex research problems.

Our comment on the President's proposed budget for the National Institutes of Health in Fiscal Year 1981 concerns its effect on the implementation of that policy. Four items in the budget are of particular interest to us.

First, we support the move to stabilize new and competing extramural grants at about 5000 per year. This is a positive step toward imparting stability and predictability to the support of investigator-initiated research, an issue of the highest priority with the Society. Stability of support for extramural research implies yearly funding increases sufficient to at least offset the erosion of purchasing power due to inflation. Due in part to the varying number of proposals fundied in recent years, increases per individual project have generally not kept pace with inflation. By capping the number of funded proposals, each should get yearly increases which, at a minimum, should be sufficient to hold purchasing power nearly constant. The $139 million for extramural research proposed by the President currently appears to fall short of the probable rate of cost increases impacting biomedical research. We suggest that this figure is the absolute minimum increase necessary to maintain investigator-initiated research. The actual increase needed may be higher but we are not making a specific recommendation at this time.

Second, the President has proposed a cut in research training which would permit no new training starts in FY81 and which would erode funding for training programs already in progress. The complete cessation of new training starts is not consistent with a policy of supporting a stable, long-term research program. It seems particularly inappropriate in view of the present shortfall of trainees from that recommended by the National Research Council two years ago and at a time when there is legitimate concern over the dwindling number of physicians

pursuing research careers. We suggest that training, at a minimum, should at least be kept at current levels, with support adjusted for the impact of inflation. We recommend that at least $29 million be added to the President's proposed funding level for training in FY81.

Third, we are concerned about the relatively small increase in Biomedical Research Support funds proposed by the President. As a highly effective supplement to the extramural grants program, BRS money has been used for the purchase of equipment and to provide seed support for new ideas preparatory to entering the R01 mainstream of support. The acquisiton of more modern equipment is particularly germane in the face of the rapid aging and obsolescence of present equipment. And the cap on the number of proposals funded could well increase the number of investigators who will require seed money for the development of new research ideas. We suggest that the President's proposed increase for this category be raised to $4 million for 1981.

Last, but certainly not least, we fear that the quality of intramural research at NIH will suffer if the funding increase is held at the level proposed by the President. As the premier biomedical research center in the country, the resident scientists and the achievements are in the vanguard of our health research effort. No less so than the extramural program, support for intramural research at least hold the line at current levels, with funding adjusted for inflation. We recommend that the President's proposed increase for intramural research be raised to $35 million for 1981.

Mr. Chairman, the American Physiological Society is aware of the difficult decisions which will have to made to balance the budget in 1981. We believe our recommended increases in funding are reasonable in view of the importance of research to the Nation's health care system. If it becomes impossible to provide even these modest increases, we hope that available funds are allocated on the basis of the priorities we have listed.

We also wish to make clear the fact that our position is not limited solely to asking for increased funding. If fiscal realities legitimately preclude reasonable increases in funding for the NIH in 1981, we stand ready to provide specific recommendations as to how available funds might, under such dire circumstances, be distributed in the best interests of a sound biomedical research policy.

Thank you for this opportunity to present our views today. We will be happy to provide further information now or in the future.

ASSOCIATION OF PROFESSORS OF MEDICINE AND AMERICAN FEDERATION FOR CLINICAL RESEARCH

Dr. TARLOV. Mr. Chairman, I am speaking today on behalf of two groups—The Association of Professors of Medicine and the American Federation for Clinical Research. The APM represents the chairmen of departments of internal medicine in 124 U.S. medical schools. Our members have direct responsibility for the majority of the teaching and patient care provided by the medical schools, and for a major portion of the biomedical research funded by the National Institutes of Health. The AFCR is the largest clinical research organization in the United States and is comprised of more than 10,000 medical scientists interested in promoting and encouraging original clinical research by young investigators. The majority of AFCR's members are physicians working in schools of medicine throughout the country.

RESEARCH TRAINING

I will limit my remarks today to the aspect of the President's proposed 1981 budget for NIH which most critically concerns members of both APM and AFCR—that is, research training. In recent years, a sharp dropoff in the number of physicians entering careers in clinical research has been well documented. As the attached graph shows, the number of MD's in research training supported by NIH has fallen from about 4,000 to 1,790—a decline of over 50 percent. If this trend continues, there will be very serious implications for biomedical research and for American medicine in general, since the physician-investigator possesses the unique capabilities and perspectives that form the bridge between the research lab and the bedside.

I can assure you that as a practicing physician, dependent as I am on research developments, to cut off research training at the present time commits us to a clinical care capability in the 1980's and in the 1990's that is less than sufficient, or less than the potential of our system to provide.

The reasons for the decline in clinical research manpower are multiple and complex, but Federal funding for biomedical research and training is one very important factor. In our opinion, it is imperative that this committee carefully examine the NIH budget to insure that it does not inadvertently contribute to a continuing decline of young investigators being trained for careers in biomedical research.

Upon analysis of the President's 1981 budget proposal by mechanism of support, we were pleased to learn that the President's fiscal year 1981 budget for NIH includes funding for at least 5,000 investigator-initiated grants—a goal we have supported for some time. The administration's commitment to fund at least 5,000 competing research proposals is encouraging because it would add a desirable degree of stability to the funds available to young investigators. However, further analysis led us to the disturbing conclusion that the stability of investigator-initiated grants is apparently being attained at the expense of an equally crucial program, that is, the support of the research training and the development of young investigators.

To illustrate, in fiscal 1980, $176.4 million was appropriated for research training; for 1981 the President requested $163.5 million—a decrease of $12.9 million. This so-called savings was applied to other programs, especially to investigator-initiated research grants. Also, in 1981 NIH will increase trainee stipends by 13.4 percent with the first cost-of-living raise since 1974.

Therefore, because of the administration's commitment to investigator-initiated grants the increased stipend levels for current research trainees and inflation funding for research trainees has been sacrificed. To achieve stability, support for investigators and the training of new researchers must go hand in hand; the proposed budget provides stability in one area but negates this gain by cutting the numbers of research trainees.

It is very difficult to find a solution to this problem which is both responsible in the current fiscal climate and to the rational for the future of biomedical research. The National Research Council of the National Academy of Sciences, charged since 1974 by Congress with determining the national needs for researchers, has recommended that NIH should be training a total of at least 10,975 investigators each year, or approximately 3,660 new trainees in fiscal year 1981. The President's budget request of $163.5 million falls far short of that goal and actually will provide only enough for about 7,900 trainees—about 1,600 fewer than those presently in training.

RECOMMENDATIONS

The APM and AFCR propose that the NIH budget for research training be increased to $208 million to provide support for 10,000 trainees—500 more than the number trained in 1980. This is well below the NRC's minimal goal but would compensate for the stipend increase and would allow for the infusion of a few new clinical research trainees into the system. This, we feel, is very important for the future of clinical research.

In summary, we believe that the addition of $44.6 million to the NIH budget for research training would accomplish the goals set forth above and would be fiscally responsible. I or Dr. Forrest, who is accompanying me from the AFCR, would be pleased to answer any questions and to present additional remarks for the record.

Thank you.

Dr. SCHATTE. I have a supplemental information excerpt of the Associ-ation of Professors of Medicine and the American Federation for Clini-cal Research which I should like to insert in the record.

Senator BURDICK. The information will be inserted in the record at this point.

[The information follows:]

In recent years, a sharp dropoff in the number of physicians entering careers in clinical research has been well documented. As the attached graph shows, the number of MD's in research training supported by NIH has fallen from about 4,100 in 1969 to 1,790 in 1977—a decline of over 50 percent. If this trend continues, there will be very serious implications for biomedical research and for American medicine in general, since the physician investigator possesses the unique capabilities and perspectives that form the bridge between the research lab and the bedside.

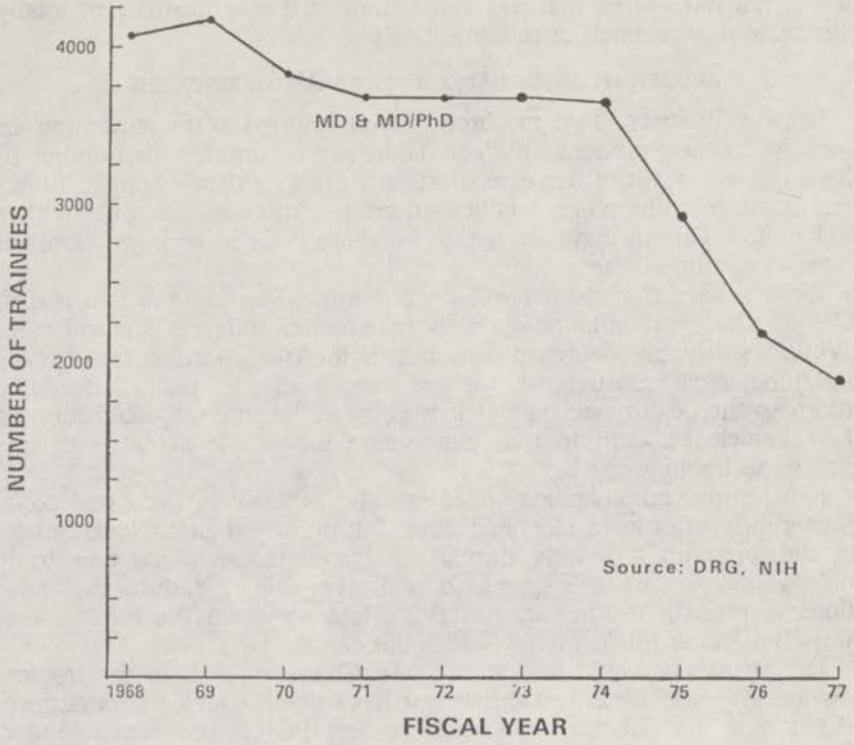


Figure 1. Postdoctoral research training awards from National Institutes of Health (includes postdoctoral traineeships and direct fellowships). Source: Division of Research Grants, NIH.

NIH TRAINING FUNDS

Senator BURDICK. The NIH Director has made a decision, I'm advised, regarding the focus on training and clinic trials and put all those funds into reserve. Do you as a group agree with this decision?

Dr. TARLOV. No.

Dr. WEARY. No.

Senator BURDICK. Why was it done then?

Dr. WEARY. I think it was done inadvisably. And of course the effort was to maintain the investigator-initiated research level as high as possible. But the problem there is, Senator, that it should be put in balance. I think that if there are limited funds you don't just cut off one thing entirely. You have to restore some degree of proportion and balance. And research manpower is one of the most valuable things we have. There is no way to replace it. If there is a gap, a generation gap or several years where trained people are not being produced, there is no way to replace these people somewhere down the line.

I think it is inadvisable to cut funding off so precipitously and abruptly. I think some balance has to be established. If the funds have to come out of investigator-initiated research that is unforunate. I hope

it will not have to be that way but I think it is inappropriate to totally eliminate new research or training funds.

BUDGET RECOMMENDATIONS VERSUS FISCAL RESTRAINT

Senator BURDICK. Two or three of you testified as to requesting an increase in the President's budget. There are a considerable number of Senators who want to decrease drastically the President's budget. Looking at the morning paper I noticed there is a drive to take out another $11 billion. Do you have any guide for those of us in appropriations on how we can do all those things?

Dr. WEARY. I don't; but I will say one thing, Senator, and that is this. One of the great inflationary costs in America today is medical care. While it's difficult, always to demonstrate the cost effectiveness of medical/biomedical research, if we are ever going to really effectively decrease the health care budget it is going to be through acquisition of new knowledge. Add to that better care for people comes with improved technology.

Now, improved technology does not always result in decreased costs. Sometimes it results in increased costs, but improved care. Nevertheless, in the long run it is only through increased research and new technology that we are ever going to really be able to reduce the inflationary spiral in health care costs. It's looking down the road a long way. But I thnk this is money well spent.

Dr. MILLAR. I would like to say, Mr. Chairman, that in the tropical disease area, the Defense Department has some 8 overseas laboratories. Right now the Office of Management and Budget has recommended that they be closed. If that should happen, the Gorgas Memorial Laboratory would be one of the very, very few tropical disease research laboratories left in operation.

We need to maintain an area where research can be performed and where people can be trained. At present, our laboratory trains 24 Navy medical officers a year in tropical medicine, on four 6-week courses. One of the diseases studied, leishmaniasis, occurs not only in the American region but also through Kenya, the Sudan, Egypt, the Middle East, and into southern Russia. If you don't know about these conditions, how can we protect our U.S. personnel assigned to that area?

Now, Mr. Chairman, with regards to your previous question concerning support of basic research versus clinical trials, I think it is important to support both; a proper mix is necessary. Currently, our health care delivery system is basically a catchup or acute crisis care; we need to go into the type of research that develops primary preventive practices and early secondary preventive practices and not just tertiary preventive medicine, so that control and prevention of disease will reduce some of the costs in medical care.

Senator BURDICK. Well, yes, I know you all have a good case. In the five subcommittees I'm in, everybody who appears before me has an excellent case. But I have to be part of the solution somewhere along the line.

Thank you for your contribution this morning.

Dr. WEARY. Thank you very much.

HEART, LUNG, AND BLOOD INSTITUTE PROGRAMS

STATEMENTS OF:
DR. DONALD KERWIN AND DR. NAOMI LUBAN, NATIONAL HEMOPHILIA FOUNDATION
MIKE GORMAN, CITIZENS FOR THE TREATMENT OF HIGH BLOOD PRESSURE
DR. JOHN ECKSTEIN, AMERICAN HEART ASSOCIATION

CITIZENS FOR THE TREATMENT OF HIGH BLOOD PRESSURE

Senator BURDICK. The next group consists of those involved with the Heart, Lung and Blood Institute and related programs. Please come forward. Will you introduce yourselves for the record, please.

Your full statements will be made a part of the record. Start as you wish.

Mr. GORMAN. All right Senator. I was going to read a part of my statement. I think I will read instead from the Bible or Talmud, or from last year's appropriations report as to why President Carter's figures this year are all wrong.

I quote the section of the subcommittee report talking about hypertension. There is a new State project grant program to assist State health departments. In allowing such a large increase for the hypertension program the committee is investigating its strong continuing support for this and other programs. Progress made through this program has been impressive and it's imperative that the momentum of this program continue. When the Carter administration proposes this year the same amount as it proposed last year and $2 million less than the appropriations committee and Senate voted we don't think that provides for momentum.

That is something Mr. George Bush knows something about, momentum and the lack of——

HYPERTENSION

Senator BURDICK. Right at that point; Mr. Gorman, you raise the question of hypertension in the report. For 1979, $11 million was appropriated for this hypertension area.

Mr. GORMAN. That's right.

Senator BURDICK. Then it increased to $20 million. That was the momentum?

Mr. GORMAN. That's right.

Senator BURDICK. In 1981 we continued the momentum at $20 million. We made quite a jump in 1980 didn't we, almost double.

Mr. GORMAN. That's right. Of course it started off as a very small program. We are talking about 35 million people who have hypertension. It's a major cause of 75 percent of all strokes. This is a program we had an awful time getting started back in 1975. People said, "Well, so you've got high blood pressure, nothing wrong with you, no symptoms." It's very tough to diagnose the disease yet it has a more disastrous effect than any disease known.

What we are recommending is the authorization level of $29 million

for next year, and we are recommending that in response to a 5-year clinical study just done on how we can improve detection and treatment of hypertension—10,000 population sample.

We could reduce hypertension by another 20 percent if we provide systematic and vigorous care of these people. If we don't, they are detected in an airport, somewhere else. Someone takes Mr. Bloodpressure anyplace. There is very little followthrough. They just have a little card that tells them what their blood pressure is. Only about one in five go to a doctor following a screening, because it costs money.

TIGHT BUDGET CLIMATE

One final point. I know this is a tight budget climate. I have been around a few years. It's always a tight budget climate. I have never heard anybody say here, "We're going to throw money at you. Take it. Run away." It always seems the administration comes in screaming, "What a horrible budget," and the roof is falling—Congress puts it back on.

Senator BURDICK. An 18.5-percent interest, and 19-percent inflation rate is not Chicken Little.

Mr. GORMAN. No; but I would like to say that the people screaming now for cuts in the Federal budget are bankers. Why don't we cut them a little bit. They're making some dough. I mean Citicorp, David Rockefeller, they seem to be collecting my 18.5 percent. Why don't they sacrifice a little.

Senator BURDICK. We don't have quite the same control over them.

Mr. GORMAN. Nationalize them—off the record. But that is a little frustrating once in awhile. I think we come in and testify to our needs and you people will dispose of them. You have to evaluate them against all the other requests and needs in the Federal Government. But you were asking before, a pertinent question of the previous witness, on how are you going to help us find a compromise.

Well, I have one solution. If you want to go through with these cuts, $10, $11, $20 billion, I would suggest we have a big export program; that we export 50 million Americans back to Europe or where they came from because there is not going to be any way to support health, food, education, or other programs on a tight budget. Maybe the bankers of America want that, but I don't think it's a good idea. That is partly facetious.

Thank you.

PREPARED STATEMENT

Senator BURDICK. You made a good presentation for your case. Your prepared statement will be inserted in the record at this point.

[The statement follows:]

STATEMENT OF DR. MIKE GORMAN

We believe that the thrust of any testimony before a Congressional committee on any program ought to concentrate on two major points -- the accomplishments of the particular effort since its inception, and a factual assessment of its ability to meet present and future demands.

On the first point, there is a general consensus that the hypertension control initiative is the most successful disease prevention program in the annals of American medicine. Back in the early 1970's when the program got under way, the dimensions of the problem seemed overwhelming. About 35 million Americans had definite hypertension, with only about half of those aware that they had the disease and only a small percentage of those who were aware in treatment. Furthermore, an additional 25 million Americans had what was defined as "borderline" hypertension, which indicated to many physicians that they were candidates for hypertension unless their so-called "borderline" or "mild" hypertension was treated.

In contrast to this picture of the pervasive nature of this disease, there was little public recognition of the serious consequences of untreated hypertension. Hypertension is the major factor contributing to 500,000 strokes and 175,000 stroke deaths which occur in this nation every year. Hypertension is also a very significant factor in the 1,250,000 heart attacks and the 650,000 heart attack deaths that occur each year.

In the period 1972 through 1978, we have seen a major reversal in these figures. Deaths from stroke, which for decades was viewed as an incurable affliction, plummeted by 32 percent in a seven-year period -- an unparalleled drop in the control of a major disease. The reduction in heart attacks was almost as dramatic. In that same period of time through 1978, the reduction in mortality from the nation's major killer was more than 20 percent.

However, raw statistics fail to convey the enhancing effect of this effort upon the lives of average Americans. In a major address last year Dr. Michael D. DeBakey, Chairman of Citizens for the Treatment of High Blood Pressure and a world authority on heart disease, told a medical audience that the 300,000 lives saved during this seven-year period was the most persuasive proof he had

ever seen of the effectiveness of a coordinated preventive campaign applied against chronic diseases previously thought incurable.

While the aforementioned figures are more than sufficient to justify a considerable expansion of the existing program, a recently completed five-year clinical study opens up a vast new area for hypertension control that was not envisioned when the program was started in 1972. The Hypertension Detection and Follow-up Program was designed to test the hypothesis that a systematic, aggressive approach to hypertension treatment, including a maximal emphasis upon follow-up and compliance over a five-year period, would result in significant reductions in mortality when compared with the routine care presently existing in the community. The conclusion was unequivocal -- if everyone who is now under treatment for high blood pressure were given systematic care and continuous follow-up, we could reduce premature deaths among hypertensives by 17 percent. This figure is not a conjectural one -- it is squarely based upon reductions in mortality achieved in 14 large communities across this country in which the systematic follow-up approach was used.

However, the most striking finding of the Hypertension Detection and Follow-up Program is that this same systematic treatment of approximately 25 million Americans who have mild hypertension can reduce premature deaths by 20 percent. This very large segment of the hypertension population has rarely been treated in the past because there was no scientific proof of the benefits of such treatment. Now the proof is in and Dr. Robert Levy, Director of the National Heart, Lung, and Blood Institute, warns physicians: "If you have patients with mild hypertension, do not assume they do not require some form of treatment. If you do, you may be denying them years of life."

Another very significant finding of the HDFP study is directly relevant to the interests of this Committee. The study corroborates in almost every detail last year's Committee report observation, that the greatest opportunities for significant progress in hypertension control lie in concentrating on high-risk, underserved populations -- particularly minorities. The HDFP study is the first to give a complete picture of the staggering dimensions of the incidence of hypertension among blacks. In the very large sample, twice as many black males had pressures above 96 diastolic

as did white males; in the same diastolic range, the incidence of hypertension among black women was almost three times as great as among white women. Even more striking, in the severe hypertensive range above 115 diastolic, black males with hypertension outnumbered their white counterparts by a five to one ratio, while black females had seven times the incidence of severe hypertension as compared to white females.

However, the HDFP study reveals that this statistical pattern is highly susceptible to positive change. At the conclusion of the five-year HDFP clinical trial, blacks in the systematic care group achieved a 22 percent reduction in mortality when compared to blacks who did not receive the systematic care; on a comparable basis, whites realized only a ten percent reduction in mortality. Additionally, blacks in the systematic care group did remarkably well in achieving high blood pressure control -- two-thirds of the sample accomplished the goal by the end of the fifth year. This, and much ancillary data, explodes the persistent myth that high-risk groups in our minority populations cannot be motivated to bring their blood pressure to within a desirable range.

By the same token, these findings highlight the need for greatly expanded patient tracking and compliance programs. The Senate Appropriations Committee report last year, noting that "50 percent of diagnosed hypertensives drop out of therapy within the first year of being detected," urged increased emphasis upon long-term maintenance therapy. There is general agreement among those conducting hypertension control programs in either the public or private sector that the screening and detection phase is practically completed; the really difficult task ahead is to get the diagnosed hypertensive into a treatment regimen and then to keep him there over the remainder of his life.

In light of the magnificent track record of the hypertension control program over the past seven years, added to which we now have the new opportunities for life-saving treatment outlined in the HDFP report, the Administration recommendation of $20 million for the hypertension project grant program is totally unrealistic. It is nine million dollars less than the authorizing level and not a single cent over the amount currently appropriated for the program. With this stringent and unimaginative level of funding, how do you

reach the 25 million mild hypertensives who comprise 70 percent of the population and incur 60 percent of the excess mortality attributed to high blood pressure? How do you reach the millions of black Americans and other minorities who are now outside of the treatment mainstream but who, when drawn into it, add precious years to their lives?

At a press conference last November announcing the dramatic findings of the HDFP project, Dr. Levy put the economic and humanitarian challenge quite succinctly:

"Tens of thousands of Americans with high blood pressure are now probably dying at an earlier age then they should...If we apply the lessons learned as a result of this project, we will see a return well into the billions of dollars as the number of premature deaths decrease among the millions of hypertensives in this country."

Talking in terms of a saving of billions of dollars is undoubtedly valid, but it may have a vague connotation to the average American. However, he does understand this -- if one person in his family or in his circle of friends is treated for hypertension and thus avoids a stroke, the economic benefit may be incalculable in the saving of several hundred thousand dollars to maintain that stroke victim over the remainder of his lifetime. Apart from the economics of the issue, how calculate the total gain to a family which in previous years might have been crushed by the long-term disability of the head of the house?

The standstill recommendation of $20 million for Fiscal 1981, if sustained, will have a dampening effect on the accelerating efforts of states, localities and private organizations. When the hypertension grant was transformed in 1978 from a formula to a project basis, the states enthusiastically accepted the competitive nature of the new grant and worked very hard during the past year gathering baseline data and developing comprehensive plans in relation to the Federal seed money. While the planning efforts were under way, they were apprised of the HDFP data demonstrating the need for vastly expanded treatment and compliance programs covering additional millions of mild hypertensives and previously neglected minority groups. As noted in last year's Senate committee report, state and local governments have constantly stretched their financial commitment to this program, contributing far more than the Federal funding. We have

talked to a number of state hypertension coordinators since the Administration recommendation was released; the majority of them state flatly that they will not be able to extend their reach to the mild hypertensives and the minority groups who could benefit so enormously by being included in a wider treatment network.

Mr. Chairman, we therefore recommend that the full authorizing amount of $29 million be appropriated for the hypertension project grant in Fiscal 1981. We hasten to add that this $29 million ceiling, which was imposed upon the program before the results of the 1979 nationwide clinical trials were available, must be revised upward in the legislation renewing the grant.

AMERICAN HEART ASSOCIATION—HEART DISEASE AND TREATMENT

Dr. ECKSTEIN. Senator, I am not only immediate past president of the American Heart Association, I am also dean of the medical school at the University of Iowa and recent testimony of the National Heart, Lung, and Blood Institute Advisory Council. I will summarize briefly.

I am testifying for the American Heart Association. I think it is unnecessary to point out that heart disease comes under the purview of the NHLBI and constitutes the greatest killer. Heart disease is No. 1, vascular disease of the brain No. 3, and lung disease, No. 4.

Research has been effective. Deaths from coronary artery disease have decreased by 22 percent in the last 10 years.

Again, I use the word "momentum." That momentum can be lost if the existing programs are curtailed and promising new programs, particularly those in arteriosclerosis, are left unfunded.

Now we are concerned about the appropriation for NHLBI in total. The present appropriation is $527 million for fiscal year 1980. Last year, we felt we lost $12 million because of the confusion over the priority scores and mechanics of that part of the buildup of the appropriation.

So we would like to see that restored. We think that in order to break even, to maintain these programs at their existing level, there ought to be—I hate to say it, but an inflation adjustment of $92 million. Then 1 percent for new initiatives, $6 million. For a total of $637 million to support research, education, prevention and control and the training programs of NHLBI.

TRAINING

I have some comments that I would like to add if I may. One has to do with the 5,000 training grants that you asked about of the previous panel, or that someone commented about.

That would not work very well for NHLBI. According to our information, the number of grants proposed for the 1981 budget for NHLBI, the allocation of grants, would be 601.

We haven't funded so few grants for many, many years. In 1976, the number was 707. In 1980, it was 750. So we would be taking it in the chops again if it's admitted that we have got the short end on the priority scores last year.

We are not against the 5,000 level. But for NHLBI, it would be an extradetrimental blow.

One other comment on the training budget.

I think we have to be very careful about the conversation going around nowadays about reducing training for a few years, reducing it seriously, and that we can get away with it with no negative consequences.

Now, training has been decreasing in the biomedical research training programs, it's been going downhill for quite a while. This started with the phaseout of the traditional training authorities of NIH back in 1973.

Senator BURDICK. Doesn't that thinking come from the director?

Dr. ECKSTEIN. I am not sure where it comes from, but it's being presented. I am afraid that training has been going downhill for some time.

We are not just talking about cutting it off for a few years and then reinstituting it. I think we are already feeling the effects of the cutback.

I sit as dean of a medical school and interview people who are being recruited for faculty positions and so on. And you can see the erosion in quality of the candidates for these faculty positions.

They don't have the training that they had a few years ago. They haven't had the opportunity to build up the momentum in biomedical research needed to continue research.

I think research training, under discussion now in terms of budget, is a very, very serious matter.

I would like to associate myself with the arguments of the individual who was sitting in this seat in the previous panel when he was asked about this. I don't think we can cut out the training.

Senator BURDICK. Do you have any colorful solutions, Dr. Eckstein?

Dr. ECKSTEIN. Well, I can be colorful. But I think it would be difficult to come up with an answer.

Senator Burdick. Your prepared statement will be inserted in the record at this point.

[The statement follows:]

STATEMENT OF DR. JOHN ECKSTEIN

I am Dr. John W. Eckstein speaking in my capacity as the Immediate Past President of the American Heart Association. The American Heart Association is a voluntary health agency consisting of over two million medical and nonmedical volunteers and supported by contributions from about 35 million adult Americans. Since 1948, this voluntary health agency has been dedicated to reducing the death and disability resulting from cardiovascular disease. A major portion of its work has comprised investment in biomedical research. That investment this year totals more than $20 million.

I bring also to this testimony my personal experience. I currently serve as Dean of the College of Medicine at the University of Iowa. Prior to my appointment to that position, I was active for many yeras in cardiovascular research associated both with the American Heart Association and with projects supported by the National Heart, Lung, and Blood Institute. I have recently finished my term of service as a member of the National Advisory Council for the National, Heart, Lung and Blood Institute.

From this background and on behalf of the American Heart Association, I assure you that we are acutely aware of the responsibility of this committee to scrutinize priorities in federal spending. The current economic climate dictates that such priorities need to be examined with critical care to be sure that investments made by the federal government address the principal problems of the nation.

The American Heart Association wishes to highlight what we believe to be a crisis in research funding for the National, Heart, Lung and Blood Institute. Research sponsored by the National Heart, Lung, and Blood Institute addresses one of the most important health problems of our society. Among the leading causes of death, heart disease ranks number one, cerebrovascular disease number three, and chronic obstructive lung disease ranks number four. Research aimed at controlling these conditions all are in the purview of the National Heart, Lung, and Blood Institute. The combined total of deaths from these diseases is more than a million of our citizens a year, representing more than fifty percent of the deaths from any cause in this country. The economic burdens from these illnesses are estimated in excess of $80 billion annually. Dollars alone, however, cannot address the human suffering caused by these conditions. Premature death of husbands and fathers, crippling long-term illnesses from stroke, disability from angina or peripheral vascular disease, agonizing air hunger from emphysema, are known to almost every family in the country.

You are aware that gratifying progress has been made in combating these illnesses. In the past ten years, cardiovascular death rates have decreased at almost double the rate of decrease for other treated diseases. Death from coronary heart disease has declined more than an additional twenty-two percent and death from stroke over thirty-three percent during this interval. A major factor in the declining death rate from stroke has been the success in control of hypertensive diseases which can be directly traced to programs sponsored by the National Heart, Lung, and Blood Institute.

The American Heart Association is proud to have cooperated with the Institute in the development of the research program which has made these gains possible. Because of your support of the Institute, a planned program of research has been generated with the full cooperation of active research scientists. Our success in establishing a sound science base, has enabled the Institute to support programs which investigate the applicability of these discoveries to the care of patients. Finally, there has been substantial success in disseminating proven techniques which have become part of medical practice.

Despite these promising results, much remains to be done. While we can control high blood pressure and we can repair obstructed arteries, we are only on the threshold of finding the cause of these disorders. Until we know the causes, we cannot prevent the diseases. Until we can prevent the disease, we can make little additional gain in controlling either the associated cost or suffering.

Because of these concerns, the American Heart Association strongly urges this Subcommittee to set the appropriation level for the National Heart, Lung, and Blood Institute at $637 million for FY 1981. This budget figure is necessary to maintain the existing level of basic research into life processes. Discoveries arising from these studies are the foundation on which the control of disease must rest. The most effective means to support these studies has proved to be adequate funding for investigator-initiated research competing in critical peer review.

We all know that the budget for the National Heart, Lung, and Blood Institute is seriously under-financed for the current fiscal year. Last year the Congress approached the budget for the National Institutes of Health with the laudable intention to appropriate money enough to permit each Institute to fund a reasonable and equivalent number of approved competing grant applications. As has been brought to your attention, because of a misunderstanding about the impact of peer review scores, the appropriation for the National Heart, Lung, and Blood Institute lacked some $12 million needed for the grants line. The result is that instead of funding forty percent of competing grants, the National Heart, Lung, and Blood Institute can fund only about twenty-four percent. Additionally, this shortfall fixed the Institute with an increase in appropriations of only 4.2 percent this year. Given the prevailing rates of inflation, such a constraint must result in decreased ability to sponsor research.

We urge this Subcommittee to correct this deficit in the following fashion:

The actual appropriation for the Institute this year is $527 million. However, the correct projected base for this year should be $527 million plus $12 million shortfall, a total of $539 million.

It is estimated that the rate of inflation to the cost of biomedical research is approximately seventeen percent. Again, in order to preserve a "break-even" status in the research program of the National Heart, Lung, and Blood Institute, this seventeen percent allowance must be added to the $539 million base figure, a total of $631 million.

At this level of funding, however, there remain some initiatives which must be underwritten in order to ensure continued progress. These critical high priority items we believe to be the following:

First, in the last year the Institute has initiated a program aimed at reversing the serious decline in the training of physicians for lifelong careers in biomedical reserch. Failure to reverse this trend would risk the disappearance of an extraordinary important resource -- the physician-scientist.

Second, the Hypertension Task Force assembled by the National Heart, Lung, and Blood Institute has produced a program of high priority needs as the next step to define the real causes of this disease. These programs should be encouraged.

Third, addressing the control of hypertension, the recent findings of the Hypertension Detection and Follow-Up Study suggest the importance of expanded investment in control measures, particularly in minority populations.

Fourth, exciting new discoveries suggest that we are on the threshold of understanding ways in which naturally occurring blood vessel damage leads to the development of arteriosclerosis. Concerted effort is necessary to broaden these investigations.

Our suggestion is a one percent increment to the budget to address these critical needs. Thus, the American Heart Association recommends an overall budget figure of $637 million for the National Heart, Lung, and Blood Institute for FY 1981.

Thank you for the privilege of testifying before this Committee.

NATIONAL HEMOPHILIA FOUNDATION

Dr. KERWIN. Mr. Chairman, I am Dr. Donald Kerwin, I am a hemophiliac. I have also served as associate professor at the Georgetown University School of Medicine and I thank you for allowing me to speak on behalf of others like myself.

Hemophilia is a lifelong disease characterized by the inability to clot blood normally. It almost always leaves in its wake, physical, emotional, and financial problems for those of us so afflicted and those who share our burden, be them family, friends, or health professionals.

I am 45 years old, old enough to individually remember and I think, luckily, to have survived what must be considered the Dark Ages of

hemophilia care. My earliest memory includes being literally directly transfused with my father's blood—but only when I was having an episode of major blood loss.

Ordinary bleeds, if you will, were treated with passage of time and whatever solace my parents could offer. I am sure that my case is not unique.

It has been my good fortune, however, to reach adulthood relatively intact and to pursue a career in medicine. My professional life has enabled me to judge the enormous strides that have been made in hemophilia care.

Certainly in my personal life, I have benefited from them as a patient. To have therapy at home for self-infusion is a blessing beyond description.

To know with reasonable certainty, as each of you can, that you will be able to work or study or play the following day is a joy now potentially available to all of us with hemophilia.

I admit gladly that in recent years, my government, through its support of basic and clinical research in coagulation disorders, has served me and others well. I submit more detailed testimony to be made part of the record describing what has been and is being done, and what is needed, to continue to grow.

RECOMMENDATIONS

Our recommendations are a request for an additional $.5 million to make up for the deficiencies that present programs have developed due to inflation.

We believe this will insure that a full range of comprehensive care treatment teams, patient family home care training programs, outreach services to urban and rural families, adequate third-party insurance coverage, and better data collection will be reinstated or maintained at the 22 currently funded programs.

We also request an additional $1 million to expand what has been a successful model of care to underserved areas of the country; approximately five new programs serving 30 percent of unserved patients and their families can be established with these new dollars.

Thus we request an increase in appropriation of $4.5 million which is adjudged to be well within the authorized limits of the current law.

Thank you.

Senator BURDICK. What about the Presidential budget?

Dr. KERWIN. I don't know the answer to that one. It's beyond my ken.

Dr. LUBAN. I am just here to answer any questions that you might have.

Senator BURDICK. This is a year of choices. If you had to make a choice, would you protect the hemophilia service program, or the more long-range research program? Either of you can answer that.

Dr. KERWIN. That is an extremely tough question. I have heard recently within the past 6 months of at least in the research stages, the possibility of a pill that we will be able to take that will raise the clotting factor we lack.

That will need research money. That is certainly extremely important to us. On the other hand, what is available to children now, improvements over what people my age experienced when we were youngsters, we need go no farther than to Children's Hospital locally.

You don't want to lose that either. So I can't make that choice. We need both.

Senator BURDICK. You have a slight idea now what our problems are going to be.

Dr. LUBAN. As a pediatric hemotologist who does some research, I think if I had my druthers, I would go for continued appropriations to serve children.

PREPARED STATEMENT

Senator BURDICK. Your prepared statement will be inserted in the record at this point.

[The statement and the following information was inserted in the record regarding the programs discussed and dental research:]

STATEMENT OF DR. DONALD M. KERWIN

Mr. Chairman and members of the Sub-committee: I have hemophilia, a lifelong, blood disease which creates numerous health, social and financial problems for it's victims. I would like to tell you how your past and future support for comprehensive hemophilia treatment and hemophilia research has helped and will help me and thousands of other hemophiliacs to be healthier, more productive citizens.

In 1974, National Hemophilia Foundation representatives appeared before Congress in support of a bill providing for a national program of comprehensive hemophilia diagnostic and treatment centers. In response to the enormous health, social and economic impacts of hemophilia, Congress, in 1975, enacted Section 1131 of P.L. 94-63, which established the Comprehensive Hemophilia Diagnosis and Treatment Center Program and provided direct federal funding for the comprehensive care of hemophiliacs. In each of the last 4 years this committee has voted 3 million dollars in appropriations for this program.

Your support has enabled twenty-two (22) core comprehensive hemophilia centers, and 60 satellite service programs to be established. Approximately 5,900 hemophiliacs in 42 states and the District of Columbia are served by this program. (This represents approximately 30% of the total hemophilia population). Federal funding is a small percentage of each of these centers' total revenues* for mandated services; but their use has had a tremendous impact.

The impact of this program on the lives of hemophiliacs and their families is reflected in the program's progress towards its goals. Since our last testimony, additional data supporting the impressive progress of the program has become available.

Comprehensive Hemophilia Diagnostic and Treatment Centers are mandated to provide:

- Multi-disciplinary diagnosis and treatment services,
- Professional and paraprofessional training,
- Accessible health care delivery through affiliation with other service providers,
- Psychosocial, financial and vocational counseling services,
- Individualized, written, comprehensive care plans for each treated patient, and
- Community participation through a community advisory board.

A 1978 study performed by the National Institute of Advanced Studies, using a sample of 9 federally funded hemophilia treatment centers showed that:

- The number of hemophilia patients served during the first year of federal funding increased 24% over the year prior to federal funding.
- The number of funded centers increased from 17 to 22 after the first year of funding.
- The total number of patient encounters increased at all centers studies, after federal funding.
- Federal funds have been used to increase the availability of dental, physical therapy, social and vocational services, making truly comprehensive care available to both the hemophiliac child and adult.

* This data is cited in the attached legislative fact sheet references.

- The number of patients on home care which enables earlier treatment and a more normal, independent lifestyle for the patient and his family increased after federal funding.

- Financial counseling services were established to maximize third party reimbursement, reduce out-of-pocket costs to patients, and decrease financial losses to the center and/or its host facility.

Finally, federal funding has attracted both local government funds and encouraged third party reimbursement for hemophilia treatment. A survey of 43 State Crippled Childrens' Services Directors showed that the presence of a federally-funded hemophilia treatment center in a state increases the number of hemophilia patients served by CCS by more than two-fold compared to states which do not have a federal hemophilia treatment center. Through the efforts of federal hemophilia treatment centers and the National Hemophilia Foundation, twenty-three states now have State legislation mandating subsidization of blood products, and/or treatment programs for hemophilia. As a result of efforts by hemophilia center staff and patients, Blue Cross/Blue Shield and other health insurance companies have established insurance plans which cover hemophilia treatment. In addition, if a treatment center, foundation chapter, and State legislation coexist, more financial support is garnered for patients. Additional data collected from federally funded treatment centers underscore the program's gress.(Refer to Tables I, II and III which illustrate the effectiveness of HSA funded centers)

What is the ultimate impact of this legislation on the lives of hemophiliacs and their families? - and - What additional support is needed to maintain this progress and share it with other areas of the country?

As a result of this legislation, those of us with hemophilia and our relatives who help us live with it can now enjoy a nearly normal life style. Breakthoughs in science and the existence of a top-notch federal treatment program which has translated those breakthroughs into diagnosis, treatment and care with remarkable speed, have meant more opportunities for us in education, in employment, for a happy family life, as well as better physical and mental health. We can now infuse the missing clotting factor in our blood at home instead of interrupting our daily schedule to go to the hospital. We are more educated about our disease through the intensive patient education provided by the comprehensive care team and can play a more active role in maintaining our health and preventing disability. Although we are from all socio-economic levels, our care is more affordable and those of us served through this federal program pay similar out-of-pocket costs.

My testimony is supported by hard facts from a number of published studies and reports showing that comprehensive health care and home infusion therapy have resulted in decreases in average annual cost per patient, in hemophiliac crippling, and in the number of days lost from school and work.*

I am confident that these remarks have high-lighted to cost-effectiveness of this federal program in your minds. Simply stated: Congress's investment in comprehensive care programs which promote home infusion therapy will pay off through a reduction in

* These studies are cited in the attached legislative fact sheet references.

disability, unemployment, and medical care payments to hemophiliacs and families made vulnerable by the hardship of this chronic disease.

However, I believe our past testimony may not have emphasized clearly enough that Congress should protect its investment of 12 million dollars in the treatment of hemophilia by maintaining the level of care intended through the enabling legislation. Congress will get less for its money in the long run without higher appropriations to this program. Children and adults who have benefitted from comprehensive hemophilia care continue to need this level of care in order to be as independent and productive as possible.

Let me briefly explain our needs and justify our appropriations request:

A. There are several areas of the United States where little or no services for hemophi exist. According to the Department of HEW, approximately 13 states and 10 parts of other states are not served by the federal comprehensive hemophilia treatment program. This represents approximately 70% of the hemophiliacs. This information is substantiated by an extensive 6 month survey done by the National Hemophilia Foundation which aimed to identify all hemophilia treatment services in the U.S.* It is estimated that almost 70% of the estimated total hemophilia population does not have access to services through the federal comprehensive treatment center program. With only 23 states mandating funds for hemophilia treatment services, only some of which are comprehensive, the number of unserved, eligible patients is reduced. Only a small percent have available centers offering some aspects of comprehensive care. The Department of HEW approved four grant applications since 1976 from medical facilities in these high need areas* but funds were not allocated because the 3 million dollar appropriation was inadequate.

B. While the original level of spending in the first year of the program was only 2.4 of the 3 million dollars, the level of spending for Fiscal Years 1978 and 1979 have not allowed additional funds to be obligated for approved grants.

C. Inflation has rapidly eroded the level of funding for this program by 1 million dollars over the period 1976 -1980.** Centers will be hard-pressed to continue to increase their level of services when funding has decreased by one-third.

D. This phenomenon is a direct result of scientific breakthroughs and the excellent medical care that is now being given. An increasing number of hemophiliacs is another consideration in the request for funds.

I would like to quote from the National Institute for Advanced Studies Report. "Assuming that the present birth rate remains constant, by aging in the current hemophiliac population, the NIAS estimates that the U.S. hemophilia population will incre as a proportion of the U.S. population, one-third over the next 30 years due to the increased survival rates from the availability of plasma concentrates." This means approximately 25,000 hemophiliacs by the year 2000, compared to the estimated current

* The Directory of Hemophilia Treatment Centers, 1979

total population of 19,000. Thus, Mr. Chairman, the problem of hemophilia care progra is getting larger and not smaller.

E. Unmet needs across the board.

Finally, one across-the-board need at all existing treatment centers is the need t collect more data on the effectiveness of the program and to be able to cooperate in clinical research. Presently, the lack of funding to permit treatment center staffs to engage in these activities reduces the future development of administrat and clinical services at these centers.

I believe that on the basis of information presented in this testimony and the data supporting these statements, the hemophilia community is justified in urging yo support for an increased level of funding to protect Congress's past investment in preventive care as well as to reduce the long-term costs resulting from disability which can be prevented through adequate care. We request an additional 1 million dollars to proliferate what has been a successful model of care in underserved areas of the country. Approximately 5 new programs serving 30% of unserved patients and their families can be established with these new dollars.

We request an additional 1/2 million dollars to make up for deficiences present programs have developed due to a non-increased budget to ensure that a full range of comprehensive care treatment members teams, patient/family home care training, outreach services to rural families, adequate third-party insurance, and better data collection are reinstated and/or maintained at the 22 currently-funded programs.

Thus we request an increased appropriation of $4.5 million. This is well within the authorizing limits of the current law.

As the solution to hemophilia resides in new investigations we are vitally concerned with survival and appropriate funding to the National Institutes of Health. In regard to the funding for the 2 institutes of the National Institutes of Health which support research, on blood and blood diseases, we make the following recommendations:

- For the National Heart, Lung and Blood Institute, instead of $548,399,000 as requested in the President's Budget for Fiscal Year 1981 that you appropriate $641,000,000.
- In regard to the National Institute of Arthritis, Metabolism, and Digestive Diseases that you appropriate $400,000,000 instead of the President's Budget of $365,711,000.

EFFECTIVENESS OF HSA FUNDED CENTERS

TABLE I

Evaluation of Patient Accrual

	Year prior to implementation of P.L. 94-63	Fiscal 1979
Number seen at primary center	1,017	2,438
Number seen at affiliated centers	442	741
Total	1,459	3,179
Number receiving regular comprehensive care	672	2,255
Number on home therapy	373	857

TABLE II

Evaluation of Patient Services: "Encounters"

	Year prior to implementation of P.L. 94-63	Fiscal 1979
Hemophilia Clinic (Hematologist/ Pediatrician/Nurse)	5,111	7,840
Orthopedist	747	3,609
Physical Therapist	438	3,195
Social Worker	389	2,486
Vocational Counselor	21	1,029
Psychiatrist/Psychologist	84	775
Genetic Counselor	117	857
Oral Surgeon	491	1,707
Mean Encounters/patient/year	5	21

TABLE III

EFFECTIVENESS OF HSA FUNDED CENTERS

	Historical Controls (Year prior to implementation of P.L. 94-63	Fiscal 1979
Average days/year lost from work or school	20-60	10.5
Average number of hospital admissions/year	6-36	1.1
Average days/year spent as in-patients	14-60	2.5
Average costs of health care/year	$8-22,000	$4,875
Average out-of-pocket expenses/year	$1-5,000	$ 671
	Prior to implementation of P.L. 94-63	Fiscal 1979
Percent of patients with third party coverage	74%	85%*
Percent of unemployed adults	36%	16%

Comparison figures, NHLBI Blood Resource Studies, 1972:
41% of adult hemophiliacs unemployed and on welfare
* Insurance likely to be considerably more comprehensive.

FACTS ABOUT HEMOPHILIA AND THE COMPREHENSIVE HEMOPHILIA DIAGNOSTIC AND TREATMENT CENTER PROGRAM

Hemophilia

Hemophilia is a congenital, hereditary blood clotting disorder which affects males almost exclusively. Hemophiliacs' blood does not clot, due to the inactivity of a plasma protein in their blood. Hemophiliacs may experience uncontrolled, painful bleeding and hemorrhaging. Chronic joint bleeding results in progressive joint damage and crippling without adequate treatment.

Hemophilia equally affects people of all races, nationalities, and economic levels. Of all known genetic diseases, hemophilia has the fastest known mutation rate. Approximately 1/3 of all cases occur in families without a known history of the disease.

There is no cure for hemophilia. However, through the work of science, the lifespan of the hemophiliac has been extended. The median age of the projected hemophilia population was 11.5 years in 1970.[1] The estimated median age in 1977-78 was 19 years.[2]

THE NUMBER OF HEMOPHILIACS IN THE U.S. IS GROWING EVERY YEAR. Based on a prevalence rate of 1.8/10,000 males, the number of hemophiliacs in the U.S. in 1976 was estimated at 19,000. Because plasma concentrates* are allowing hemophiliacs to live longer, it is estimated that the hemophilia population will increase by one third over the next thirty years.[3] (This means over 25,000 hemophiliacs in the year 2006).

The availability of plasma clotting factors has radically changed the treatment of patients and improved the quality of their lives dramatically. In the past 10 years, research supported by the National Institutes of Health has been translated into hemophilia diagnosis and care with remarkable speed. National Heart, Lung and Blood Institute grants have made possible: 1) the isolation of the Factor VIII molecule (the inactive plasma protein in classical hemophilia) in highly concentrated Factor VIII preparations, 2) development of a highly accurate detection system for female carriers of the classical hemophilia trait, 3) advancement in the basic knowledge of the biochemistry of the Factor VIII molecule which takes scientists closer to finding a cure for hemophilia.

Hemophiliacs can now be treated through self-care by infusing the clotting factor concentrate at home. Home infusion therapy enables earlier treatment and a more independent, normal lifestyle for the patient and his family.

Hemophilia is an extremely expensive, chronic disease. Because hemophiliacs live longer with their disease than many other chronic disease populations, the catastrophic costs must be borne for a lifetime. The average annual cost of blood product alone for hemophilia patients on home care is approximately $6,000. A 1978 survey estimated that the total costs of hemophilia care for severe hemophiliacs average $8,000 in a year. Families have spent as high as $56,000 in a year.[4] Third party coverage varies markedly from state to state, but in all instances is not adequate to meet the needs of hemophilia patients.[5]

Cryoprecipitate and clotting factor concentrates, which are used to treat hemophilia, can be derived from human blood only.

The Comprehensive Hemophilia Diagnostic and Treatment Center Program

The National Hemophilia Foundation is grateful to Congress for their continued support for the national program of hemophilia treatment centers. In 1975, Section 1131 of P.L. 94-63 established the Hemophilia Diagnostic and Treatment Center Program and provided for direct federal funding to establish a demonstration program for comprehensive hemophilia care.

* Made from the clotting factor in human blood which stops bleeding in hemophiliacs.

Comprehensive Hemophilia Diagnostic and Treatment Centers are only partially supported by the federal government. Federal funding as a percentage of total center revenues, ranged from a high of 21% to a low of 6%, in eight centers surveyed by The National Institute for Advanced Studies, a well-known social research organization.

Twenty-two (22) core hemophilia treatment centers with a network of 60 satellite facilities serve approximately 5,900 hemophilia patients in 42 states and the District of Columbia.

Persons with other clotting disorders also receive services at hemophilia treatment centers. It is estimated that 20% of all patients treated at comprehensive hemophilia centers have clotting disorders other than hemophilia. Approximately 1 out of every 4,000 persons in the U.S. has a blood clotting disorder (for example, von Willebrand's disease and other blood factor deficiencies).[6]

The provisions of the hemophilia treatment center program include:

Multi-disciplinary diagnosis and treatment services,
Professional and paraprofessional training,
Accessible health care delivery through affiliation with other service providers,
Psychosocial, financial and vocational counseling services,
Individualized, written, comprehensive care plans for each treated patient, and
Community participation through a community advisory board.

One of the promising aspects of this federal program is its promotion of home-based infusion therapy. Home infusion therapy has resulted in decreases in average annual cost per patient, in hemophilic crippling, and in the number of days lost from school and work, according to several studies.[7]

Report on Program Progress

The progress of the Comprehensive Hemophilia Diagnostic and Treatment Center Program has been well established. The number of federal hemophilia treatment centers has grown from 17 to 22 in four years. Cooperative linkages have been established between these 22 centers and 60 satellite facilities. These affiliations have allowed the program to expand to 42 states, which are covered in part or wholly by hemophilia center services.

This progress is documented in the 1978 study performed by the National Institute for Advanced Studies which used a sample of nine federally-funded hemophilia treatment centers. The following information was presented in their final report:

-'The number of hemophilia patients served during the first year of federal funding increased 24% over the year prior to federal funding. Outreach to underserved population areas is a major program service.'

-'The total number of patient encounters increased at all centers studied, after federal funding. Hours of operation and frequency of regularly scheduled clinics increased or stayed the same.'

-'Federal funds were used to increase the availability of dental, physical therapy, social and vocational services, making truly comprehensive care available to both the hemophilic child and adult.'

-'The per unit cost of Factor VIII Concentrate[8] decreased or remained the same after federal funding.'

-'The number of patients on home care increased after federal funding.'

-'A major new service was financial counseling which aims to maximize third party reimbursement, reduce out-of-pocket costs to patients, and decrease financial losses to the center and/or its host facility.'

Federal funding has attracted both local government funds and encouraged third party reimbursement for hemophilia treatment. A survey of 43 State Crippled Childrens' Services Directors showed that the presence of a federally-funded hemophilia treatment center in a state increases the number of hemophilia patients served by CCS by more than two-fold compared to states which do not have a federal hemophil

treatment center. Twenty-three states now have State legislation ma dating subsidization of blood products, or, in a few cases, the deve ment of hemophilia treatment programs. Through the efforts of feder hemophilia treatment centers and NHF, Blue Cross/Blue Shield and othe health insurance companies have established policies covering hemoph treatment.

The progress of this program cannot be measured by statistics alone. A profound change in the quality of life for the hemophiliac and his family has resulted from the increased availability of a range of comprehensive services delivered by a multi-disciplinary team. The promotion of self-care and the existence of supportive, allied medic services means more independence, less future disability and greater productivity for today's young patients. It means greater potential on the part of older patients benefitting from comprehensive service aimed at reducing the impact of their disabilities on them, their family, and society.

The Future

The level of funding for Comprehensive Hemophilia Diagnostic and Treatment Center programs has been 3 million dollars for four years (Fiscal Year 1976-Fiscal Year 1980). Inflation during this period has rapidly eroded the potential of this funding.

Several areas of the United States have inadequate hemophilia treatment services. The tremendous advances in treatment and care have no reached hemophiliacs living in these areas.

Almost 70% of the estimated total hemophilia population does not receive services through the federal comprehensive treatment center program.

The National Hemophilia Foundation urges Congress to protect its investment of 12 million dollars in the treatment of hemophilia by maintaining the level of care intended through the enabling legislation. Additional funds for the expansion of comprehensive care and home infusion training services to underserved areas are needed. We request an increased appropriation of at least 4.5 million dollars t sustain and broaden the remarkable accomplishments your past support has made possible.

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3. NIAS Final Report

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5. NIAS Final Report

6. NIAS Final Report

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8. Dried concentrate of Factor VIII, which is Antihemophilic Factor, used in treating classic hemophilia.

DATA COLLECTION FROM ELEVEN HSA-BCHS FUNDED
HEMOPHILIA COMPREHENSIVE DIAGNOSTIC AND TREATMENT CENTERS

Study Participants

Gulf States Center		Houston	Ronald S. Weinger, M.D.
Iowa Rural Comprehensive Care Program		Iowa City	C. Thomas Kisker, M.D.
Minnesota Comprehensive Center		Minneapolis	J. Roger Edson, M.D.
Mountain States Regional Center:	a)	Denver	William E. Hathaway, M.D.
	b)	Salt Lake City	Edward Hershgold, M.D.
	c)	Tucson	James J. Corrigan, M.D.
New England Comprehensive Center		Worcester	Peter H. Levine, M.D.
New Jersey Comprehensive Center		Piscataway	Parvin Saidi, M.D.
New York Center:	a)	New Hyde Park	Richard A. Lipton, M.D.
	b)	New York City	Louis M. Aledort, M.D.
	c)	Rochester Region	Mary M. Gooley, R.N.
North Carolina Comprehensive Center		Winston-Salem	Christine A. Johnson, M.D.
North Central California UCD Program		Sacramento	Charles F. Abildgaard, M.D.
Pennsylvania Comprehensive Care Program		Hershey	M. Elaine Eyster, M.D.
South Texas Comprehensive Center		San Antonio	Paul M. Zeltzer, M.D.

OUTCOMES FOR HEMOPHILIACS AT THE ELEVEN FUNDED CENTERS

	Historical Controls	Fiscal 1979
Average days/year lost from work or school	20 - 60	10.5
Average no. of hospital admissions/year	6 - 36	1.1
Average days/year spent as in-patients	14 - 60	2.5
Average costs of health care/year	$[illegible] - 22,000	$4,875
Average out of pocket expense/year	$1 - 5,000	$671

	Year before HSA Funding	Fiscal 1979
Percent patients with third party coverage	74%	85%*
Percent of unemployed adults	36%	16%

Comparison figures, NHLBI Blood Resource Studies, 1972:

41% of adult hemophiliacs unemployed and on welfare

* Insurance likely to be considerably more comprehensive

OUTCOMES FOR 220 MASSACHUSETTS HEMOPHILIACS
BEFORE AND AFTER HSA FUNDING

	Year before HSA Funding	Fiscal 1979
Average days/year lost from work or school	12.2	5.5
Average no. of hospital admissions/year	2.1	0.3
Average days/year spent as inpatients	6.4	0.9
Average costs of health care/year	$8,850	$5,810
Average out of pocket expense/year	$ 950	$ 267
Percent patients with third party coverage	85%	99%
Percent of unemployed adults	27%	7%

PATIENTS ENROLLED

	Year before HSA Funding	Fiscal 1979
No. seen at Primary Center	1017	2438
No. seen at Affiliated Centers	442	741
Total	1459	3179
Number receiving regular Comprehensive Care	672	2255
Number on Home Therapy	373	857

ENCOUNTERS

Hemophilia Clinic (Hematologist/Pediatrician/Nurse)	5111	7840
Orthopedist	747	3609
Physical Therapist	438	3195
Social Worker	389	2486
Vocational Counsellor	21	1029
Psychiatrist/Psychologist	84	775
Genetic Counsellor	117	857
Oral Surgeon	491	1707
Mean Encounters/Patient/Year	5	21

STATEMENT OF CHARLES JAMES CARRICO, PROFESSOR OF SURGERY, UNIVERSITY OF WASHINGTON SCHOOL OF MEDICINE

Thank you very much for allowing me to appear as a citizen witness to speak on behalf of the budget of the National Institute of General Medical Sciences (NIGMS) and to emphasize the importance of continued support for research and training in the fields of trauma and burns. I would like to briefly outline my background for the Committee. My name is Charles James Carrico. I am a Professor of Surgery in the University of Washington School of Medicine. I am Surgeon-in-Chief at Harborview Medical Center, one of the major teaching hospitals in the University of Washington system. Harborview Medical Center has also been designated as the Regional Burn and Trauma Center for the Pacific Northwest. As part of my responsibilities outlined above, I am Director of the Trauma Center and as such am responsible for the overall care of approximately 3,000 burned and otherwise injured patients who are admitted to this facility annually. In addition, another 18,000 to 20,000 patients are treated for injuries in our emergency facilities each year. I am currently Principal Investigator of an NIGMS-funded Burn and Trauma Research Center at the University of Washington and in addition am responsible for the administration of a Institutional National Research Service Award designed for the training of young scientists in the fields of burns and trauma. In addition, I am Chairman of the Washington State Committee on Trauma of the American College of Surgeons.

My interest in the area of care of the injured patient can be illustrated by listing some of my national responsibilities. I am Vice Chairman of the American College of Surgeons Pre- and Post-Operative Care Committee; am a member of the NIH Study Section on Surgery, Anesthesia, and Trauma; and a member of the American Association for the Surgery of Trauma; and am a Founding Member of the American Trauma Society.

It is with pleasure and enthusiasm that I can come before the Committee and speak in support of the budget of the National Institutes of General Medical Sciences, particularly as it relates both directly and indirectly to the support of research and education in burns and trauma. A considerable part of this enthusiasm is generated by the fact that in the last 20 years giant steps have been made in the management of patients with all sorts of injuries. The NIGMS, through its sponsored research and training, deserves a considerable portion of the credit for many of these advances. Before I try to briefly illustrate some of these advances, let me briefly point out to the Committee the magnitude of the problem. I realize this may be redundant since many witnesses in the past have made such statements, but the fact that injury is the leading cause of death among Americans under 45 years of age deserves endless repetition. There are an estimated 50 million injuries resulting in 100,000 deaths in this country each year. A problem of even greater magnitude is the resulting disability. The National Injury Information Clearinghouse (U.S. Consumer Products Safety Commission) estimated that in 1978 there were 10.6 million disabling injuries with some 390,000 of these resulting in permanent disability. The estimated annual cost of injury deaths and disability in the United States is $18 billion. Some of these injuries, such as burns, are very dramatic. Others are less obviously dramatic but are, nevertheless, equally disabling to people primarily in the most productive years of their lives. All these numbers are a little overwhelming to me but can be reduced to a graspable level by pointing out that every hour 10 Americans die from injuries and another 40 are permanently disabled. This is even more alarming when it is realized that many of these deaths and disabilities should be preventable.

To try to point out some of the major advances which have occurred under the stimulus or direct support of NIGMS funding, let me suggest two brief illustrations. First, a patient with massive multiple injuries from an automobile accident. What difference in the treatment of this patient has resulted from research efforts in this area? First, the initial fluid management of this patient would now involve both blood and salt water. This management has reduced the incidence of kidney failure to tiny numbers as compared to 15 years ago and was a direct result of research sponsored by the NIGMS. The traumatized patient also has a significant chance of developing lung failure if not treated rapidly and appropriately. Work carried out under the leadership of NIGMS grants has elucidated some of the causes of respiratory failure, allowed us to prevent respiratory failure in many of these patients, and to more adequately treat it in others. If the patient in my illustration were lucky enough to survive his episode of shock and respiratory failure 15 years ago he would almost certainly have failed to survive because of other complications of his severe injuries. More recent information has demonstrated the importance of nutritional support and of control of infection. With the advances in support and nutrition and ongoing advances in control of infection, this patient now has a high probability of surviving. Equally important, such patients with multiple fractures have their fractures treated within the first day following injury and thus not only survive but return to work in a matter of weeks rather than a matter of months and have a markedly reduced disability. An even more dramatic example of the advances in the management of such patients can be illustrated by an 8 year old child who had received 50% burns when gasoline exploded around a campfire. In the fairly recent past this child almost certainly would have died, or if not would have been hospitalized for several months and anticipated severe life-long disability. Developments again spearheaded by NIGMS-supported scientists in fluid resuscitation and management of infection have virtually assured that such a child with this size burn should survive in major burn care centers. Again, the approach to disability limitation

is important and recent developments regarding early excision and grafting of such burns not only further enhances the child's chances of survival, but greatly limits the duration of hospitalization and disability. Thus such an injury received during the summer now may well be treated and the child recovered so that he/she can return to school in the fall. I can cite enumerable specific examples of smaller advances which have led to these major advances, these include the use of laser instrumentation for control of bleeding in the management of burns, attempts to generate artificial skin by Dr. Burke in Boston, studies of lung water and lung failure which promise to even further enhance our ability to prevent and treat pulmonary failure, and many others. However, the overall significance of these is their impact on survival when added together and applied to patient care. As illustrated above this impact has been immense.

Rather than spending further time with more illustrative examples, allow me to address the issue of why NIGMS is uniquely equipped to support research in this fairly difficult area. As you know, the Institutes of General Medical Sciences has a responsibility for supporting programs in a broad range of areas. This ranges from trauma to genetics and includes bioengineering, cellular and molecular basis of disease, pharmacology/toxicology, and a broad range of projects in the area of clinical and physiological sciences. Thus this is a unique institute in that it has, by its very nature, the opportunity to bring together clinical scientists and basic scientists. It is this unique mixture of the clinical scientist with his awareness of clinical problems and possible approaches and the basic scientist with his broad background and knowledge of basic techniques which has resulted in many of the advances alluded to above. Thus, while my particular interest is in the areas of trauma and the physiologic response to injury, I, along with many others, would like to emphasize the importance of general support of the Institute budget as well as the specific areas of injury related research.

In my few remaining minutes, I would like to address the vehicles by which these advances have been made and, hopefully, will continue to be made. The strength of NIH sponsored research has been, and in my opinion will continue to be, peer-reviewed individual grants. Thus the individual investigator makes an observation, gets an idea, consults with his colleagues and after appropriate peer review, receives money to pursue new and exciting ideas. Many of the basic concepts which have led to advances in the care of injured patients have occurred in this way. An outstanding example is the observation of Dr. G. Tom Shires regarding the role of non-blood solutions in the resuscitation of shock due to blood loss. The second vehicle which is being employed for studies of patients with injuries is the Burn and Trauma Research Center. The major strength of the Centers is the Core, which allows scientists from a number of disciplines to focus together on particular problems of injured patients. The Research Center also makes possible studies on these very ill patients which would be very difficult, if not impossible, to conduct without the Core facilities. These Centers, in addition to their great strength in fostering interdisciplinary research, form a vehicle for training of nurses and physicians for all disciplines in the care of the traumatized patient. The third area of major emphasis has been the Institutional National Research Service Awards (frequently referred to as Training Grants) which are a major vehicle for attracting new scientists into this growing field of interest. All of these efforts together have resulted in significant improvement in trauma care and in significantly raising the level of awareness about the magnitude of this problem. Again, the NIGMS deserves a lion's share of the credit for many of the advances which have resulted and I come before this Committee to urge adoption of their budget.

Once more, let me thank the Committee for the change to appear, for its support in the past of the research efforts outlined. I hope that some of the illustrations that I have mentioned are adequate to convey in a small way the benefits which the American people have received from projects supported through the Institute of General Medical Sciences and have convinced you to continue this very worthwhile support. Thank you.

STATEMENT OF THE AMERICAN DENTAL ASSOCIATION

The American Dental Association recognizes that the present economic climate dictates a commitment to fiscal restraint in the funding of our public programs. Difficult choices will have to be made among competing activities whose cost and effectiveness have not been challenged in the past. For the Department of Health and Human Services, this task is complicated by the fact that many of the largest expenditures are for programs where payments are mandated by law. Thus the burden of absorb-

ing reductions must be borne by a relatively smaller number of projects which are subject to the annual appropriations process. The Association nevertheless believes that an equitable balance can be struck if prudent increases are limited to these areas where a federal presence is justified, and where a record of efficiency and effectiveness can be demonstrated.

Health Care Delivery

The American Dental Association has a long standing record of support for programs to improve access to dental care for underserved and other special population groups. Almost thirty years ago the Association adopted policy urging its constituent societies to survey the dental needs of these populations, develop demonstration projects which address these needs, and implement broad-based efforts to reduce or eliminate barriers to comprehensive dental care.

More recently, the 1979 ADA House of Delegates approved a landmark report titled, "Prevention and Control of Dental Disease Through Improved Access to Comprehensive Care". The report contains a series of 32 significant recommendations which, we believe, can serve as a national strategy for bringing all citizens into the mainstream of the dental care delivery system. Of particular importance is the decision to focus existing resources of the Association on five population segments: (1) the poor and working poor, (2) the elderly, (3) the underserved and remote-area residents, (4) the handicapped, institutionalized and homebound, and (5) the worker without dental prepayment insurance.

Fundamental to the thrust of the "access" program is the concept that improved oral health of our citizens requires a shared responsibility to be borne cooperatively by the dental profession, government at all levels, the private sector and the individual. In recognition of an appropriate federal role in achieving these objectives, the Association is presently endorsing separate legislation to provide comprehensive dental care for the elderly under Medicare Part B, (H.R. 1015) and mandate dental services under Medicaid for children of low income families, (H.R. 4962).

This recognition of a federal role does not, however, include the provision of dental services in those areas where dental care is available from the private sector. Nor does it extend to the support of those

federal health care delivery programs whose effectiveness can no longer be demonstrated. It is for this reason that the Association opposes any further increase in funding for the Community Health Center program and for the National Health Service Corps.

Community Health Centers

Federally supported Community Health Centers, formerly known as Neighborhood Health Centers, were initially established in the mid 1960s in response to what was perceived to be a shortage of health care service in certain areas and, the inability of defined population groups to purchase necessary health services. Since that time, however, there have been significant developments in efforts to improve access to health care, including a major increase in the supply of all categories of health providers as well as the enactment and expansion of federal programs of financial assistance under the Social Security Act. Barriers to adequate dental care remain despite these accomplishments. However the willingness and capability of the private sector to respond to these problems lessens the need for reliance upon federally subsidized health care centers.

The Administration's 1981 budget requests a total of $391 million for Community Health Centers. This is an increase of $50 million over the current year and more than $114 million over the level appropriated for 1979. The Association is concerned that this dramatic increase in funding has not been accompanied by a careful accounting to determine whether these Centers are the most appropriate and effective vehicles to improve access to care. With respect to dental services, the ADA believes that the cost of Community Health Service financed care far exceeds that provided by a private practitioner. Similarly, recent studies have revealed an unacceptably low utilization rate for health services by the population groups these Centers were intended to serve. We cannot, therefore, find any justification to support the Administration's budget proposal to expand health services at 51 existing Centers and to construct an additional 14 new Centers. The Association therefore recommends that any further increases for this program be withheld pending a thorough evaluation of the cost, effectiveness and future direction of the Community Health Center program.

National Health Service Corps

The Association believes that the Department has unilaterally

changed the thrust of the Corps to such a degree that it bears little resemblance to the intent of the original law. We are particularly disturbed over the apparent shift in emphasis away from the solo practice delivery model to the promotion of a permanent federal presence in the form of fixed-site clinics. Department officials now indicate that a majority (80%) of future Corps dental placements will be in "integrated delivery systems", i.e. Community Health Centers and other fixed-sites. In addition to penalizing those underserved communities which do not have these health centers, this approach virtually precludes the evolution of Corps sites into self-sustaining private practices.

The validity of the private practice model for dentistry is clearly demonstrated by the experiences in Washington and other States included within HEW Region 10. Of the eight National Health Service Corps dental sites that have been established since 1972 in private practice settings, seven have converted to successful independent practices, and the eighth Corps site is expected to follow this pattern. Despite this impressive record, Region 10 is under the same pressure as all other HEW Regional Offices to give priority in dental Corps assignments to fixed-site centers.

A second, negative aspect of the current operation of the National Health Service Corps can be seen in the low percentage of dental placements in underserved areas which are designated as having the greatest need (priority 01 and 02). The Association understands that almost 50 percent of all Corps dental assignments have to date been in areas with an 03 and 04 identification; the lowest quartile. This results in part from the emphasis on fixed-site placements and in the latitude allowed for site selection by NHSC personnel. It is also a reflection of the failure of Corps officials to work cooperatively with, and take into account the efforts of, local public and private groups in programs to improve access to care. By placing dentists in areas of marginal need, the Corps has placed itself in direct and unwarranted competition with private practitioners. On occasion this has forced the private dentist to close his practice and, upon completion of the Corps dentist's assignment, the community is left without any dental resources. These situations could be avoided if the local dental societies are given a more meaningful role in the designation of underserved areas and the possible placement of Corps personnel in these areas. At a minimum, there must

be a greater opportunity for the local society to comment on proposed Corps assignments to their communities, and if appropriate and feasible, to offer less costly and more lasting alternatives to the NHSC.

In summary, the ADA believes that the National Health Service Corps was enacted as an interim measure; one that would serve as a catalyst for the development of private practices. Unfortunately this concept has largely been abandoned as the Department has moved to create what appears to be a permanent federal health care delivery system. We therefore strongly urge the Committee to deny any additional increases for the NHSC until Congress has the opportunity to review and presumably amend the expiring statutes for the program in connection with its renewal of the health manpower statutes.

Health Professions Education

The Administration predicts that the supply of primary care providers will exceed the need by 1990. For this reason, capitation grants and other direct federal health manpower assistance programs are to be terminated. While the Association agrees that additional mandatory enrollment increases are not only unnecessary but also potentially counterproductive, we cannot understand how the proposed elimination of institutional grants, direct student loans, general practice residency support, as well as reductions in other key manpower programs, will achieve the Department's goal of better geographic and specialty distribution for the health professions. As the Committee is aware, those objectives were in fact the very purpose of the 1976 amendments to the health manpower law. Furthermore, the ability of the dental education system to respond to the initiatives contained in such programs as capitation grants is directly related to a stable and predictable level of federal assistance. Unfortunately the Administration's proposed rescissions and reductions would seem to ignore this basic premise.

Institutional Support

An immediate dilemma presented by the proposed elimination of capitation grants is the substantial, additional expenditures which dental schools have incurred to comply with the requirements for receiving institutional grant support. To cite one example, the majority of dental schools have chosen to establish ambulatory teaching programs located in dentally underserved areas. This has been done at a consid-

erable cost, not only to construct and equip these teaching sites, but to also provide the necessary faculty and support personnel. The question is whether Congress and the Executive expect our dental training institutions to launch these new and costly programs - programs we hasten to emphasize which address the same priorities identified in the Administration's budget - when they are threatened with a loss of funds to maintain them. We believe that the geographic and specialty distribution of health professionals should be addressed and that as a national resource, the dental schools can play an important role in this effort.

It is also important to recognize the more far-reaching consequences of the proposed reductions in the Department's health manpower budget. In the absence of institutional and other assistance programs many dental schools, particularly the private institutions, would be forced to raise tuition to unacceptably high levels. Such actions would compound the already serious problem of student indebtedness. An immediate effect of this consequence would be reflected both in the number of applicants to dental schools as well as in the economic and, possibly, the academic profile of those students who do pursue a career in dentistry. Recent data indicates there has already been a noticable decline (26 percent) in the number of applicants to dental schools since 1974. Of greater significance however, is the very real potential that growing student indebtedness will translate into higher health care fees and the establishment of practices in economically attractive areas - thus contributing to the twin problems of rising health care costs and geographic maldistribution of health personnel. In summary, the American Dental Association recommends a fiscal year 1981 appropriation of $70 million for schools of dentistry, medicine and osteopathy. This is approximately the same level as provided in the current year appropriation.

Student Assistance

The most recent information available to the Association indicates that a sizable majority of the more than 22,000 dental students require financial assistance to complete their education. It is reasonable to assume that both the absolute number of students seeking aid, as well as the level of assistance required, will grow in proportion to the anticipated rise in tuition rates. Between the academic years 1973-74 and

1979-80, for example, the average tuition increase at all dental schools exceeded 140 percent - with extremes as high as 200 percent. It is currently estimated that the annual dental student educational expense (exclusive of living costs) exceeds $12,000. The position of the Administration on this issue is one in which students are expected to assume an increasingly higher percentage of their educational costs. There is, it seems, an initial confusion between the needs of the students while in training and the exaggerated implication of high income following graduation. For dentistry, the Administration has also chosen to ignore the substantial cost to establish a practice; in this instance about $40-$50,000.

Federally insured loans are offered by the Department as the principal mechanism for health professions students to finance their education. In the opinion of the Association, this program as presently structured is so completely inadequate and unacceptable that it should not be considered as a viable student assistance authority - even as a supplemental source of aid. For this reason the Association urges a fiscal year appropriation of $28 million for Health Professions Student Loans.

National Health Service Corps Scholarships

The American Dental Association believes that a fundamental contradiction exists in the Administration's approach to the National Health Service Corps and its scholarship program. Corps scholarships are advocated at one level of HEW as a mechanism to address the problem of access to care. This contrasts with the position of another arm of the Department which suggests that these scholarships represent a student assistance program. We respectfully submit that it cannot serve both objectives. The dilemma which results from this duality is readily apparent when the following statistics are considered. It is estimated that the 1979-80 entering class of the 60 dental schools is in excess of 6,400 students, with a total dental school enrollment of approximately 22,000. According to the Department, approximately 185 new NHSC scholarships are available for dentistry this academic year. As should be obvious, this number of dental corps scholarships is woefully inadequate if the NHSC program is viewed as a student aid mechanism. Conversely, if the number of Corps scholarships allocated for dentistry were made equal to the

to the demonstrated financial needs of the dental enrollment, the number of graduates obligated to serve in an underserved area would be far in excess of the requirements of the National Health Service Corps program. In summary, the Association strongly recommends that the Department administer the National Health Service Corps as it was originally intended; namely as a temporary alternative until more permanent solutions can be found to remedy the problems of access to care. The actual number of Corps scholarships which are provided to dentistry should, in turn, reflect the present and projected need for dental personnel in documented shortage areas. Student aid should more properly be addressed within the context of direct loans, an improved guaranteed loan program, loan repayments, and scholarships for minority and other disadvantaged students.

Dental General Practice Residencies

Section 786 of the Public Health Service Act requires that not less than 10 percent of the amounts appropriated in each fiscal year for grants to Family Medicine and General Practice Dentistry shall be made available for dental residency training. These programs have been particularly effective in providing the future general practitioner with the skills and experiences necessary for the provision of comprehensive, primary dental care. For reasons which we fail to understand, the Administration is once again requesting the elimination of funds for this important program. Such action is particularly surprising in view of the Administration's stated emphasis on the need to increase the number of primary care practitioners. The Association accordingly recommends a continuation of support for Section 786.

Dental Research

The Administration's 1981 budget requests $70.4 million for the National Institute of Dental Research. Although this amount provides an increase over the current fiscal year, that increase is so minimal that it will not even approach the escalation in inflation which annually reduces the impact of the Institute's research dollars. In order to understand the importance of a strong federal dental research effort it is necessary to recognize two basic factors. The National Institute of Dental Research continues to be the major source of funds for the support and growth of dental research in this country. A conservative estimate

is that 85 percent of total dental research spending since World War II has come from NIDR. Unlike the medical community, there is little if any significant private funding for dental research at the present time. Therefore adequate federal support of the Dental Institute is not only desirable, it is absolutely necessary to continue the ongoing, productive research in dentistry. The second basic factor to be understood is the nature of dental disease itself. Most prevalent oral health problems are progressive and irreversible. For that reason, prevention is a key element in the dental research strategy. The extent to which successful preventive methods and technologies (such as fluoridation) can be identified and applied on a large scale basis is directly dependent on advances in basic dental research. This is the role of the National Institute of Dental Research.

The American Dental Association approves in principle the recommendations for increased dental research funding that have been proposed by the American Association for Dental Research. However, we wish to emphasize two additional areas that are of particular concern to us; namely, adequate funding for (a) the training of dental researchers and, (b) the support of clinical trials in those instances in which laboratory and animal data currently indicate or suggest significant advances if the research can be applied clinically.

With respect to funds for training researchers, there is a demonstrated need to increase the pool of candidates available for dental research. It has been estimated that approximately 120 people appropriately trained for research activities whether in D.D.S./Ph.D. programs, faculty research training or clinical research training, are required each year just to compensate for attrition. This does not take into account the very real need to also expand the research pool.

As to adequate support for the clinical research, the Association believes that efforts must be accelerated to transfer research results to the practice of dentistry. Promising trials under laboratory conditions cannot be transferred readily to clinical practice without the controlled clinical trial. There are a number of areas that require grant support for clinical research. This includes developments in the areas of dental caries and periodontal disease as well as nutrition, particularly as it relates to the cariogenicity of foods. Dental mate-

rials are also being developed which may serve as replacements for amalgam or as substitutes for gold. The latter area is very timely because of the recent rapid increases in the price of gold and silver. Without adequate clinical evaluation, wide need of these substitutes cannot take place.

Dental Disease Prevention

The American Dental Association commends the Administration's increased budget request for fluoridation project grants. The Department of Health and Human Services estimates that "the 1981 request will support expansion of fluoridated water systems to serve an additional 5.2 million people living in 423 communities and attending 194 rural school systems. The $9.6 million proposed could save as much as $480 million in dental care costs."

The U.S. Surgeon General recently described the importance of fluoridation in the following manner:

"Increased attention to the prevention of disease and to health maintenance can reduce much of the human suffering and expense that results from ill health. Fluoridation of a community's water supply is an excellent example of a disease prevention effort that can improve the health status of our Nation's citizens and reduce health care costs for children. Fluoridation is the most effective, least costly public health measure for preventing tooth decay - one of the most prevalent health problems, yet only three of every five persons who could be provided the benefits of fluoridation now receive them.

More than 30 years of research and community experience have demonstrated the benefits and safety of fluoridation. Tooth decay, the leading chronic disease in children, can be reduced by as much as two-thirds in children who drink fluoridated water from birth. Many of these children can be completely free of dental decay. Lifetime benefits can be derived from drinking fluoridated water and the cost of children's dental care can be cut in half. Extensive scientific research has uncovered no valid evidence that any health problem is caused or aggravated by drinking optimally fluoridated water."

Health Maintenance Organizations

The Department has requested $69 million for the support of HMOs in fiscal 1981. This is an increase of more than 100 percent since 1979 and represents the eighth year of federal assistance for this

health care delivery mechanism. Despite these subsidies, HMOs have visibly failed to achieve the level of public acceptance predicted by their advocates. At the present time there are still only 109 federally qualified HMOs, with a total enrollment of approximately 5.6 million people. Of particular significance is the fact that a sizable percentage of that enrollment is attributable to a single federally qualified HMO, the Kaiser Plans. If the enrollees of this program are subtracted from the total figure, the growth rate of Health Maintenance Organizations which meet federal standards is far from impressive. The Association believes that HMOs have been afforded more than an equal opportunity to demonstrate their viability in competition with the traditional private practice, fee-for-service delivery system. Further federal support cannot be justified and we respectfully recommend that no funds be appropriated for HMOs in the fiscal 1981 budget.

Statement of Public and Scientific Affairs of the American Society for Microbiology

The Board of Public and Scientific Affairs (BPASA) of the American Society for Microbiology (ASM) wishes to submit the following statement for the record in support of more funds for biomedical research and training conducted by the National Institutes of Health.

The American Society for Microbiology is a nonprofit educational and scientific organization dedicated to the promotion of scientific knowledge of microbiology and related subjects. The Society, with over 30,000 members, is the largest single life science organization in the United States. It embraces 16 subspecialty divisions and publishes eight scientific journals and numerous books. Underlying the Society's dedication to the advancement of scientific knowledge is its commitment that science serve the public interest.

The Board of Public and Scientific Affiars endorses the Administration's decision to stabilize investigator-initiated research projects awarded by the National Institutes of Health. This will greatly facilitate long-range planning and management of the national biomedical research effort. Although we agree in principle with the Administration's effort to stabilize individual research grants, we disagree with the level of stabilization and the distribution of funds among the institutes within NIH.

Perhaps one of the greatest problems in funding for biomedical research,

from a scientist's point of view, is the stop-and-go funding for individual institutes and programs. This method of funding often satisfies proponents of a particular disease, yet it does little to foster the continuity of medical research, which after all is interrelated and thus furthers our knowledge of all diseases, regardless of the title on a particular grant.

The American Society for Microbiology supported congressional attempts during the last few years to stabilize and to balance NIH funding among the various institutes and to fund the best science. Last year, Congress appropriated funds for NIH sufficient to fund about one third of all approved grants. Coupled with the goal of balance among the institutes was the idea of stabilizing funding for a certain number of new and competing grants each year for all of NIH.

During the past three years, 5,200 competing grants were funded by NIH in FY 1978, 5,944 in FY 1979, and a projected 4,768 in FY 1980 (for a three-year average of 5,304). The Appropriations subcommittees anticipated that appropriations for FY 1980 would fund 5,003, somewhat higher than the projected 4,768. Thus, stability still remains a problem.

The President's FY 1981 budget estimates funding 4,998 competing grants, 306 fewer than the average of the last three years. Additional funds for 306 grants would not assure stability, however, because the individual institutes rather than NIH as a whole are responsible for funding any particular grant. We contend, therefore, that each institute should theoretically be funded sufficiently to award the same number of competing grants as the average for the last three years for that institute. The President's FY 1981 budget would fund more than the three-year average in NIDR, NIAMDD, and NEI; about the same in NINCDS, NIEHS, and NIA; and substantially fewer in NCI, NHLBI, NIAID, NIGMS, and NICHD. An additional $68,152,000 is required to provide an additional 646 grants at those institutes receiving substantially fewer awards under the Administration's FY 1981 budget. This would bring the total competing grants to 5,644, with an estimated average award rate of 37 percent.

Our budget recommendations for research grants at NIH for FY 1981 are very close to those of the Delegation for Basic Biomedical Research. We differ only in minor aspects in attempting to stabilize competing investigator-initiated awards among the institutes. Ideally, we would prefer to hold each institute to the number of competing awards for any year, equal to their last three-year average. This is difficult, however, because each institute can justify easily an increase in the number of new awards on the basis of exciting developments and prospects in their various fields. This approach

seems to be the most equitable in these times of budgetary restrictions. We concur, however, that some adjustment should be made in the investigator-initiated competing awards funds for the Heart and Lung and Child Health institutes, as suggested by the Delegation. In addition, we recommend that NIAID be given $4,670,000 for an additional 58 competing grants over the Administration's request because of their low payline score in FY 1980 and their projected decrease in award rate for FY 1981. Clearly, any institute with a low award rate and low score payline is not funding a significant number of meritorious awards.

It is our hope that the approach outlined here will permit a competing award rate by each institute of no less than 35 percent, and preferably closer to 40 percent.

The President's FY 1981 budget includes no funds for the support of new and competing research training awards at NIH. In the short term, this will discourage young people from entering the research field, as it did in 1973, when there was a major cut in training grants. Although training grants were restored, the research community is still suffering from the effects of this policy. For example, we are now experiencing a shortage of clinical investigators in the biomedical research field. The perception that research is unstable will be reinforced by a sudden curtailment of funds for new and competing research awards. As in the individual research grant area, Congress should establish a policy of stability and predictability in research training. Without stability, young people will have no assurance of support through the full term of their training, i.e., three to five years.

One example will illustrate the disastrous effect for biomedical research of decreasing and destabilizing training support. The NIAID Study Group on Sexually Transmitted Diseases recently reported that there is a serious shortage of well trained new investigators in the entire field of sexually transmitted diseases and that research is being limited because of a shortage of experienced investigators. Similarly, NIH-wide, there are other pockets of extreme shortages of intellect and manpower which limit the search for new knowledge. How will the momentum of research generated in the past be sustained in the future without a cadre of bright young scientists? How will researchers be developed in areas of need and promise without training grants? One can assume that the quality and quantity of research will decline if training cuts are sustained.

The President's budget for research training at NIH reflects a continuation of the OMB policy to discontinue federal support for research training in the

basic biomedical sciences. If continued, this policy will entirely wipe out training in five years. The Administration's decision ignores congressional intent to continue support of those programs as evidenced in the National Research Service Act of 1974. Such a policy change should not be undertaken without proper review by Congress.

In FY 1981, training will be down 11 percent from 1979, representing a loss of 1,727 training positions. This reduction was necessitated by a congressionally directed stipend increase without a concomitant increase in funds. Dr. Fredrickson, NIH Director, told the Senate Labor-HEW Appropriations Subcommittee on February 5, 1980, in response to questions on last year's congressional directive to increase the number of trainees supported and their training stipends, that it was "not possible to increase stipends and maintain the same number of trainees."

It is estimated that the number of trainees will fall to approximately 9,470 in FY 1981. The ASM believes this is below the level to which training should not fall. It is not that we believe "more is better," but rather that there is a critical mass that must be sustained to keep the biomedical research effort seated and viable.

We recommend that there be established a stable base of support for research training until Congress and the research community gather more information on whether or not the cuts in research training will adversely affect the biomedical research effort in this country. We believe that the critical mass floor for trainees should be around 11,000 and recommend that the Congress appropriate money to stabilize the current number of trainees at around this number. The amount needed to stabilize at the current level and to allow an increase in stipends would be approximately $202 million, or approximately $38 million more than was requested by the Administration.

Although we support stabilization of individual investigator-initiated research grants, we would also argue for a strong program at NIH in contracts and centers. Otherwise, we run the risk of diminishing our ability to transfer the fruits of basic research technology to health care delivery. It is through contracts and centers that the knowledge gained in basic research is developed for the public good. The wisdom of emphasizing <u>either</u> developmental or basic research at the expense of the other escapes us. Both are important, but we need a balanced and stable program in order to obtain the most public benefit from our dollar. We recommend that Congress examine the decline in contracts and centers NIH-wide. In this area, the ASM is particularly aware of the problems of NIAID and can

address these to the Congress. Our perception, however, is that all the institutes are experiencing cutbacks and erosion of purchasing power in contracts and centers.

The National Institute of Allergy and Infectious Diseases (NIAID) is on the threshold of many opportunities or breakthroughs in basic research that will affect the delivery of medicine in this country. This new promise arises from exciting developments in the various facets of microbiology, such as basic research in molecular and cellular biology, bacterial and viral genetics, and a definition of regulatory processes that modulate the immune response. These new technologies, many now widely used in laboratory research, can be expected to yield significant advances in clinical medicine by the end of 1980 if funds can be made available for their exploitation.

Several NIAID objectives include the development through contracts of new vaccines against hepatitis B virus and the gonococcus, the improvement of existing vaccines such as the rubella vaccine, and the development of new antiviral drugs such as interferon. Through contracts, clinical trials are also done at centers to determine the safety and efficacy of these drugs.

The basic research that is coming forth now from NIAID laboratories is being applied through clinical research in centers by developing new therapies for immunologic diseases.

NIAID-supported research through contracts and centers is at the threshold of significant breakthroughs because of new recombinant DNA and hybridoma technology. These two techniques illustrate research supported by NIAID which shows promise of exciting opportunities for the health care delivery of the nation.

The following are five examples of work funded by NIAID contracts and centers programs which we believe would be of interest to this Subcommittee:

- Hybridoma. More funds are needed to develop a stabilized hybridoma capability for producing antibodies essential to research on health and disease.

- Histocompatibility, antigens, and antisera. More funds are needed to develop cells and classifying sera used to determine the role of antigens in transplant survival and disease susceptibility and to provide needed reagents for manipulation and mastery of the immune system. The research is right on the threshold of breakthroughs. This includes lupus and chronic allergic diseases.

- Vaccines. More funds are needed for the development of vaccines now in various stages, such as the vaccines against gonococcus, hepatitis B virus,

and the more effective live flu vaccine. Robert M. Channick, Ph.D., in the NIAID Intramural Program, is able to manipulate through recombinant DNA activities the genome of the virus (develop a master strain which reflects the antigens that are constantly being changed, which is why we have a new flu epidemic each year). If Dr. Channick is successful in developing the master strain, we will have an antigen against all flu viruses. With support now, it is possible we could have this breakthrough within the next five to ten years.

• Antiviral drugs. More funds are needed to conduct controlled clinical trials with new drugs, such as Acyclovir against herpes viruses, and to develop interferon against viral infections.

• Recombinant DNA risk assessments. More funds are needed to test the capacity of Escherichia coli strains containing foreign DNA to colonize the gut, cause illness, transmit foreign DNA to indigenous flora, and spread illness from person to person.

We, therefore, recommend the addition of $3,390,000 to fund an additional 25 contracts (or only five more than in FY 1980) at NIAID, and of $1,060,000 to permit continuation of eight centers at NIAID. This would provide stability for NIAID's contracts and centers programs and would permit this vital research development to continue.

We appreciate this opportunity to present our views on the FY 1981 appropriations for the National Institutes of Health.

STATEMENT OF ORA M. ROSEN, M.D., PROFESSOR AND CHAIRMAN, DEPARTMENT OF MOLECULAR PHARMACOLOGY, ALBERT EINSTEIN COLLEGE OF MEDICINE

My name is Ora M. Rosen and I am chairman of the Department of Molecular Pharmacology at the Albert Einstein College of Medicine. My principal area of interest is in the fundamental mechanisms of hormone action and the basic causes of Diabetes mellitus. My curriculum vita is enclosed. I appreciate the opportunity to submit this written statement concerning the program of the National Institute of General Medical Sciences and its importance to biomedical research and research training. By supporting non-categorical research, the National Institute of General Medical Sciences maintains the bank of basic knowledge upon which medical applications rely. Unlike purely technical feats such as putting a man on the moon, medical advances depend absolutely upon fresh ideas, clues and observations that arise quite unpredictably from basic research. It is particularly important to reemphasize the value of genuine basic research now that there are dramatic examples of applied research such as the generation of monoclonal antibodies by hybridoma cell lines and the utilization of recombinant DNA technology to synthesize human insulin, growth hormone, and interferon. Certainly not even the most astute biologist would have predicted that the fundamental studies of bacterial genetics or the development of methodology to grow mouse myeloma cells would have led so directly and in such short time to the dramatic developments cited. All the more reason for continuing to support the basic research upon which all the applications are based. At my own institution, the National Institute of General Medical Sciences is supporting research programs devoted to subjects as diverse as the genetic control of cell growth and development, the genetics of protozoa and the development of yeast membrane mutants - programs designed to elucidate basic mechanisms of regulation and control in a variety of living forms ranging from 'simple' bacteria, protozoa, yeast and molds to complex mammalian cells. It can no longer be considered outlandish to imagine that an important clue to understanding cancer cells could come from investigations of membrane function in yeast or bacteria.

The role of the National Institute of General Medical Sciences in supporting research training is of equal importance. Most of my colleagues and I were supported either as graduate students or after attaining an M.D. or Ph.D. degree by fellowships granted by the National Institutes of Health. This support enabled us to pursue training in biomedical research and to ultimately become the teachers of another generation of students supported by the training program of the National Institute of General Medical Sciences. In the pharmacological sciences, where my interests reside, this support enables us to train young people to investigate mechanisms of drug action and to ultimately use this information to develop new and better therapeutic agents. It permits students to develop the professional expertise to detect, monitor and protect society from the toxicological by-products of industrialization. In addition to its support of Ph.D. training, the National Institute of General Medical Sciences has, for years, sponsored a program which I consider one of the most important training programs in the country, namely, the Medical Scientist Training Program. The program encourages outstandingly talented college graduates to obtain both clinical and basic research training with the ultimate acquisition of both M.D. and Ph.D. degrees. Graduates of these programs have already begun to people the faculties of medical schools across the nation - bringing with them sophisticated approaches to medical problems and concern for improving health care. Through the years, my most creative students have been supported by this program and although they worked in areas of fundamental biochemistry and cell biology in my laboratory, they are beginning their 'combined' careers as medical scientists by tackling problems of human disease such as immunological deficiency states and Diabetes mellitus.

By supporting research training and fundamental biomedical research, the National Institute of General Medical Sciences uniquely sows the seeds for the next generation of biomedical scientists and teachers. This institute has not been seduced by fads of quick applications; its long-term goals deserve your serious support.

STATEMENT OF DR. ROY C. PAGE, DIRECTOR, DENTAL RESEARCH INSTITUTE OF THE WARREN G. MAGNUSON HEALTH SCIENCES CENTER, UNIVERSITY OF WASHINGTON

Mr. Chairman, my name is Dr. Roy C. Page. I am Director of the Dental Research Insitute of the Warren G. Magnuson Health Sciences Center, University of Washington, Seattle. I am also Professor of Pathology in the School of Medicine at the same institution.

Today I am representing the American Association for Dental Research (AADR). We appreciate having the opportunity to present testimony on the implications of the Administration's proposed Fiscal 1981 budget for the National Institute of Dental Research (NIDR). We respectfully request that the full text of our testimony be included in the record.

The membership of the AADR includes over 3,300 scientists from numerous basic and clinical science disciplines located across the United States in universities, research institutes, hospitals and industrial laboratories. These scientists have a common aim -- that is to successfully carry out a concerted multidisciplinary attack on the major diseases affecting the teeth, the mouth, and the orofacial region of the body. We are pleased to make our organization, which is headquartered here in Washington, and its resources available to the Members and staff of the Congress. We have come to understand that, without information as to what is being done in the dental research community, as well

as what can be done, Members can be left to make judgments without an underlying basis of information.

The focus and significance of dental research are often misunderstood. It is important to note that the dental research community is an integral and important part of the national health research effort. Progress in our area of responsibility contributes to and is dependent upon programs in general biomedical research. Although frequently not perceived as such, dental diseases are important. In one way or another they affect virtually every American. We will spend a minimum of $14 billion on dental care in 1981. In spite of this, over 24 million Americans are totally without teeth because of oral diseases; over 127 million Americans have periodontal disease, and dental decay is at least equally prevalent. We have neither the manpower nor the resources to control these diseases through treatment. The National Institute of Dental Research, which has been charged by the Congress to reduce and, where possible, to eradicate oral and dental disease, remains the smallest of the institutes at a budget of approximately $68 million and without substantive growth since 1973.

It is significant that at the present time, less than one-half of one percent of the total cost of dental care in America is spent on research. It is the position of our Association that a major investment in basic and clinical research, leading to cost-effective means of prevention and control, provides the best approach by which to deal with these problems. This investment can produce a substantial return to the American public and ultimately reduce government subsidization of dental care.

We will provide evidence that (a) a large and productive cadre of well-trained scientists now exists and (b) the fund of basic scientific knowledge, although not complete, is sufficient for direct application to management of some of these diseases.

In the mid 1960's the National Institute of Dental Research initiated programs aimed at providing superior training for individuals interested in careers in dental research, and attracting first-rate scientists to work on dental disease problems. Research programs were directed toward basic, in contrast to clinical, problems. These efforts flowered during the decade of the 1970's, during which numerous advances in our basic understanding of caries and the periodontal diseases were made. During the same decade, few clinical scientists were trained and we had only minimal clinical research activity. There were two reasons for this. First, our fund of basic science knowledge was inadequate to sustain major clinical research efforts and secondly, there were but few training programs to produce clinical

investigators. A large and rapidly growing body of basic information now exists. In the areas of caries and the periodontal diseases and to almost the same extent in other areas, the information is sufficient to warrant major efforts at clinical application. Recent developments in the field of the periodontal diseases serves as an illustration.

The chronic periodontal diseases are the main cause of tooth loss in adults. In these diseases, the gum and bone tissue around the teeth are destroyed and the teeth must be extracted. Until recently we did not know the cause. It is now clear that these diseases are infections and that, at least in many cases, hereditary factors make individuals and families susceptible. The bacteria involved are gram-negative and anaerobic (cannot live in air), and they are highly susceptible to antibiotics. In the majority (probably greater than 80%) of young children, teenagers and young adults with moderate to severe periodontitis, some of the white blood cells (the neutrophils and monocytes) are defective. These defects make the individuals prone to periodontal diseases. These defects can be detected by use of a laboratory test of cell movement. Information now available indicates that the defects are transmitted in the genes from parent to offspring. Although the types of patients with these defects probably comprise only a minority of the periodontitis patient population, their importance extends far beyond their numbers. They are the patients who lose most or all of their teeth at a young age and require dentures or very expensive specialized treatment throughout their life.

The limited clinical observations which have been made so far indicate that periodontitis in individuals with white blood cell defects is unusual in that it is rapidly destructive and it is remarkably responsive to simple treatment methods such as administration of antibiotics and tooth cleaning. Whether or not this is the case can be determined by clinical research of the type for which we are asking support. If the preliminary observations hold true, teeth can be saved in many individuals who would otherwise lose them, the cost of treatment can be reduced significantly, and the treatment methods can be simplified greatly. We have the knowledge now to develop diagnostic units where individuals with severe periodontitis can be subjected to white blood cell testing, analysis of pocket bacteria with determination of antibiotic sensitivities, and development of an appropriate rational treatment plan.

It should be stressed that the area of the periodontal diseases has been used only for illustrative purposes. An equally strong case can be made for many other aspects of dental research. The current state of our basic science knowledge and the need to increase it further, combined with the low level of

our clinical research activity, are central to our request for significant increases in the NIDR budget. In order to achieve the mission assigned by the Congress, we believe that significant increases must be made in some parts of the budget of the National Institute of Dental Research. Our specific recommendations are as follows:

1. CLINICAL RESEARCH SUPPORT PROJECTS (CRSP)

Currently there are few existing sites where clinical dental research can be performed to the fullest extent. In order to assess and extend the technologies derived from a substantial base of biomedical information, it will be necessary to develop organized and concentrated clinical research units. These units should evaluate the effectiveness of established dental therapies and should determine, develop, and test the effectiveness of new clinical approaches to diagnosis, cure and prevention of dental disease.

These projects will enhance an assortment of clinical research in the fields of dental caries, periodontal diseases, dental materials science, nutrition, and behavioral science. These clinical dental research projects would be coordinated in order to perform independent as well as collaborative research with similar unit projects. Since these projects will be located with an appropriate geographic distribution, it will be possible to assess laboratory-derived technology from a variety of different populations. The following list provides examples of the kinds of research which can be done.

- Testing of dental materials to replace gold, which currently costs more than $600 per ounce.
- Determining the cariogenic potential of foods.
- Testing of replacement of decay-producing bacteria with mutant strains of non-decay-producing bacteria.
- Characterizing bacteria associated with periodontal disease.
- Evaluating diagnostic indicators on patients with altered white blood cells who are susceptible to periodontal disease.
- Testing of laboratory-derived micorbiologic data in the context of diagnosis and prevention of caries and the periodontal diseases.
- Assessing efficacy of various periodontal therapies on defined groups of periodontal disease patients.
- Developing testing methods to determine the cause of chronic facial pain.
- Testing for effective orthodontic and surgical procedures to repair damage caused by traumatic injuries, cleft palate and cleft lip, and inherent facial disfigurement.
- Evaluating systems to repair jaw defects using donor bone and the patient's own bone.

Development of the nation's clinical dental research potential will require new resources. We recommend funding of ten Clinical Research Support Projects (CRSP) for a period of five years. This period of time should be sufficient for the development of results and trained clinical personnel to allow for a transition from project grants to individual investigator-initiated clinical projects (ROIs). For purposes of management and coordination of effort, five projects should be initiated in 1981, three projects in 1982 and two in 1983. Each unit would require a different, but appropriate, combination of clinical dental researchers, epidemiologists, behavioral scientists, statisticians, and auxiliary personnel. Some of the necessary requirements would include dental clinical units, data processing capability and a patient management system for ambulatory care.

The initial minimum cost for the first year would be $450,000 for each project. The subsequent four years should average approximately $350,000 in constant dollars per project. The appropriation necessary for the initiation of five projects for 1981 would be $2,225,000 (see Table I).

2. TRAINING

We recommend a modest increase in funds for training to a total level of $5 million. Three training initiatives are worthy of special emphasis. Support should be provided for the DDS/PhD programs, dental faculty research training and clinical research training fellowships.

3. INDIVIDUAL INVESTIGATOR INITIATED PROJECTS (ROIs)

We recommend a budget of $32,809 million. This would provide for 5% growth and 13.4% for inflation. In addition, the grant period should be extended from three to five years where possible, in order to stabilize "roll-over" and reduce the number of unfunded high priority grants. Funding longer range projects will also lend stability to research efforts and the community of established investigators.

4. CLINICAL PERIODONTAL CENTERS

Three Clinical Periodontal Centers have been established and are now in operation. These were initially underfunded, and they remain so. We recommend a budget of $2.270 million, which would permit funding of the existing Centers at a level of approximately $450,000 and provide for establishing one additional Center.

5. DENTAL RESEARCH INSTITUTES

NIDR established five dental research institutes in 1967-68. The purpose of this program was to create centers of excellence where scientists from a broad spectrum of basic and clinical disciplines could be drawn together for a

multidisciplinary research effort. The Institutes Program is scheduled for formal evaluation during the coming year. The Institutes have received no increase in budget for more than five years, and they are currently being forced to cut back in programs, in research, and in professional personnel. We recommend an increase over the present 1980 budget of $2.5 million for a total budget of $10.476 million for the Institutes Program.

6. INTRAMURAL RESEARCH

Various review bodies have recommended that the clinical research component of the intramural research program be strengthened. In response to these recommendations, a new Clinical Director has been recruited and is now on board. We recommend a budget of $14.835 million, which would permit creation of two new clinical positions and offset inflation.

7. INSTRUMENTS AND EQUIPMENT

Funds for major items of equipment have been extremely limited for over half a decade. During this time there has been a revolution in research methodology. A survey has revealed that much of our equipment is outdated and worn out. This is especially true for the Dental Research Institutes and Centers. We recommend addition of approximately $3.5 million to the NIDR budget to permit retooling and updating of the nation's research facilities.

Table I

AMERICAN ASSOCIATION FOR DENTAL RESEARCH BUDGET RECOMMENDATIONS FOR FISCAL 1981

	Millions
Clinical Research Support Projects (CRSP)	2.250
Training	5.000
Individual Investigator Initiated Projects (ROIs)	32.809
Clinical Periodontal Centers	2.270
Dental Research Institutes	10.476
Intramural Research	14.835
Instruments and Equipment	3.500
Contracts	5.048
Direct Operations	6.539
Program Management	1.380
Other	1.606
TOTAL	85.713

AMERICAN ASSOCIATION FOR DENTAL RESEARCH BUDGET RECOMMENDATIONS FOR FISCAL 1981

	Millions
CLINICAL RESEARCH SUPPORT PROGRAM (CRSP)----------	2.250

Provides for establishing five clinical research program projects aimed at (1) assessing and extending the technologies derived from our base of biomedical information, (2) evaluating efficacy of established therapies, and (3) development of new approaches to diagnosis, cure and prevention in the fields of dental caries, periodontal diseases, materials science, nutrition and behavioral science.

INDIVIDUAL INVESTIGATOR-INITIATED GRANTS (RO1s)----------	32.809

Provides for 5% growth and offsets inflation.

DENTAL RESEARCH INSTITUTES----------	10.476

The five research institutes have had no budget increases in over five years; they are now being forced to cut back in programs, research and professional personnel.

CLINICAL PERIODONTAL CENTERS----------	2.270

Three centers were established and one additional one is needed. All were badly underfunded initially and remain so. Funds would permit increased funding to approximately $450,000 for existing centers and establishment of one new one.

TRAINING----------	5.000

Three initiatives are worthy of special emphasis: support for DDS/PhD programs, Faculty Research Training Programs, and Clinical Research Training Fellowships.

INTRAMURAL RESEARCH----------	14.835

NIDR has a new clinical director and is launched on a program to increase the level of clinical research.

EQUIPMENT AND INSTRUMENTATION----------	3.500

Funds for equipment have been extremely tight for almost a decade. During this time, there has been a revolution in research methodology. Requested funds will permit updating and retooling of the nation's dental research capabilities.

CONTRACTS----------	5.048
DIRECT OPERATION----------	6.539
PROGRAM MANAGEMENT----------	1.380
OTHER----------	1.606
TOTAL	85.713

STATEMENT OF DR. BORYS SURAWICZ, F.A.C.C., ON BEHALF OF THE AMERICAN COLLEGE OF CARDIOLOGY

I am Dr. Borys Surawicz, Professor of Medicine and Director, Cardiology Division of the University of Kentucky College of Medicine in Lexington, Kentucky. I am also President of the American College of Cardiology; it is this latter capacity that I present this testimony today.

The American College of Cardiology is a professional medical specialty society representing more than 10,000 specialists in heart disease, circulatory disorders, and other related diseases. We appreciate the opportunity to present before this important Committee our views concerning the FY 1981 appropriations for the National Heart, Lung, and Blood Institute and the National Library of Medicine.

National Heart, Lung and Blood Institute

The primary mission of the National Heart, Lung, and Blood Institute is to conduct, develop, and support programs which have as their ultimate objective the prevention of cardiovascular, pulmonary, and blood diseases. Disease prevention is dependent upon the development of research knowledge and successful application of these research advances. This is the ultimate goal of the Institute and much of our immediate attention must be focused on the support of research projects aimed at developing new and improved means for controlling these diseases and those already affected. However, neither disease prevention nor its treatment can be successfully achieved without a thorough understanding of the basic etiology and pathophysiology of the disease and its identifiable risk factors. Thus, the NHLBI has pursued its primary goal of disease prevention by initiating basic and clinical research projects that lead to the development of working hypotheses. These hypotheses are then tested and evaluated in clinical trials. The results of these tests form the new knowledge disseminated to the public by the Institute's Prevention, Education, and Control programs.

The knowledge attained during the past 30 years has led to tremendous advances in combating cardiovascular diseases. These advances continue at an undiminished rate. For instance, recent

studies supported by the NHLBI have shown an important relation between the level of high density lipoprotein (HDL) in the blood to the risk of coronary heart disease. The higher the level of these substances, the lower is the risk of disease. Recent biomedical evidence suggests that this protective effect of HDL may be caused by its ability to remove cholesterol from arterial walls or to prevent it from being stored within this wall. This new concept stemming from basic research, offers a potential for development of new rational types of treatment and prevention of coronary heart disease. Other NHLBI studies have resulted in: the design of new support devices to help the heart maintain its pumping function during the acute period just after a heart attack; the further development of coronary bypass surgery; and the use of radioactive isotopes in evaluations of the state of the heart muscle and in assessment of the heart's effectiveness in pumping blood. These are just a few of the developments that have resulted from NHLBI-supported research.

In the area of new technology and applied research, cardiac pacemakers should be singled out as devices that increase life span, and improve lifestyle in many thousands of people each year. These devices have been undergoing continuous technological improvements that increase their usefulness and affectiveness.

In the area of epidemiology, long-term population studies have enabled scientists to identify high blood cholesterol, elevated blood pressure, diabetes, and cigarette smoking as proven independent risk factors associated with coronary disease.

Equally important is the manner in which the Institute has developed, pursuant to Congressional mandate, the capability of translating the new knowledge into extremely effective prevention programs. One such program, the National High Blood Pressure Education Program, is designed to educate physicians, patients, and the general public about blood pressure and other identifiable risk factors of coronary disease. The following data documents the effectiveness of the basic research and clinical programs of the Institute:

1. Since 1972, the percentage of hypertensive persons unaware of their condition has dropped from 49% to less than 25%.

2. Patient visits for hypertension have increased by 50% since 1971.

3. The number of hypertensive patients in whom blood pressure is effectively controlled has increased by more than 100%.

4. The average blood cholesterol level of the male population has decreased over the past several years, and there is evidence that this is causally related to a substantial change in the dietary intake effect.

At the present time, the Institute is initiating efforts to expand the important education and control programs to combat hypertension and other risk factors (efforts which will be frustrated in the absence of substantially increased funding for the NHLBI).

The success of the NHLBI in meeting your mandate can be documented in numbers as well. Largely due to the Institute's comprehensive program of activities from basic biomedical research and clinical trials to education and disease control activities, the national cardiovascular mortality rate has decreased over 30% in the last 25 years. Cardiovascular mortality has fallen by over 10% in every adult age grouping, in both sexes, and in both majority and minority populations. The impact is made even more dramatic when one considers the statistic that in 1977 alone, there would have been 300,000 more cardiovascular deaths than the number that actually occurred.

Life expectancy in the United States has increased during the past three decades by nearly 15 years. A significant portion of this increase in life expectancy can be attributed to the decline in cardiovascular death rates, a decrease that is almost double the pace of deaths from other causes. The American College of Cardiology would like to acknowledge that you, as members of this Committee, are in large measure responsible for these advances, for you have authorized and supported these programs.

The acknowledgment of the above achievements and documented successes should not let us forget the grim statistical fact that cardiovascular disease still leads all other causes of death in the United States. Each day, heart attacks strike 3,400 and stroke, another 1,600 Americans. An estimated 35 million Americans have hypertension, a major risk factor of both heart

attack and stroke. Most important to note, is that, of the ten leading causes of death in the United States, four are within the domain of the NHLBI: heart disease, stroke, major lung disease, and generalized arteriosclerosis. These problems must be attacked with undiminished vigor by the Institute, and we offer the following recommendations regarding the FY 1981 Labor-HEW Appropriations bill as a means of assuring that the ability of the NHLBI to meet this Nation's mandate is promoted to the maximum possible extent.

The great progress that has been made in combating cardiovascular diseases has been the direct result of the wise and frugal investment of this Committee during the past decade. However, this pattern of substantial support was partially reversed last year. In considering FY 1980 NIH Appropriations, the House Labor-HEW Appropriations Subcommittee settled on a formula for funding the same payline in each Institute at NIH. As you are by now aware, the NIH supplied the Appropriations Committee with raw score data for the NHLBI and normalized score data for most of the remaining Institutes. Had NHLBI normalized scores been used, the results in funding under the formula established would have resulted in $12.0 million more than the $527.4 million appropriated. In FY 1980, the Institute will only be able to fund 24% of its approved investigator-initiated research grants; I should note that, the Institute was funding over 40% of its approved grants three years ago and over 60% six years ago. This year, the NHLBI will be able to support no new clinical trials, and no increase in support for its National Research and Demonstration Centers or its Specialized Centers of Research.

The Administration proposed for FY 1981 an appropriations level of $548 million. Under this proposal, the NHLBI could fund only 20% of its approved grants, could support no new institutional or individual training grants, and could support no new manpower development programs. We deem this approach to health research funding totally inadequate.

The American College of Cardiology recommends that $627 million be appropriated for the National Heart, Lung, and Blood Institute in FY 1981. Although our detailed fiscal recommendations are reflected in the attached table, the American College of Cardiology would like to emphasize some of the accomplishments which would be made possible by funding at our recommended levels.

The NHLBI would be able to fund about 33% of its approved investigator-initiated research grants, a very modest rate of funding when considered in the context of recent years. Specifically, the Institute would initiate and expand its research activities in the following priority areas: The Role of Salt and Water in the Pathogenesis of Hypertension; Longitudinal Studies of Coronary Heart Disease Risk Factors in the Young; Migration and Culture Change in Relation to Coronary Heart Disease; Studies on Efficacy of Combinations of Biobehavioral and Pharmacologic Treatments of Essential Hypertension; and Behavioral Studies of Prevention Techniques.

Funding at our recommended levels would allow also a modest expansion of Arteriosclerosis Specialized Centers of Research (SCORs), the conduct of clinical trials in Systolic Hypertension in the Elderly, and of the "Effect of Selected High Priority Platelet Active Drugs on Mortality and Morbidity during the First Three Months Following Myocardial Infarction."

The American College of Cardiology is particularly concerned with the precarious state of manpower training in the Federal biomedical research community. Within the constraints of available resources, the NHLBI has been dedicated to training more investigators in research areas related to cardiovascular, pulmonary, and blood diseases. The Administration's budget request would provide for the funding of no new institutional or individual training grants or awards. The College believes that this would be injurious to the future of cardiovascular research. In recent years, the number of trainees entering research training has declined. We believe that this has been caused by uncertainty in funding, by the burdensome regulations in the National Research Service Awards Program, and by the insufficient stipend support which is totally non-competitive with comparative private sector salary levels.

We applaud the Congress for having alleviated, in Public Law 95-622, some of the burdensome aspects of the National Research Service Awards Program and for authorizing the Secretary of HEW to increase stipend support. But, this Committee must be aware that, despite the fact that the mandate of the National Heart, Lung, and Blood Institute has been substantially expanded

during the past decade, the number of trainees in the heart and vascular disease area has decreased from 1,111 in 1972 to 857 in 1978. Even more significantly, the number of trainees who are clinical investigators (i.e., trainees with an M.D. degree) has declined by two-thirds during that same period.

The American College of Cardiology is firmly committed to the proposition that a high-quality National Program directed toward the prevention of cardiovascular, pulmonary, and blood diseases requires the support of research training and manpower development. The dramatic improvement in the care of patients with cardiovascular diseases, i.e. saving more than 300,000 lives per year, is a result of your investment in developing young physician investigators. The need for trained scientists has grown well beyond that required for replacing senior colleagues who retire or move into other endeavors. It is nearly certain that a fiscal neglect of training today will spell disaster to the biomedical research community tomorrow. Providing training that will enable the next generation of biomedical scientists to build upon knowledge required in this decade is the best available investment for the maintenance and protection of future medical science. Accordingly, we recommend that the National Heart, Lung, and Blood Institute be afforded sufficient funding to provide for a modest 10% increase in the number of full-time equivalent trainees.

Funding at our recommended levels would also enable the Institute to continue its vital clinical research training activities; these manpower development programs are afforded no new support under the Administration's FY 1981 budget request. Three years ago, the Institute introduced the Minority Hypertension Research Development Summer Program to foster the recruitment and development of minority health manpower to work in areas of research related to hypertension. Since that time, the NHLBI has initiated Special Emphasis Research Career Awards, Preventive Cardiology Academic Awards, and Clinical Investigator Awards. The development of research manpower in the future is mandatory if today's research results are to be translated into prevention of heart disease tomorrow. Thus, it is imperative that this Committee strongly counteract the Administration's intent to phase out these programs.

In a recent Presidential Proclamation, President Carter declared the month of February, 1980 as American Heart Month. In the proclamation, credit was given to the National Heart, Lung, and Blood Institute for its National effort to reduce illness, disability, and death from heart diseases through nationwide programs of biomedical research in the cardiovascular field, training of research personnel, and information and education programs for health professionals and the public. President Carter also invited Congress and the Nation to join him in reaffirming our commitment to the search for new ways to prevent, detect, and control cardiovascular diseases in all its forms. The American College of Cardiology believes that the FY 1981 appropriations bill represents the most important opportunity for this Committee, as our country's pre-eminent health policy makers, to reaffirm your commitment and support for the National Heart, Lung, and Blood Institute by adopting our FY 1981 appropriations recommendations.

National Library of Medicine

The mission of the National Library of Medicine is to assist the advancement of medical and related sciences to the collection, dissemination, and exchange of information important to the progress of medicine and health. As medical science yields research knowledge, medical and scientific literature have proliferated. Over the past decade, the National Library of Medicine has been faced with a vast growth in the volume of literature (110% over a ten-year period), and a very significant increase in the demand for basic library services such as interlibrary loans, reader requests, serials, monographs, and reference inquiries processed. On-line searches of our data bases, a service vital to the advancement of medical research, has risen to more than one million per year.

This Committee has supported the construction of the Lister Hill Center Building from the outset. However, there is a need to fully exploit the potential of this remarkable facility. This structure will house the research programs of a library and will be involved in conducting research and development to improve the transfer of health information. Funds are needed for equipment and positions to develop in-house

multi-disciplinary expertise in computer and communications technology. Among the most critical problems facing the NLM is adequate staffing to perform the aforementioned mission. The functions and services of a library are largely labor-intensive and require sufficient personnel to acquire, organize, and disseminate biomedical literature. Fulfillment of basic library services is in jeopardy because personnel levels have fallen below the Fiscal Year 1968 level. In order to maintain the high quality service for basic library operations, the NLM is in need of additional personnel and cost-of-living increases for current staff.

This Committee has indicated its desire to assure the expeditious transfer of research results "from bench to bedside." The NLM is in a unique position to facilitate this objective. The library assists health institutions in providing information to practitioners, researchers, faculty, and students. This is accomplished through the Medical Library Assistance Program which provides grants and contracts to the library community and the biomedical research establishment. We support additional funding for a recently developed research effort to study and evaluate advances in computer sciences that have potential application in biomedical communication.

Given the current rate of inflation, the Administration's budget for FY 1981 represents a 10% reduction below the 1980 budget level. The inflationary rates for libraries exceed the nationwide inflationary rate particularly for such items as the cost of acquiring literature (estimated to be about 20% a year) and the even greater inflationary rate for obtaining foreign literature resulting from the declining purchasing power of the dollar. Accordingly, in order to maintain and further develop the information programs of the NLM and to provide for the increase of 30 staff positions, the American College of Cardiology recommend that $49.2 million be appropriated to the National Library of Medicine in FY 1981.

CONCLUSION

Mr. Chairman and distinguished members of this Committee, on behalf of the American College of Cardiology,

I wish to express our deepest gratitude for your having invited us to present our views on this important subject. If we can provide you with any further information or documentation regarding our recommendations for the National Heart, Lung, and Blood Institute and the National Library of Medicine, please let us know.

Thank you.

FY 1981 APPROPRIATION RECOMMENDATIONS

OF

THE AMERICAN COLLEGE OF CARDIOLOGY

National Heart, Lung, and Blood Institute

	Administration FY 1981	ACC FY 1981
Research Grants	365,100,000	432,700,000
(includes Research Centers, Research Career Awards, Clinical Research)		
Training	31,029,000	34,409,000
Intramural Research	42,777,000	42,777,000
Research and Development Contracts	77,246,000	85,246,000
Direct Operations	26,459,000	26,459,000
Program Management	5,788,000	5,788,000
TOTAL	548,399,000	627,379,000

STATEMENT OF DR. EFRAIM RACKER, M.D., PROFESSOR OF BIOCHEMISTRY, ALBERT EINSTEIN COLLEGE OF MEDICINE

I appreciate the opportunity to submit a statement on behalf of the National Institute of General Medical Sciences.

It is my deep conviction that advances in basic science are not only essential for progress in the cure of organic diseases but that they are our only hope for better control of pain, crime, and mental and social disorders.

I started out as an M.D. interested in clinical medicine and particularly psychiatry. I was an intern and resident in medicine and I am licensed to practice medicine in the State of New York. Yet for the past 35 years I have not taken advantage of this privilege because I feel that I can make a greater contribution to society by doing basic research in biochemistry. I am now Professor of Biochemistry at Cornell University. I would like to illustrate how the basic research I am doing may help in the understanding and cure of diseases.

It was discovered over 50 years ago that tumor cells ferment sugar more rapidly than most normal cells. The end product of this fermentation unfortunately (or rather fortunately) is not alcohol but an acid - lactic acid. For many years we have analyzed the reason for the rapid fermentation. Finally, we discovered, at least in some of the tumor cells we had examined, that the membrane of tumor cells contains a leaky pump. The pump of normal cells which expells sodium and imports potassium is a very efficient machinery. In tumor cells, however, a great deal more energy is spent and wasted for this process, thereby creating conditions which accelerate sugar fermentation. Recently, we have isolated the pump from tumor cells and have analyzed it in a test tube. Again, we observed that it is inefficient and we found drugs (in plants) which repair the leak. We may soon be in a position to determine whether or not the leaky pump is relevant to the malignant properties of tumor cells. Perhaps it is not; perhaps the leaky pump is secondary to some other changes in the membrane that are relevant to malignancy. Nevertheless, the leaky pump is a clue that may eventually lead us to the primary defect that transforms a normal cell into a tumor cell. Moreover, by comparing the pathological pump from the mouse tumor with a normal pump which we have isolated from the brain of the same mice, we gather information that will tell us how the normal cell achieves the remarkable efficiency it has. This may someday help us to understand why patients with cystic fibrosis have changes in sodium balance or why in some kidney diseases sodium absorption is damaged. Let me remind you of the story of chlorpromazine, a drug which revolutionized psychiatry and has saved us billions of dollars. The history of chlorpromazine started with a search for a cure for malaria, led to its use in surgical shock and finally was discovered to cure some mentally disturbed patients.

While we were analyzing the leaky pump in tumor cells and trying to repair it so that fermentation of sugar would slow down, a new idea occurred

to us. Perhaps we could take advantage of the fact that all malignant tumors produce a lot of acid. Although the tumor cell makes acid it does not tolerate it and therefore contains another pump which excretes the lactic acid. We decided to study the properties of this pump and to look for drugs that may block it. Since tumor cells make much more acid than normal cells such a drug should kill tumor cells before it kills normal cells. We are now analyzing the basic properties of the pump which excretes acids and we are also synthesizing drugs which we hope will block the action of this pump. We have already made some chemicals which are effective in the test tube, but some are not stable enough when injected into animals and some are too toxic. But we have a simple test-tube assay which allows us to evaluate many drugs rapidly. During all these attempts we are guided by the knowledge of chemistry and biochemistry that has accumulated in the past because of basic research.

I know that most members of Congress believe in the importance of basic research but the eternal question is how much support is enough. What guidelines can you use? My answer is a simple one and is contained in the report of the Director of the National Institute of General Medical Sciences. As long as we are unable to support highly meritorious applications for research, I believe we are not using our potential of basic research exploration. As long as a bright, young student is turned off from entering the field of basic research because he is told he will find it difficult to get a job, we are jeopardizing the future health of our nation.

Of course, there is always the question of priorities. But as long as we spend vast amounts of money for luxuries such as large cars, snowmobiles, cigarettes, and liquor, we should be able to spare enough to keep our research moving with the times.

STATEMENT OF DR. LEON RESNEKOV, F.C.C.P., PRESIDENT, AMERCIAN COLLEGE OF CHEST PHYSICIANS

I am Dr. Leon Resnekov, President of the American College of Chest Physicians. I am also Professor of Cardiology, University of Chicago School of Medicine. I am submitting these views for the record on behalf of the American College of Chest Physicians (ACCP).

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 1981 Appropriations for the National Heart, Lung, and Blood Institute and the pulmonary activities of the National Institute of Allergy and Infectious Diseases. As you will note in the statement to follow, we have suggested specific dollar amounts for most of the line items related to these vital segments of the National Institutes of Health.

NATIONAL HEART, LUNG, AND BLOOD INSTITUTE

May I preface this statement by emphasing that the ACCP fully supports the activities of 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. We commend as well the Director of the Division of Lung Diseases, Dr. Claude Lenfant. 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 1980.

We believe that in times of limited resources, the emphasis of the Institute's programs should be on prevention of cardiopulmonary diseases, and the biomedical research manpower.

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 lung. 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 United States, account for more than 100,000 deaths each year, 46 million days lost from work, and 40 million days of bed restricted activity; in addition, pulmonary disease costs the economy approximately $20 billion annually in lost productivity and wages and medical care costs.

Although respiratory diseases effect all ages, they are most devastating among the very young and the very old. In the newborn, the most common cause of death is the neonatal respiratory distress syndrome (RDS). 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. 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 disease 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.

It was only 8 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 initiated. We are pleased to report that the NHLBI under the able leadership of Dr. Levy and Dr. Lenfont and the biomedical community have worked together quickly and effectively in developing plans that are now represented in the National Heart, Blood Vessel, Lung and Blood Program.

RESEARCH

The statutory objective of the research grants and contracts program of the NHLBI is to develop the basic knowledge about the lungs. The Institute's activities in cardiopulmonary research have evolved and been nurtured by originating new efforts directed at fulfilling these basic research needs and expeditiously capitalizing on opportunities to translate research results into health care application through clinical trials, demonstration, education, prevention, and control.

As I noted above, neonatal RDS is presently the major pulmonary disease and leading cause of prenatal 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.

The Institute has been at the forefront of the biomedical research community's basic research effort to augment existing knowledge about the structure and function of the lung. To this end, the American College of Chest Physicians enthusiastically endorses the NHLBI's support of research projects regarding: the mechanisms of lung tissue damage and repair; oxygen toxicity and endolethial damage; pulmonary edema; lung inflammation; and the role of chemical, mechanical, and neural mechanisms in the control of ventilation. The Institute has also innovatively targeted essential research at chronic bronchitis and emphysema, fibrotic and immunologic lung diseases, and respiratory failure.

In the area of diagnosis, the NHLBI's Division of Lung Diseases has supported numerous studies which have resulted in the development of new tests for detecting subtle alterations in pulmonary function. These tests can indicate the presence of early progressive chronic obstructive lung disease, such as emphysema, chronic bronchitis, and asthma -- diseases which afflict 14 million Americans.

The NHLBI has made remarkable strides in alleviating the deleterious impact of cardiopulmonary disease. We believe that it is imperative that research support for this vital Institute be augmented. The Administration's proposed budget for research is wholly inadequate. It would enable the NHLBI to fund only 20 percent of its approved investigator-initiated research grant applications. This corresponds very unfavorably with the funding rate of 90% a decade ago, and 50% as recently as FY 1977. Under the Administration's budget request, the Institute would fund about 300 less research grants than it did three years ago.

Our recommendations, outlined in detail at the end of this statement, would provide for the funding of about 40% of approved grant applications.

What would funding at our recommended level provide for? It would enable the Institute to substantially increase its re-

search in prevention of pulmonary diseases. Senator Magnuson, you have often stated at theses hearings that the key to prevention is health research. With this assertion, we concur. This Institute, given adequate fiscal support, would be able to fund many essential prevention-oriented research projects, including:

-- Morbidity and mortality studies of pulmonary and cardiovascular disease in communities, ultimately resulting in the establishment of a surveillance system.

-- The assessment of physician practices in respiratory disease prevention, including strategies for smoking prevention, identification of patients at high risk to develop respiratory disease and diagnosis and management of occupational respiratory diseases.

-- Studies of the efficacy of antenatal administration of steroids in prevention of hyaline membrane disease.

-- Research on the prevention of pulmonary empysema in patients with alpha-1-anh-trypsin deficiency.

CLINICAL TRIALS

The American College of Chest Physicians is quite excited about the NHLBI's clinical activities, since these programs embody the potential to provide a vehicle for research, application of research-generated information to clinical practice, and dissemination of the results of these clinical trials to the practicing physician who treats the pulmonary patient. Through the vehicle of research grants, tremendous progress has been made in the program of Specialized Centers of Research (SCORS) and the National Research and Demonstration Centers.

Currently, 19 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 1975, the Institute solicited competition for pulmonary SCOR grants in four very important areas which it seemed require further emphasis: chronic disease of the airways, pediatric pulmonary vascular disease, fibrotic and immunologic pulmonary diseases, and pulmonary vascular diseases. As noted above, 19 of these SCORs

are being funded under FY 1980 appropriations. In December 1977, the Institute, based on the results of the Extracorporeal Membrane Oxygenator Trial, announced its intention to expand pulmonary SCOR grants into another important area: acute respiratory failure. Although the blueprint calls for the establishment of five or six respiratory failure SCORs, only three have been initiated; the remainder can be established only if the FY 1981 appropriations measure is sufficiently high to allow such funding. Our recommended funding level would provide for a modest expansion of pediatric pulmonary SCORs and chronic obstructive lung disease SCORs.

The National Heart, Blood Vessel, Lung and Blood Act of 1972, the 1976 extension legislation and the 1978 extension legislation authorized the Institute to develop the National Research and Demonstration Centers--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. However, it is distressing to note that due to fiscal constraints only three such centers have been developed to date: one each in the areas of heart, lung and blood.

And under the Administration's budget request, there is insufficient funding for the establishment of any new pulmonary centers. Nonetheless, we are pleased to report that recent efforts by the Pulmonary Diseases National Research and Demonstration Center of University of Vermont offer the promise of encouraging results. Just one example of the work of this Center is the development of a computer-assisted preparative evaluation system to aid in the identification of patients likely to have respiratory problems during and after surgery. Funding at our FY 1981 recommended level would enable this Center to expand the development of a health professional education program for home health nurses and physical therapists who provide services and information

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to persons with chronic respiratory problems and to expand the development of a lung cancer and cigarette-smoking intervention program.

MANPOWER TRAINING

Finally, we would like to express our strong support for the manpower development grant awards programs within the Institute. The Pulmonary Academic Awards Program for example, 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 NHLBI, and one which the ACCP believes is imperative to attain, is to have an award grantee at every American medical school. At present, and under the Administration's proposed FY 1981 budget, less than one-half of the Nation's medical schools will be privileged to have a Pulmonary Academic Award grantee enrolled therein.

The second training program which the College feels is deserving of substantial funding is the Pulmonary Faculty Training Program. Under this program a medical school which does not have an active program in pulmonary medicine nominates a faculty member to serve for three years at one of the six designated pulmonary faculty centers. During this period, the trainee receives a stipend from the NHLBI. He then returns to the medical school from which he was nominated where, compensated by the NHLBI, he devotes two years to establishing a pulmonary research program. Pursuant to the agreement, the medical school compensates the trainee to direct the program for an additional three years. We believe that this exciting program, which involves an eight year commitment from the trainee, the medical school, and the NHLBI, represents a magnificent means of insuring a future reservoir of talent to conduct and teach pulmonary research. We regret that, at this time, there are only 26 trainees participating in this program. Increased funding for the NHLBI at our recommended levels would provide for the expansion of this essential, innovative research training mechanism.

Congress has, during recent years, made a number of improvements in the Nation's principal biomedical research training mechanism, the National Research Service Awards (NRSA) program. This has been necessitated by the substantial decrease in the number of NIH-supported trainees and fellows in recent years. The tax burden on trainees has been eased, the program's authorization levels have been increased, and the Secretary has increased trainee stipends. These improvements are designed to provide an incentive for young physicians and scientists to enter the arena of research, and we applaud them.

But the bottom line for the success of the NRSA is still full-time equivalent support. The number of individuals trained has declined from 1,433 in 1971 to 1,159 in 1977. More significantly, the number of NHLBI trainees who are clinical investigators (i.e. Trainees with an M.D. degree) has declined by almost 70% during the same period. This trend must bc reversed or this Nation will lack the manpower to conduct research in the future. Accordingly, our recommendation would provide for a 10% increase in the number of full-time equivalent trainees supported by the NHLBI.

II. CARDIOVASCULAR PROGRAMS OF THE INSTITUTE

In his testimony before this Committee last month, NHLBI Director, Dr. Robert Levy, stated that disease of the heart and blood vessel account for over 50% 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 14%. 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 several 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 could -- if allocated sufficient funding -- initiate several new program studies. These include studies of the role of salt and obesity in hypertension; an anti-arrythmia trial by administration of beta-blocking agents, a clinical trial of hypertension in the aging, and a new SCOR in pediatric cardiovascular disease. The Administration's budget provides no support for new clinical trials.

It is the belief of the College that our FY 1981 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

The Administration's proposed budget provides for the National Heart, Lung, and Blood Institute an allocation of $548.0 million. Such an appropriation would permit funding of competing new investigator-initiated research grants at only 20% of those which have been approved for funding. It would provide for a decrease in new institutional or individual training starts. It would not allow the Institute to expand its existing research contractual obligations (such as clinical trials.) The Administration's budget request for FY 1979 would, in sum, impede the progress and momentum of the National Program to combat heart, lung, and blood disease.

The College has formulated its budget recommendations with fiscal restraint in mind. We applaud the advancements that have been made during the last decade in cardiopulmonary and cardiovascular medicine. However, in assessing the fiscal plight of the

Institute, we urge you to take note that the NHLBI really houses three separate Institutes -- one each for disease of the heart, diseases of the lung, and disease of the blood and blood vessels. Moreover, the 1972 Heart and Lung Act (P.L. 92-643) and the 1976 extension legislation (P.L. 94-278) provide that only 15% of the overall NHLBI budget be allocated to pulmonary research and training activities.

Our recommended budget of $638.9 million for research, training, and prevention, education, and control activities would provide for the funding of approved competing research applications at a rate of 35%, much greater than the 20% embodied in the Administration's proposal but shy of the 90% approval rate of a decade ago. The ACCP budget request of $36.3 million would also provide for expansion of the important research training programs discussed above. An appropriation consistent with our recommendations would enable the Institute to meet, and moderately expand, its existing FY 1980 contractual commitments. Finally, our recommended fiscal allocation would provide for the implementation of a number of programs which have already received high priority ratings from the NHLBI's advisory committees.

PULMONARY ACTIVITIES OF THE NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES

As a medical specialty society representing thousands of specialists in pulmonary medicine, the American College of Chest Physicians is concerned with those aspects of lung disease which are the subject of research in other Institutes within NIH.

The National Institute of Allergy and Infectious Diseases is sponsoring important research in influenza and other diseases with respiratory implications. NIAID scientists and grantees are presently attempting to ascertain the origins of new epidemic-causing influenza viruses and to develop more effective vaccines. Also under study are the respiratory syncytial and parainfluenza viruses (which cause serious respiratory distress in infants and young children), and bacterial disease such as pneumonia, otitis media, and meningitis.

Viral infections of the upper respiratory tract are extremely serious in our patients who suffer from chronic lung conditions, such as asthma, emphysema, and cystic fibrosis. The development of more effective means for preventing these acute respiratory infections and for treating them is a goal of the NIAID. The ACCP applauds the research advances that have been cultivated by the National Institute of Allergy and Infectious Diseases and urge increased funding for these research and training activities.

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 and noted the respiratory disease research of the NIAID. Within the lung programs, moreover, we have tried to recommend certain priorities among the almost infinite array of possibilities.

Again, may I thank you for this opportunity to submit our views to this important Committee.

NATIONAL HEART, LUNG, AND BLOOD INSTITUTE

(in millions of dollars)

	FY 1981 Administration Budget	FY 1980 ACCP Recommendation
RESEARCH GRANTS		
Includes Noncompeting continuous, competing continuations, SCORs, Research and Demonstration Centers, Pulmonary Faculty Training Awards	365.1	438.2
TRAINING PROGRAMS	31.0	36.3
RESEARCH AND DEVELOPMENT CONTRACTS	77.2	89.4
Includes Clinical Trials and Prevention, Education and Control Programs		
INTRAMURAL LABORATORY AND CLINICAL RESEARCH	42.8	42.8
DIRECT OPERATIONS AND PROGRAM MANAGEMENT	32.2	32.2
TOTAL	548.4	638.9

STATEMENT OF DR. ERNST R. JAFFÉ, CHAIRMAN, PUBLIC INFORMATION COMMITTEE, AMERICAN SOCIETY OF HEMATOLOGY

Thank you for allowing me to present testimony before this Subcommittee on behalf of the American Society of Hematology in connection with the Fiscal 1981 appropriation for the National Institutes of Health.

I am Dr. Ernst R. Jaffé. I am the Head of the Division of Hematology in the Department of Medicine, as well as Professor of Medicine, at the Albert Einstein College of Medicine, Bronx, New York. I am also now serving as the Chairman of the Public Information Committee of the American Society of Hematology. This Society is the only national organization of hematologists. It is comprised of physicians and biomedical scientists who are concerned with research, patient care, and teaching activities as they relate to blood. Blood, the liquid of life, is all-pervasive, for it perfuses all organs and tissues of the body, bringing essential oxygen and nutrients to the sites where needed, and carrying away carbon dioxide and the waste products of the body's metabolic activity. Afflictions of the blood include the acute and chronic leukemias and lymphomas; the anemias that can result from nutritional deficiencies, inherited abnormalities of the oxygen-carrying pigment, hemoglobin, and the metabolic machinery (enzymes) of the red blood corpuscles, or the presence of abnormal proteins that coat and damage the red blood cells; the excess production of the formed elements of blood (polycythemia); and the countless disorders of bleeding and blood clotting, among which the best known ones are the hemophilias and the thrombotic disorders. Since decreases in red blood cells, white blood cells, and platelets (the tiny particles involved in blood clotting) not infrequently occur, singly or in combination, as consequences of many other diseases--cancer, kidney disease, chronic infections, and poorly understood systemic disorders--hematologists are also vitally concerned about the complications of many other illnesses that can and do affect the blood indirectly. Treatment for the lack of formed elements in the blood often involves the transfusion of packed red blood cells, white blood cells, or platelets. Hematologists, therefore, are responsible for the heavy demands for blood for transfusions, both for the therapy of hematologic disorders and for the often unavoidable blood-destroying effects of medicines administered in the treatment of solid tumor malignancies, leukemia, and lymphoma.

Because blood is everywhere in the body and aberrations in its quantity or quality can influence profoundly the functions of the organs and tissues, it is not surprising that some funds from every single Institute in the NIH, and the Division of Research Resources, have been devoted to extramural blood and blood-related research. In Fiscal 1979, this investment amounted to $171.1 million, essentially unchanged from the figure of $180.4 million for Fiscal 1978 because of a change in the definition of blood-related research. Of the Fiscal 1979 dollars, 43.4 per cent came from the appropriation to the National Heart, Lung and Blood Institute, 25.6 per cent from the National Cancer Institute, and 11.0 per cent from the National Institute of Arthritis, Metabolism, and Digestive Diseases. Thus, 80 per cent of the blood-related research was supported by these three Institutes. The practicing hematologists and the researchers who are members of the American Society of Hematology, therefore, are vitally concerned about the continued viability of all of these programs. The problems observed and the questions raised at the bedside lead to the bench research in the laboratory. The information obtained there is often promptly translated into a clearer understanding of the disease processes and ultimately to their treatment.

What have been the successes in these efforts, and where are there promising leads for further exploration and, hopefully, exploitation to the benefit of the health of the citizens of the United States? Since this hearing is concerned primarily with the National Heart, Lung, and Blood Institute, let me just comment on a few of its grant-supported activities. Although most recently developed commercially in Japan and the United States, the early research on blood substitutes, the fluorocarbons, was supported, and newer work is supported, by this Institute. While probably not the final answer to the national blood problem, these compounds have given promise of providing oxygen-carrying capacity in certain unusual cases. Treatment of hemophilia, the bleeding disease, has been materially simplified by the development of fractionation techniques that permit the collection of the specific plasma protein that these patients need to prevent or treat hemorrhage. The process to obtain these proteins is extremely expensive and difficult. Efforts, therefore, are being made to develop and perfect less expensive and more efficient methods that would increase the yield from human plasma of the anti-hemophilia factor. At the same time, the isolation of

other plasma components that may be of therapeutic value is being actively explored. Hepatitis, the causative virus of which may be transmitted by blood transfusions, continues to be an important problem, especially with the identification of the non-A, non-B virus that is now responsible for 90 per cent of the post-transfusion hepatitis cases. Means to identify the unsuspecting carrier of this virus are necessary to reduce the risks. Such efforts are currently underway, and need to be continued. Many other areas of concern to the NHLBI are being explored and need to be maintained. For example, studies on fats in the diet and their effects on the formation of blood clots (thrombi) in the deep veins of the legs and other parts of the body, the improvement of methods to collect safely and efficiently the white blood cells and the platelets from blood donors, and the role and extent of cardiac impairment in sickle cell disease.

The NHLBI suffered most severely in the appropriations made last year. It has estimated that it will be able to fund only about 25% of approved research grant applications in Fiscal 1980. The Administration has proposed only a 4 per cent increase for Fiscal 1981, much less than the present and anticipated rate of inflation. It estimates that it will be able to fund only about 19% of approved grants in 1981, the lowest level in the Institute's history. Regardless of the reasons why the NHLBI received only a very modest increase in Fiscal 1980, the Institute needs to be "made whole" this year to permit it to allocate sufficient funds to the three areas described in its title for which it has a mandate. To do less would be "penny wise and pound foolish."

To continue to maintain, not even increase, the present efforts in the important area of the training of young physicians and biomedical scientists to do the research is critical. If the Administration's budget requests for the NHLBI, as well as the other Institutes, are sustained, no new or competing renewal awards for research training or fellowships will be possible in Fiscal 1981. Only those trainees now in the pipeline, whose stipends will have been increased to more reasonable levels on July 1, 1980, will be able to continue and complete their essential post-graduate training experience that will permit them to make future discoveries. A gap of even one year in the orderly process of recruiting research fellows will seriously impede progress, and may so discourage potential trainees that they will

seek their careers in more lucrative clinical practice, or in industry. Academic and research hematology, therefore, will have been ill served by such a decision at this time.

I mentioned at the beginning that blood is everywhere in the body, and in the Institutes of the NIH. The American Society of Hematology, therefore, is also vitally concerned about adequate support for research in blood diseases in the NCI and the NIAMDD, as well as the other Institutes. The NCI has supported both basic research and clinical trials in the important area of the leukemias and lymphomas. Enormous progress has been made in the chemotherapy and radiotherapy of these dread diseases, and with the introduction of bone marrow transplantation in selected cases. Children, young adults, and older people, however, still die of these diseases, and the final answer--prevention or invariable cure--has not been obtained. Only further basic research, complimented by appropriate clinical trials, can ever hope to solve this particular cancer problem.

In the NIAMDD, the hematology program is concerned with basic laboratory research and clinical investigations, especially in relation to disorders of the red blood cells. Because patients with Cooley's anemia (thalassemia), and those that require inordinately large numbers of blood transfusions because of other diseases, tend to accumulate iron in their tissues, leading to early death from heart or liver failure or the complications of diabetes, efforts have been made to develop agents that will remove the excess iron from their bodies. These efforts have met with significant success, but again the easiest, most inexpensive, and safest methodology remains to be invented. The development and testing of potentially useful compounds is slow and tedious: many different chemicals must be synthesized or isolated from natural sources, they must be tested in the laboratory to determine their abilities to bind iron, then they must be evaluated in experimental animals that have been overloaded with iron, and finally they must be tried cautiously in patients. In addition, the best and least uncomfortable method for their administration must be determined.

Similarly, great progress has been made recently in identifying the genes responsible for the synthesis of abnormal human hemoglobins, especially sickle cell hemoglobin, and the deficient genes responsible for the various forms of thalassemia. Prenatal diagnosis of these disorders has been

accomplished with these new and sophisticated techniques. The procedures, however, are still extremely difficult, and can be performed in only a very few laboratories in this country. Better methods, requiring smaller samples of blood or tissue, and providing more unequivoal answers, are needed to make this valuable tool readily available to those who need and want to know what fate lies in store for their children even before they are born.

Lead poisoning, most often a problem for children in the seriously deprived areas of large urban communities, is still a serious issue, despite the efforts to eliminate lead-containing paints. Iron deficiency, due to dietary inadequacy, is also a frequent occurrence in the slums. Recently, it has been observed in rats that iron deficiency enhances the absorption of lead from the gastro-intestinal tract. If this phenomenon also occurs in man, it may explain the high incidence of lead poisoning in iron deficient children, and may provide an impetus to correct both disorders at the same time.

In summary, my colleagues in the hematologic community and I wish to thank you, Mr. Chairman, and the members of the Subcommittee for your attention and for your kind consideration of our presentation. The fields of biomedical research, training, and patient care in general, and the exciting and ever-widening field of hematology in particular have made their contributions to the betterment of human health through your past generous support. The research work will be done by those that have been trained to do it if you will only continue to observe our past accomplishments and provide us with the means to go forward.

FUNDING RECOMMENDATIONS

For the three institutes which support the major part of the research in hematology:

NHLBI - We support the Coalition for Health Funding's proposal of $610,000,000, instead of the President's proposed budget of $548,399,000. We believe that such funding is necessitated by the research funding shortfall caused last year because of the confusion of the "raw score" issue.

NIAMDD - We support the Coalition for Health Funding's proposal of $395,000,000, instead of the President's proposed budget of $365,711,000.

NCI - We recommend a level of $1,170,000 for the Cancer Institute, instead of the President's proposed budget of $1,007,800.

SUBCOMMITTEE RECESS

Senator BURDICK. You know we are not ogres on this subcommittee, you understand that. We are trying to accommodate ourselves to your needs as much as we possibly can. If you have any further comments, you can make them.

If any members of the subcommittee have any questions, we will mail them to you.

So we will stand in recess until 2 o'clock. We thank you.

[Whereupon, at 10:48 a.m. the subcommittee was recessed, to reconvene at 2 p.m., this same day.]

(AFTERNOON SESSION, 2 P.M., TUESDAY, MARCH 11, 1980)

NONDEPARTMENTAL WITNESSES

NATIONAL INSTITUTE OF NEUROLOGICAL AND COMMUNICATIVE DISORDERS AND STROKE

STATEMENTS OF:
J. ALFRED RIDER, CHILDREN'S BRAIN DISEASES
MARJORIE GUTHRIE, NATIONAL COMMITTEE FOR RESEARCH IN NEUROLOGICAL & COMMUNICATIVE DISORDERS

ACCOMPANIED BY:
STANLEY APPLE
ROBERT RUBEN
ROBERT CROWELL
PHILIP ANGLIM

BATTEN'S DISEASE

Senator SCHWEIKER [presiding]. The Subcommittee on Labor-HEW will please come to order. This afternoon we have three large panels to discuss various institutes and programs. I realize that we have a lot of people who have traveled distances to be here. So we will try to be fair and give everybody at least an opportunity to speak.

While I understand the panels have been asked to try to limit their presentations to 15 minutes, we will stretch that a few minutes. I won't be too concerned if we go 20 minutes. But I do want to allow some time for questions and time for the other panels. So we will try to stick within that time limit.

Is Dr. Rider going to proceed?

Dr. RIDER. It's a pleasure to testify before the Senate Labor Subcommittee, Appropriations, and to support the budget request of the National Institute of Neurological and Communicative Disorders and Stroke.

I would specifically like to address myself to the need for continuing the support of funds for research on Batten's disease. We are pleased with the wording expressed in last year's report, namely Batten's disease continues to be a high priority of the committee.

Batten's disease is a neurological disease which may have incidence as high as other diseases such as Huntington's chorea. It is a particularly devasting disease in that it manifests itself in otherwise normal children at an early age.

We hope that you will include the same wording in this year's report. It is my understanding that last year the House Labor-HEW Appropriations Subcommittee recommended to the NIH that specifically $625,000 be set aside for research on Batten's disease. Although the inflationary rate is approximately 14 percent, we would hope you would take into consideration the need for approximately a 12-percent in-

crease, or $700,000, for research on Batten's disease in your appropriations to the NIH in the next fiscal year. This would be to maintain a present level of research.

It has only been the last 12 years that research on Batten's disease has occurred largely, as a result of funds from the Children's Disease Foundation, and in the last 2 years, by increased appropriations to and from the NIH.

Batten's disease is a neurological disorder which may have an incidence as high as 1 in 12,500 births, similar to other diseases such as PKU and Huntington's chorea. It manifests itself in previously normal children at the approximate ages of 4 to 8 and is characterized by a slow progression of clumsiness, stumbling, failure of vision, seizures, changes in personality and dropping of scholastic grades. The disease eventually leaves its victims totally disabled and unable to care for themselves, and usually ends in death in the late teens or early twenties.

One of the most promising theories about the disease has resulted from the discovery of a lack of the enzyme perioxidase in Batten's disease. This results in an accumulation of a yellow pigment, ceroid lipofuscin, in the brain cells producing slow destruction and progressive deterioration. These changes are quite similar to the changes that take place in all brains as they age, thus, effective treatment for Batten's disease might very well also delay the normal aging process.

There has now been discovered a simple blood test to identify children with the disease, and the carriers. Furthermore, there has been identified a strain of dogs and sheep who coincidentally and miraculously have a disease similar to Batten's disease in humans, thus providing an animal testing model.

Funds must be available to perfect the diagnostic blood tests to better elucidate the pathophysiology of the disease to assist with genetic counseling and to initiate and evaluate therapy such as feeding or injecting peroxidase and/or various antioxidants. It has been found, for example, that horseradish and avocado are high in peroxidase.

Research is the only way to solve this disease and prevent the devastating tragedy in families who have children so afflicted and effect tremendous savings to society as a whole.

The cost of care for each child is enormous and may be as high as $50,000 to $100,000 a year. Thus, 10 children such as these would cost much more per year than the funds we are requesting.

Finally, the possible research spinoff of enabling us to alter the aging or senility process in all humans makes the value of this research unlimited.

In the last year research has expanded and is progressing rapidly. This momentum must be maintained.

Because of the constraint on time, I cannot review the research studies underway, but I have enclosed them in the prepared addendum. Suffice it to say that there are over 20 principal investigators from major universities, medical centers, and institutes throughout the United States and Canada involved in various phases of research pertaining to Batten's disease. If funding is provided, the chances of the development of a specific treatment program in the foreseeable future appears to be very good.

Senator SCHWEIKER. Your statement will be inserted in the record at this point.

[The statement follows:]

STATEMENT BY J. ALFRED RIDER, M.D.

SCIENTISTS ACTIVELY WORKING IN RESEARCH ON BATTEN'S DISEASE

1. Donald Armstrong, M.D., Assistant Professor of Neurology, University of Colorado Medical School; (*a*) relationships of peroxidase to Batten's disease; (*b*) canine retinal degeneration—an approach to therapy; and (*c*) peroxodase deficiency and peroxidase regulating enzymes.

2. James H. Austin, M.D., Professor and Chairman, Department of Neurology, University of Colorado Medical School; treatment of Batten's disease with peroxidase.

3. Robert J. Baumann, M.D., Department of Neurology, University of Kentucky and Section on Epidemiology OBE, Office of the Director, N.I.N.C.D.S., Bethesda, Md.; leukocyte ultrastructure.

4. Milton Brightman, M.D., Laboratory of Neuropathology and Neuroanatomical Sciences, NINDS and National Institutes of Public Helath/HEW; transport of horseradish peroxidase across bloodbrain barrier.

5. Glyn Dawson, Ph. D., Associate Professor, Depts. of Pediatrics and Biochemistry, The University of Chicago; pre-natal diagnosis and enzyme replacement therapy.

6. Edward Dratz, Associate Professor of Chemistry and Biochemistry, University of California, Santa Cruz; measurement of fluorescent lipopigment, peroxidized fatty acids, vitamin E, effects of antioxidants on lipopigment formation.

7. Denham Harman, M.D., The University of Nebraska Medical Center; brain lipid composition.

8. K. U. Ingold, Ph. D., Associate Director, National Research Council of Canada, Division of Chemistry; resistance to oxidation and the natural antioxidant levels in membranes from human cells.

9. Edwin H. Kolodny, M.D., Associate Director, Eunice Kennedy Shriver Center for Mental Retardation, Inc., Waltham, Mass.; pathogenesis of the neuronal ceroid-lipofuscinoses.

10. Martin M. Maltemps, Ph. D., Assistant Professor of Physics, University of Colorado Medical Center; monitoring of peroxidase and free radicals in canine retinal tissue subject to a degenative disease in which there is an accumulation of pathologic lipopigments of the ceriod type—a model for Batten's disease.

11. Jaime Miquel, Ph. D., NASA, Ames Research Center, Moffett Field, Calif.; analysis of pigment lipofuscin.

12. Vimal Patel, M.D., Assistant Professor of Pathology, Indiana University School of Medicine; antioxidant treatment of Batten's disease.

13. Alan K. Percy, M.D., Associate Dean, Office of Research, Charles R. Drew Postgraduate Medical School, Los Angeles; solutory effect of selenium, erythrocyte gluthathione peroxidase.

14. Michel Philippart, M.D., Neurophychiatric Institute, University of California, Los Angeles; treatment of Batten's disease with antioxidants.

15. Mark Poznansky, M.D., Associate Professor of Pathology, University of Alberta; enzyme replacement and enzyme engineering.

16. Raju Pullarkat, M.D., New York State Institute for Basic Research in Mental Retardation; lipopigments in aging and in ceriod-lipofuscinoses.

17. Julius Schultz, M.D., Director, Papanicolaou Cancer Research Institute, Miami, Fla.; discovery and characteristics of leukocyte peroxidase and the purification and administration to animals.

18. Aristotle Siakotos, M.D., Professor of Pathology, Indiana University Medical Center; development of a reliable blood test for Batten's disease through studying koppang dogs.

19. Satish Srivastava, Ph. D., Department of Human Biological Chemistry and Genetics, The University of Texas Medical Branch; (*a*) purification and properties of leukocyte peroxidase; and (*b*) biochemical studies in neuronal ceroid-lipofuscinoses.

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20. Al Tappel, Ph. D., Division of Food Science and Technology, University of California, Davis; properties and functions of glutathione peroxidase and pentane analysis of lipid peroxidation damate to quantitate effects in nutrition.

21. John R. Wherrett, M.D., Professor of Neurology Program, University of Toronto; isolation of fluorescent material in the juvenile form of Batten's disease.

22. Leon Wolfe, M.D., University of California, San Diego; (*a*) characterization of the accumulated retinol compounds in Batten's disease; and (*b*) an analysis of urine sediment in subjects with Batten's disease.

NATIONAL COMMITTEE FOR RESEARCH IN NEUROLOGICAL AND COMMUNICATIVE DISORDERS

Senator SCHWEIKER. Thank you. Marjorie, are you next?

Ms. GUTHRIE. Yes.

Senator SCHWEIKER. Go right ahead, then.

Ms. GUTHRIE. Thank you, Mr. Chairman. It's a pleasure to come here and sit before you again, especially because last year you were so responsive to our national committee.

Our National Committee for Research in Neurological and Communicative Disorders represents 50 million Americans who are suffering from problems of the brain and central nervous system, and communicative disorders and stroke. The National Committee is made up of 25 professional societies and 25 voluntary health agencies. We have a very distinguished panel. We want to thank you for last year, and hope that this year you will be equally responsive, because we have just begun to realize the potential of our efforts, thanks to the funds that we were able to get last year.

Let me introduce our first speaker, Dr. Robert Crowell; teaches surgery at Harvard Medical School. He's head of the neurosurgery part of stroke care at Massachusetts General Hospital. As a scientist, he studies both the clinical and basic science aspects of stroke medicine.

Dr. Crowell.

STROKE

Dr. CROWELL. Mr. Chairman, stroke and head injury represent an enormous problem in this country. There are 3½ million Americans alive with stroke today, and another half million strokes occur yearly. There are 1 million individuals afflicted with head trauma.

Together, those two problems have an annual economic cost in excess of $6 billion. Both problems affect young people as well as older citizens. Research is the only hope for saving of life, anguish, and dollars in this area. There has been progress in research on these two problems.

At the basic science level, it has been demonstrated that some of the damage may be reversible and therefore treatable. Medications have been developed, specifically blood thinners have been worked out which can keep diseased arteries open in stroke patients. Moreover, it is possible using medication, to control brain pressure in some stroke injury and head injury cases.

The future depends on research. Basic research to better understand the process of brain injury will be needed to guide our way in diagnosis and treatment. In the area of diagnosis it looks very promising that painless computer x-rays may be developed to give us good pictures of brain arteries and tissue.

In the therapeutic area a new operation has been developed, a brain bypass, to bring in a new supply of blood to the brain to avoid stroke. This exciting new prospect must be evaluated in careful clinical trials.

In summary, to solve these serious health problems facing us, we need your support, gentlemen. And to continue the initiatives that already have been started.

Thank you.

COMMUNICATIVE DISORDERS

Ms. GUTHRIE. Next is Dr. Robert Ruben, who is chairman of ear, nose, and throat medicine and surgery at Albert Einstein College of Medicine in New York City and its six affiliate hospitals. He heads the communicative disorders group at those hospitals, which now serves several thousand children with hearing, speech, and related genetic disorders. He also heads a group of basic scientists working on deafness.

Dr. RUBEN. Mr. Chairman, I am very honored to be here today. With the time given to me, I would like to talk about communicative disorders.

We have people here who are trapped in bodies and cannot express themselves. They either cannot talk, or, if they talk, cannot be understood; or can be understood, perhaps cannot hear, and then cannot talk. Those are what we call communicative disorders; disorders of voice, speech, language, and hearing.

Approximately 10 percent of the American population is afflicted with one or more of these maladies today. Each one of us stands a great chance of being likewise afflicted. The cost of care alone for those with hearing impairments and speech impairments is annually over $20 billion. The real cost in terms of decreased economic opportunity of lives and families has not been measured.

The problem is so broad that I wish to talk about one small segment which I think will illustrate the difficulties we face. Genetic deafness is one which accounts for at least half of all congenital deafness. It also accounts for perhaps more than half of all deafness acquired during life; whether a toddler, an adolescent, young person, a person in the prime of life, but especially amongst our senior citizens.

Today, through the work of the NIH and NINCDS, there have been many excellent scientific opportunities afforded so that we as a nation could provide prevention and cure for these disorders. However, there is not scientific and clinical manpower available to do this. For instance, in genetic deafness, there are only two identifiable human geneticists in the entire United States who work concentratedly in this area.

The same is true of the embryologists, the developmental biochemist, et cetera. We have the research opportunity. There is the need for funding for those individuals to be trained to go into this area.

I think that we have made progress, we also have tens of millions of Americans who are incurably afflicted. We can do nothing to make them better. We must, as physicians do all the time, simply care for these people. Here, again, we have substantive problems. We know from both the model program sponsored by the NIH and from Western Europe that we could deliver a level of care which would substantively enhance the quality of lives of a large part of our citizenry. Most often, we do not have the funds to do this.

Furthermore, there are not the funds or the manpower available to assess the cost effectiveness of the care which we now give, or to develop new and improved methods of care.

In closing, I would like to relate this testimony to myself as a physician. Every week I see 10 to 20 children with genetic deafness. Because I have also been trained to work as a scientist, each time I make this diagnosis. I realize the opportunity does exist to either cure or have prevented this malady. Yet, I know that nothing can be done to stop the havoc within the individual, to prevent the thwarted unit of the family, the frustration, the psychological problems, to say nothing of the economic impact.

Then I must care for this child that I see. Again, I have this haunting knowledge that there is a level of care available, mainly developed in this country, which is not deliverable to the vast majority of those children I am privileged to care for.

Thus, today I am here to ask this committee to increase the appropriations for the NIHNCDS so that we may, one, recruit and train the proper manpower which is needed, that we may be able to better fund those few individuals who have the proven competency. And two, that we may also begin to assess what we are doing in care, improve it, and work out much more cost-effective care so that our dollars can be used optimally for these people.

Thank you, sir.

TRAINING GRANTS

Senator SCHWEIKER. If I might interrupt; of course, the subcommittee has been arguing with Dr. Fredrickson about the cutting of training. I gather from what you have said that you feel that is vitally important to any advances in this particular field that you are working in?

Dr. RUBEN. Yes, sir; the number, critical mass of people trained in basic science in many areas of the communicative disorders is below any reasonable expectation. In the special fields I have just illustrated, the moneys just do not exist. Even if one had the money, we don't have the manpower. This is even more important to individuals like myself and the other physicians on this panel as well, who are trained in both basic science and clinical medicine, so that we can bridge the gap.

In my field of otolaryngology, which is essentially the physicians for communicative disorders, these people are almost nonexistent.

Senator SCHWEIKER. Aside from funding, which we obviously have not had because of the administration's cut last year—and the budget this year is proposed for a similar cut—in addition to getting funds, what can we do, what must be done?

Dr. RUBEN. I think there are two things. Funding is one and the second, which is very important, is a continuity of support. Many times young people will be attracted to the field, and they will not see that there is a way of making a living in this field. This, I think, is a very important drawback.

In otolaryngology there are very, very few institutions which even have laboratories which can begin to train men and women to go into this type of work. We are at a point critically, not only for positions, but for basic scientists—we must initially develop critical mass.

Second, they have to be able to have some perception that there is a reasonable chance of making this field of medicine a lifetime career.

Senator SCHWEIKER. I shouldn't have interrupted your presentation. Go ahead.

THE ELEPHANT MAN

Ms. GUTHRIE. Next is a very special introduction. You know the members of the panel are usually professional people.

You know that I represent the consumers. And it is very moving for me to be able to introduce Philip Anglim, who plays the part of the elephant man in the play by that name, because from his experience as an actor he can bring to our discussion the very special feelings of someone who plays the part for the public, who suffers with the problems that we are addressing.

And I am very pleased that Philip took the time to come and join with us here, and will speak from the point of view of an actor who plays the part of someone who is suffering.

Mr. ANGLIM. Thank you, Majorie. Mr. Chairman, in the play, "The Elephant Man", it is my privilege to portray a man named John Merritt who lived a century ago. He was witty, bright, creative, artistic, compassionate; all those qualities that we like to think that each of us is and has, all but for the fact that he suffered from a genetic neurological disorder called neurofibro matosis, which is still prevalant today.

Because of this disorder, he was trapped inside a body which did not work. Which would not let him use the kind of mind and sensibility that he had. In the year and a half that I have been doing this play in New York and Chicago and Baltimore, and now in Washington, I have met hundreds of people who suffer like John Merritt from neurological disorders, which makes them social outcasts.

They are trapped inside bodies which either are hard to look at, which do not function properly or both. But like John Merritt, also, inside they are whole, they are creative, they are productive.

And they desperately want to make a contribution to society. They want to achieve dignity as human beings. They would like to no longer be outcasts, to be aliens, to be freaks. They would like to join their spirits without.

I think that the scientists and doctors here today are among those who can solve these problems, and I can only add my own wishes for you to give them your support in their endeavors.

Thank you.

Senator SCHWEIKER. Thank you.

BRAIN DISEASES

Ms. GUTHRIE. Our last member of our panel is Dr. Stanley Appel, who, as a doctor, treats people who have diseases of the central nervous system. As a scientist, he studies the basic causes, the nature of these diseases.

At Baylor College of Medicine, he heads the entire disciplinary program in neuroscience research and is chairman of the department of neurology.

Dr. APPLE. Thank you, Marjorie.

Mr. Chairman, it's a privilege for me to be here, primarily because our field, the field of neurology and neurosciences, deals with what I think is the most important organ, namely the brain. It's what is responsible for the quality of life, it is what makes us think and feel and act and do, and without which we do not have life in any meaningful way.

Our area is one that is responsible for understanding; and also, in terms of diseases of our organs, specifically the brain, is responsible for costs in the billions in a number of ways. Not only in terms of the losses of productivity, but also in the loss of meaningful human existence. I think one question that I would like to address is how efforts have gone in the last years when this committee helped the NINCDS increase their programs.

We were able to increase 50 percent of our approved investigator-initiated grants in a wide range of areas; including multiple sclerosis, Huntington chorea, parkinsonism, and dementia.

This has given us momentum. And it's given us momentum to begin in this very explosive area. We have also been able to enhance our technical facilities. We now have a number of new efforts in so-called PET scanning, which allows us to make statements about human metabolism without invasion of the human brain. This is an extremely important advance.

But this is just at its beginning. All of these efforts are really geared toward improving the quality of care of patients with neurologic disorders.

There are two particular areas that I would like to select out for your attention. One is the problem of regeneration of the nervous system—the problem of spinal cord difficulties—and the problem of brain difficulties whether it be stroke or trauma.

The essence of our understanding of this range of disorders depends on understanding regeneration—how the nervous system can regrow. This is really a basic science venture.

DEMENTIA

The other area that is extremely important is the whole area of dementia. I think it's probably been brought to your attention, but I would like to do it again because I think by the year 2000 as we gain greater and greater insight into other disorders which affect the nervous system and the rest of the body, we are going to be left with a population that is going to have a much increased incidence of dementia.

This population is an interesting one, as a physician I see these patients and they go through three stages.

The first stage is a stage where the patient knows that he has some memory loss, some impairment in judgment but no one else knows.

In the second stage, both the patient knows and everyone else around him knows. But the third stage is the most pathetic one, where the patient no longer knows that he has any deficit and the world around him does know.

It's sort of the converse of the situation we have heard from Dr. Ruben and Mr. Anglim. It's a body that is functioning normally but with a mind and a brain that cannot direct it in any way.

It's a very pathetic thing, and it's going to be one of the big public health problems in the future. Now, if that was all I could say, I don't think I would have as much optimism as I do now. Within the last year, thanks to the initiative that you provided, we have been able to make some important biochemical advances.

We have momentum in this and we need to keep going. But just as Dr. Ruben finds that there is a deficit with respect to manpower, so do we in basic neuroscience feel that we have a deficit.

We need the physician-scientist who can help translate these basic science advances into meaningful therapy. We made a start in experimental programs and clinical research and we need to continue this momentum.

In answer to your question of how to get this manpower and what kind of problems we are going to run into, I think we have a problem mainly of attitude.

If, in fact, you find a situation where you cannot get an individual research grant, if your future is going to be one of never being able to get one because of the paucity of funds or of the low probability, then you have a much smaller likelihood of going into this field.

One of the things we need to emphasize is not only the support for these physician-scientists, but also the individual-initiated research grants.

I think in our field, the ideas are there. There has been an explosion of these ideas. We need to invest in the people and the basic research.

We feel that our need is special. The brain is special. It makes us what we are. We think that support for NINCDS is extremely important this year and must be continued.

Thank you.

Senator SCHWEIKER. I see my colleague, Lowell Weicker, is here. There are not many panels who get interviewed by Schweiker and Weicker, so I will make note of that. We would make a good law firm, except I am not a lawyer.

Lowell, how about you, do you have any questions of this panel?

Senator WEICKER. I am here to listen.

Ms. GUTHRIE. Can I then just add something?

Senator SCHWEIKER. Right.

TRAINING CUTS

Ms. GUTHRIE. We didn't tell you and we wish to tell you that this panel, after much discussion in the field with all the scientists and people involved, is asking you to support our appropriation of $298 million.

We think we can justify why we need the dollars. We think we know what we can do with it. We think it's important, as Dr. Appel said.

Again, I want to remind you what I said last year; after we cure all the various organs of the body, if you don't have a brain, what do you have? We think it's terribly important to understand that the human

person, the human that is going to function, who is going to live for years with the problems, with the neurologic disorders, needs your guidance and your help and your understanding.

And the only way you can do it is by giving the scientists the opportunity to do the work they wish to do. The last 2 years I have traveled around the country, I have been to many medical schools. And I hear the same story about the training grants. "Don't let us down." We need those dollars so that we can keep the momentum going.

If you have questions, we are here to answer. I will listen, but the scientists will answer.

BUDGET CUTS

Senator SCHWEIKER. Well, I think the point the panel's made on training grants is very important. This particular body has been very supportive of that.

We heard this morning that the administration sort of cut those grants in the last bill and apparently is planning to do it this time as well.

We have trouble understanding what the basis for it is, because like scientists on your panel, as well as other scientists, you can't very well have much movement forward in research if you don't have that kind of input.

That, unfortunately, is going to be part of a battle, I suspect, with the budget. Right now we are waiting for the other shoe to drop. I just left a meeting with some of my Republican colleagues. Some have been to the White House, and they still don't have a clear-cut picture of what the administration is going to suggest in terms of budget cuts.

Just some rough arithmetic to show you what the problem is; if the administration does go ahead with one of the plans that has been announced, to cut back some $20 billion, which theoretically would balance the budget, it's been figured that this is a cut of 10 to 13 percent in the so-called controllable items.

Unfortunately, we become the controllable item. Health is the first expendable. This is why we have had fights before because it is easier to cut us because we are not entitled to something, in quotes.

Actually, we ought to be entitled to it, but that is the way the law works. But if that is the target and that is the goal, we really have a rough fight ahead of us because it would mean we would be singled out for 10- to 13-percent cuts.

I don't know that that is the case. Nobody knows what it is. There is some likelihood the President may address the Congress Thursday night and tell us what he proposes to do.

But as of now, we really don't know. One of the problems, is out of a $696 billion budget, only about $52 billion is controllable if you exclude defense. So if you have that kind of small target to shoot at, we wouldn't get a whack.

So that is going to be our battle. I don't think that changes the feeling of this committee that our priorities are high. Entitled or not, we are going to fight for what we feel are fair investments in the human health and well-being of our people.

Ms. GUTHRIE. I think everybody in this room would like to help you.

We understand and appreciate your position. I think everybody would like to feel that health is a No. 1 priority of the country.

The health of its people is what makes a country.

ENTITLEMENT FEATURE

Senator SCHWEIKER. It's just a shame we don't have some kind of entitlement feature built into this health component, because basically in terms of human need and human suffering and human sensitivity, it certainly matches those programs that have entitlements.

I think maybe we better begin to look at what we call "entitlement programs" and ask ourselves whether they are really entitled to something as opposed to other programs that don't meet that definition. Because that will be used as the criteria to be used against us.

One of the questions we will hear is: "What are the entitlement programs and how much are they entitled to?" We thank you all very much.

I want to say that was one of the best and articulate presentations we have had. I congratulate Marjorie and other panel members. Thank you.

RECOMMENDATIONS AND PREPARED STATEMENTS

A summary of recommendations and statements will be inserted in the record at this point.

[The recommendations and statements follow:]

Summary of NCR Recommendations

The National Committee for Research in Neurological and Communicative Disorders (NCR) advocates funding for the National Institute of Neurological and Communicative Disorders and Stroke (NINCDS) for FY1981 at $298 million.

NCR recognizes that a FY1981 appropriation level of $298 million for NINCDS represents a sizable increase over $242 million appropriated for FY1980 given the present economy. However, we propose that this level is essential given (1) the unusual momentum and potential of the brain sciences at this time, and (2) the tremendously increasing burden of neurological and communicative disorders for society.

Background

NCR is a coalition of nearly 50 voluntary health agencies and professional societies working to insure adequate funding of quality research of the central nervous system. In searching for causes, treatments and cures of the nearly 600 identified neurological and communicative disorders affecting approximately 50 million Americans, the research of the central nervous system aims towards solving some of the Nation's major health problems.

FY1981 NINCDS Appropriation Recommendation

Appropriation:	FY 1981	$242,000,000
Recommendation:	FY 1981	$298,000,000

Research Base

$35 million is needed to insure stability in the research base. The necessary objective of paying approximately 50% of approved grants is being realized. However, to maintain this essential baseline, to achieve reasonable stability of research support, and to consolidate the gains in recent years, such an increase is required. This increase would merely maintain the present effort without solving critical training problems or allowing compelling initiatives.

Training

$5 million is needed in FY1981 to provide an increase in training support. Without an increase in training funds, there would be a substantial reduction in needed training positions. In FY 1979, NINCDS funded 532 training fellowships. This number dropped to 467 in FY 1980. Without an increase in funds, the number would drop to 371 in FY 1981. An increase of $1,825,000 is needed to just maintain the FY 1980 level, which is far below the current needs. A conservative request is that training funds be increased by $5 million for FY 1981. Not realizing this objective would constitute a threat to future research in the field, and particularly to clinical neuroscience research.

New Initiatives

$16 million is needed to permit new and important initiatives. The neurosciences are in the midst of existing advances and at the threshold of many others including research on transmitters, modulators and receptors that promise further breakthroughs in such areas as pain, mental illness, and motor disorders. These advances and many others must continue.

MEMBERS OF NATIONAL COMMITTEE FOR RESEARCH IN NEUROLOGICAL AND COMMUNICATIVE DISORDERS

Voluntary Health Organizations

American Narcolepsy Association
Amyotrophic Lateral Sclerosis Society of America
Association for Brain Tumor Research
Association for Children with Learning Disabilities
Committee to Combat Huntington's Disease
Deafness Research Foundation
Eastern Paralyzed Veterans of America

Hereditary Disease Foundation
Muscular Dystrophy Association
Myasthenia Gravis Foundation
National ALS Foundation, Inc.
National Ataxia Foundation
National Easter Seal Society for Crippled Children and Adults
National Huntington's Disease Association
National Multiple Sclerosis Society
National Neurofibromatosis Foundation
National Reyes Syndrome Foundation
National Spinal Cord Injury Foundation
Paralyzed Veterans of America
Parkinson's Disease Foundation
Stroke Council of the American Heart Association
Tourette Syndrome Association, Inc.
United Parkinson Foundation

Professional Societies

American Academy of Neurological Surgery
American Academy of Neurology
American Academy of Otolaryngology
American Association of Electromyography and Electrodiagnosis
American Association of Neurological Surgeons
American Association of Neuropathologists
American Broncho-Esophagological Association
American Electroencephalographic Society
American Neurological Association
American Otological Society
American Society for Neurochemistry
American Society of Neuroradiology
American Speech, Language, Hearing Association
Association for Research in Nervous and Mental Disease
Association for Research in Otolaryngology
Association of Academic Departments of Otolaryngology
Association of University Professors of Neurology
Child Neurology Society
Congress of Neurological Surgeons
Hearing, Educational Aid and Research Foundation, Inc.
Neurosurgical Society of America
Society for Neuroscience
Society of Neurological Surgeons
Society of University Otolaryngologists
Triological Society

NCR RECOMMENDATION FOR FY 1981 NINCDS FUNDING

The National Committee for Research in Neurological and Communicative Disorders (NCR) advocates funding for the National Institute of Neurological and Communicative Disorders and Stroke (NINCDS) for FY 1981 at $298 million.

State of the Science

The recent history of brain research has been explosive. This field is among the most challenging of the biomedical sciences and will remain at the forefront for many years to come. This has been acknowledged by the report of the President's Biomedical Research Panel which singled out neurobiology as one of the five research areas meriting special emphasis. Internationally the accomplishments have been recognized by the award of 12 of the last 26 Nobel Prizes in Physiology or Medicine to neuroscientists.

Many technological advances have improved research techniques. The data being gathered by non-invasive techniques such as the CAT (computerized axial tomography) brain scans has increased the knowledge of anatomy and structural pathology of the intact brain, and the development of PETT (positron emission transverse tomography) has provided the

scientist the ability to view brain metabolism and function in action. Discoveries in brain chemistry in the past few years have identified chemicals produced by the brain which are agents important to learning, speech, language, memory, pain, emotion and sexual behavior. Advances in anatomical and physiological techniques have increased knowledge of the complex circuitry of the brain which has provided information in the study of hearing, speech, and language development. New developments in neuro-immunology may constitute the key to our understanding the treatment of disabling demyelinating and degenerative disorders of the nervous system.

Research is our only hope for understanding the intricacies of human behavior, communication and movement defined by the brain and spinal cord. Man maintains his position as the most complex and dominant species because of the mind. In science, the mind and the brain are one, and understanding the brain, the most powerful and complex force on earth, is the goal of the basic neurosciences. Disorders of the central nervous system may impair thinking and memory, speech and language, movement, feeling, hearing, sight, emotion or a combination of areas. In searching for the causes, treatments and cures of the nearly 600 identified neurological and communicative disorders, the research of the central nervous system aims toward solving some of the Nation's major health problems.

Affecting population and health care cost

Neurological and communicative disorders affect approximately 50 million Americans. This number will also increase substantially with the growing age of our population, since senile dementia and deafness will increase, as will non-primary neurological disorders such as diabetic neuropathy and secondary brain tumors. Environmental factors such as chemical agents and noise may also increase the number.

There are over 600 identified neurological and communicative disorders which collectively cost the nation an estimated $65 billion a year. The human suffering far surpasses this enormous monetary cost since these disorders affect the very organ that endows us with the characteristics that make us human.

- Approximately half of the 1,300,000 patients in nursing homes in 1978 were institutionalized because of dementia; the cost was approximately $12 billion. By the year 2025 perhaps 17-20% of the population will be over 65 years of age, with approximately 3 million requiring institutionalization because of some form of dementia. The cost could exceed $20 billion.

- 16.2 million suffer from some type of hearing loss. Approximately $13.4 billion is spent annually on care. About 11 million people have speech and language disorders costing an estimated $10 billion annually. Approximately 3 million school age children suffer from hearing loss, and 3.5 million 4-17 year-olds have speech impairments.

- 2.5 million persons are impaired from stroke. Stroke is the number three killer in America, affecting more than 500,000 new people a year and costing $4 billion annually in direct costs and lost earnings.

- 1 out of 10 children suffers some noticeable nervous system impairment, principal among these are learning disabilities, hearing deficits, seizures, cerebral palsy, mental retardation, spina bifida and autism.

- 2 million people have epilepsy. The total cost, including medication, other health care costs, and indirect expenses such as unemployment and special education is estimated to be over $3 billion.

- About half a million Americans suffer from Parkinson's disease.

- About 250,000 have multiple sclerosis.

- Nearly 1 million Americans are alive with damages from head or spinal cord injury; two-thirds are under 35. There are over 420,000 new cases of head injury a year. Overall costs for head and spinal cord injury amount to over $2.5 billion a year.

- Chronic intractable pain is the most frequent cause of disability and constitutes a severe economic and health problem worldwide.

For many of these disorders, research is the only preventive medicine available.

STATEMENT OF DR. ROBERT CROWELL, DEPARTMENT OF NEUROSURGERY, MASSACHUSETTS GENERAL HOSPITAL, BOSTON, MASS.

STROKE AND TRAUMA

The problem. Stroke is the third leading killer and number one crippler in America today. 2.5 million Americans are impaired from stroke with more than 500,000 new cases every year. The cost of this illness, in direct cost and lost earnings, amounts to more than four billion dollars annually.

Head injury has impaired almost one million Americans; two-thirds of them under 35. 420,000 new cases of head injury occur annually with an overall cost in excess of two billion dollars a year.

Prior to modern medical research, no effective treatment was available for stroke and trauma. Research has brightened the picture somewhat. And research is our only hope for future improvement.

Progress to date. Modern medical research has given us some treatment for these crippling illnesses. Basic science studies have revealed underlying mechanisms of stroke and trauma. Clinical investigations have gone further toward the development of effective diagnosis and treatment.

In the stroke field, laboratory work has shown that some strokes may be reversible in the early phase. Moreover, several drug treatments have shown promise in curbing the damage of stroke (especially phenobarbital).

As regards clinical studies, great strides have been made in the diagnosis of stroke problems. Painless, risk-free tests have been developed to give pictures of arteries leading to the brain. Use of these important tests can identify stroke-prone patients for appropriate preventive treatment. Computed tomography (CT) is a special computerized x-ray method which gives incredibly detailed pictures of the brain and damage by stroke. This device, developed by basic and clinical research, has revolutionized management in both the stroke and head trauma areas.

Stroke treatment has also advanced through research. Several medications have been developed to prevent stroke (especially dipyridimole). Extensive clinical studies have shown that blood thinners including aspirin can effectively prevent and block stroke for some patients. In addition, clinical investigation, much of it funded by NIH, has indicated that surgery to clean out blocked arteries leading to the brain (carotid endarterectomy) can prevent strokes in certain individuals.

In the area of head trauma, basic studies have indicated that certain phases of this problem may be reversible or preventable. Most exciting has been the discovery that drugs (e.g. barbiturates) can reduce increased brain pressure after injury. These methods have been tested in preliminary clinical studies which suggest that the drugs may be helpful for patients as well. Other important clinical studies have shown that in ICU care of head injuries, particularly careful monitoring of brain pressure, can significantly improve outcome for head injury victims.

Basic and clinical research have come a long way toward helping stroke and trauma victims. But there is a long way yet to go.

Prospects for the future. A number of new initiatives in basic research are needed to clarify the stroke process. In particular, the chemical features and aspects of blood products in brain tissue affected by stroke need extensive careful study. Blood clotting may well be altered in stroke; we must know more about this to treat our patients effectively.

With regard to clinical stroke studies, several diagnostic breakthroughs seem likely. A new computer technique for x-raying blood vessels seems very exciting and must be pursued ("venous angiography"). In addition, study of brain chemical function during stroke seems likely to advance understanding greatly. Using the painless, risk-free computer unit (PET scanner), valuable data should be forthcoming on the stroke process. Blood clotting in stroke patients likewise needs much further work.

In the area of stroke treatment, we can look forward to new and better ways to thin the blood for stroke. These treatments obviously need careful study before they can be used safely in patients. Other treatments to minimize stroke damage also need evaluation (mannitol, dilantin and others). A new surgical procedure has been proposed, a brain bypass graft (Extra-Intra-Cranial Bypass). The role of this operation, if any, in stroke prevention is currently under study by an NIH funded collaborative program. This crucial study will help decide which patients should receive this treatment - if the procedure provides ineffective it cannot be recommended thus saving extensive costs and potential unnecessary surgery.

In the head trauma area, further study of drug treatment to control brain pressure is of the utmost importance. Such studies must be carried out both in the basic laboratory and in the ICU setting. Extensive computerized techniques are required.

In addition to these directions, doubtless we will encounter new ideas which will need study to help our patients.

Manpower is critical to research. Over the past few years, there has been an alarming decline in the number of qualified clinical investigators. We need appropriate funding to attract and train young men and women to do this critical work. Years of postgraduate supervised training are needed to train qualified people. Without these essential young investigators, research work for stroke and trauma will wither.

The dollar investment is worthwhile. Only through research can we curb the ravages of stroke and head injury. Not only can we help our fellow Americans, we can also save money. By decreasing the extent of stroke and head injuries, we decrease the rehabilitation and nursing home needs of these patients. A moment's reflection indicates that the dollar savings could be enormous, certainly many millions.

STATEMENT OF DR. ROBERT J. REUBEN, PROFESSOR AND CHAIRMAN, DEPARTMENT OF OTORHINOLARYNGOLOGY, ALBERT EINSTEIN COLLEGE OF MEDICINE

It can be said that the very definition of what is human involves the quality of our communication. When the portals and pathways of our communication are blocked and distorted, human life is bitterly diminished. The repercussions of blocking and diminishing of communications are manifold in their effect to both the individual and the society.

One out of ten Americans now suffer from a communicative disorder. Before their lives are over, almost all Americans will be afflicted by a serious and incapacitating voice, speech, language or hearing disorder. Collectively these disorders of voice, speech, language and hearing are called communicative disorders. They affect Americans at all ages from before birth until old age. The impact on the individual is to reduce substantively his or her ability to communicate, the develop intellect, to gain employment, to develop inter-personal relations and to function in our American society. The cost to the individual, to the family and the American society is extremely high. It is known that an excess of $23,000,000,000 is spent annually for just the care of the hearing impaired and those with speech disorders. No estimate has been made of the cost of decreased productivity, let alone the qualitative cost of tens of millions of Americans with thwarted lives.

There is the opportunity, need and demand to prevent, cure and care for these devastating and costly disorders. I will use just one example from this very broad field of voice, speech, language and deafness to illustrate what can and must be done to better the lives of the American people. Genetic deafness, that is, hearing loss which is inherited, is found at all ages and in all segments of our population. Genetic deafness accounts for at least half of all congenital hearing loss and may be the direct cause or indirect cause of greater than 50% of all hearing losses which occur during the life span of the American population. Genetic hearing loss occurs in an infant, in a young child, a teenager, a young adult a person in the prime of life, and also in our senior population. At the present time, there has been developed, through the basic research funded by the National Institutes of Health and the National Institute of Neurological, Communicative Disorders and Stroke, many scientific discoveries which can be utilized to define the basic mechanisms underlying these genetic abnormalities. Some of these advances are the understanding of the genetic code, the ability to grow the inner ear, the physiology and biochemistry of the inner ear, the determination of the genetic map of man and many others.

Unfortunately, the underlying mechanisms of the various types of genetic hearing loss are not known. If they were, then we could either prevent or cure many of these disorders. The situation for genetic deafness is paradoxical when compared to all of the other genetic disorders of man. In each of these others, for example, the central nervous system, bone, blood system and others, there has been and is being developed understanding of the biochemical basis of the disorder with a resulting methodology for a prevention or cure. Why has this not happened to genetic deafness and also for all of the other genetic communicative disorders? The answer is two-fold. The first is that there is an insufficient pool of competent, basic and clinical scientists to carry out the needed work. For example, there are probably no more than two human geneticists who work fundamentally in the genetics of human deafness and the genetics of communicative disorders in the entire United States. A similar situation exists in the areas of embryology and

biochemistry when applied to genetic deafness. There is an appalling lack of sufficient scientific manpower to even begin to apply the already known knowledge in this area to genetic deafness. There is the urgent need to increase appropriations so that manpower may be recruited and trained to take advantage of the obvious opportunities to better the health of the American population in this area.

The second reason for the almost total lack of progress in this area, when compared to the rest of medicine, is the lack of sufficient funding for those few investigators who have the talent, dedication and proven skills to make advances in this field.

Although there is the opportunity for prevention and cure, we, the American society, still have tens of millions of our citizens afflicted with communicative disorders and it is our obligation to care for our fellow countrymen. The level of care which is possible, as has been demonstrated in either model systems in the United States or in the Western European countries, can greatly ameliorate the handicap of these individuals. Unfortunately, we are not able to deliver this level of care to our citizens because of severe financial restrictions. Additionally, there is a pressing need to evaluate the effectiveness of our care and to develop improved methods of care which would result in a more cost effective system of care then we now have. This type of clinical research is needed and there is the pressing urgency to provide funding so that this can be done to improve the lives of this very large segment of the American people.

In closing, I would like to illustrate the problem as I perceive it each week when I see ten to twenty children with genetic deafness. Each time that I make the diagnosis of genetic deafness in an infant or child, I realize that there is sufficient scientific opportunity to either prevent or cure the disease, if only there was the manpower and funding available to focus our science on genetic deafness. I realize each time that this boy or girl would not have to suffer, would not have his or her life distorted and their families would not have the deep frustrations and disappointments, if the resources were available to apply our knowledge. But these resources are not available and I, at best, must care for the child. Here again, I know what can be done in terms of care but I also realize that for almost all of the children I see, this optimal care is not available.

I feel that part of my responsibility as their physician is to present this situation to you today to request that sufficient funds be allocated so that we may develop the manpower to adequately take advantage of the scientific opportunities which have been afforded; to adequately fund the few basic and clinical scientists now working in the field so that they may advance understanding in this area; to provide optimal care; and to evaluate and develop better types of care than is now given to our population.

STATEMENTS OF:

DR. JAMES FIELD, NATIONAL DIABETES ADVISORY BOARD
DR. JOHN SESSIONS, AMERICAN GASTROENTEROLOGICAL ASSOCIATION
DR. BERGEIN OVERHOLT, AMERICAN ASSOCIATION FOR GASTROINTESTINAL ENDOSCOPY
DR. RONALD ARKY, AMERICAN DIABETES ASSOCIATION
THELMA KING THIEL, AMERICAN LIVER FOUNDATION
RICHARD ASZLING AND ALICE BROWN, JUVENILE DIABETES FOUNDATION
SUZANNE ROSENTHAL, COALITION FOR DIGESTIVE DISEASES ORGANIZATIONS
DR. WILLIAM FELTS, ARTHRITIS FOUNDATION
DORIS TULCIN, CYSTIC FIBROSIS FOUNDATION

NATIONAL DIABETES ADVISORY BOARD

Senator SCHWEIKER. Why don't we go ahead—Dr. Field, I guess you are going to be leadoff. Is that the plan or not?

Dr. FIELD. I am Dr. James Field, professor of medicine, from Houston, Tex.

I represent the National Diabetes Advisory Board. Our third annual report will be available the end of this month.

In the interest of time, I am only going to mention three or four items. Not since the discovery of insulin over half a century ago has the outlook for the diabetic patient been as promising as it is today.

The most significant clinical problem in diabetes is whether degenerative complications involving blood vessels, kidneys, eyes, nervous system, can be prevented by normalization of the blood sugar.

Increasing experimental evidence in animals indicates that normalization of the blood sugar can prevent or delay these life-threatening complications.

Because of the recent development of new insulin delivery systems, we can now for the first time control blood sugar on a 24-hour basis for prolonged periods of time and answer the question whether normalizing the blood sugar will prevent diabetic complications.

The planning and initiation of clinical trials to establish the feasibility of long-term blood sugar control with insulin delivery devices is of the highest priority in our view.

Time does not permit me to elaborate on the very promising research directions related to gene structure, gene expression, DNA, recombinant DNA technology and cell transplantation.

DIABETES TRAINING GRANTS

Appropriate exploitation of these diabetic research advances is critically dependent on an adequate supply of research manpower, particularly physician scientists trained in both basic and clinical sciences.

The total physician scientist pool has decreased almost 50 percent since 1966.

NIH training grant programs supported 4,600 clinical investigators in

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1971 but only 1,800 in 1977. New policies and adequate funds are urgently needed to correct the many——

Senator SCHWEIKER. Repeat those figures again.

Dr. FIELD. Yes; 4,600 NIH-supported trainees in 1971, 1,800 in 1977.

Senator SCHWEIKER. That tells a lot right there.

Dr. FIELD. New programs are needed and new funds to correct the many disincentives which make a career in clinical investigation so unattractive to graduating physicians today.

SPECIFIC RECOMMENDATIONS

The annual report of the National Diabetes Advisory Board contains specific recommendations related to manpower. While the board believes that individual investor-initiated research forms the major background of an integrated research effort, more comprehensive approaches, such as the various types of diabetes centers and multidisciplinary research programs are also important.

The budget proposed by the board provides a reasonable increase in the number of diabetes centers over the next 5 years. The board wishes to take special note of the general clinical research center program of the National Institutes of Health.

This noncategorical activity supports over 80 percent of the clinical research related to diabetes.

The modest annual increases in the budget of this program have not kept pace with the actual costs so that in the last 10 years, there has been a reduction of beds in clinical research units from 1,051 to about 670.

The previously mentioned clinical trials concerning the relationship between normalization of the blood sugar and diabetic complications cannot be done without adequate resources for the research center branch.

Diabetes morbidity and mortality can be reduced through improved application of known treatment measures and education of diabetics and health care professionals.

The Board commends the Center for Disease Control which has initiated an imaginative, promising program of community-based diabetes control projects on a demonstration basis in 12 States.

Eight new States are going to begin programs in fiscal year 1980. Inadequate resources have severely hindered the full development of this program. The board is particularly concerned by the paucity of attention accorded to the behavioral and psychosocial aspects of diabetes.

We are pleased to report that the NIMH and other NIH Institutes have recently announced their interest in receiving research applications in this area.

In summary, the American public and diabetes community should gain increased hope that the challenge of diabetes will be met.

The exciting opportunities now emerging should be fully exploited through vigorous diabetes programs.

While the board's third annual report includes a projected budget for the next 5 years, today we are providing only the budget and personnel recommended for fiscal year 1981.

We truly appreciate the previous support and urge the continued help of this committee for the cure and control of diabetes.

Thank you very much.

PREPARED STATEMENT

Senator SCHWEIKER. Your prepared statement will be inserted in the record at this point.

[The statement follows:]

STATEMENT OF DR. JAMES B. FIELD

I am Dr. James B. Field, Professor of Medicine at Baylor College of Medicine, Houston, Texas. I represent the National Diabetes Advisory Board, which was established in 1976 by Congress to review and evaluate the implementation of a long-range diabetes plan and to report annually to Congress and the Secretary of HEW on recommendations for future policies, programs and budgetary requirements. The third Annual Report of the NDAB will be available by the end of March. The report will describe the tremendous progress of the diabetes program during the last few years and the significant opportunities for future advances both in research and its application to the diabetic population. I will confine my comments to identifying the highlights of that report and focusing on those issues and recommendations which the Board feels most important for your consideration.

Not since the discovery of insulin over a half century ago, has the outlook for clinical advances in the treatment and ultimate prevention and cure of diabetes been so promising as today. Remarkable accomplishments in basic and clinical biomedical research in diabetes have provided both a theoretical and practical base for the development of a broad range of therapeutic interventions applicable to the immediate and long-term needs of the diabetic population. The Board is highly conscious of the all-too-frequent "oversell" of promise and future rewards when seeking federal funding for meritorious programs, and the inevitable skepticism which this approach provokes. However, the Board's enthusiastic optimism reflects not only its own considered and deliberate evaluation of the progress made during the last five years but also that of over 200 national and international experts in a broad spectrum of biomedical sciences related to diabetes who were convened recently by the Board to evaluate the current status of the field and assess directions of future promise.

Remarkable progress has been made on many fronts in diabetes research ranging from the most basic molecular level of investigation to the most clinically relevant issues of treatment. These advances include:

- Significant advances in the area of gene structure and expression and recombinant DNA technology applicable to a spectrum of diabetes problems ranging from the unlimited production of human insulin to a better understanding of the development of the disease itself
- Demonstration of the importance of genetic, viral and immunological factors in the development of diabetes
- Better understanding of the fundamental mechanisms involved in insulin synthesis, secretion and action
- Development of pancreatic islet transplantation techniques in animal models which cure the diabetic state
- Documentation of the therapeutic effectiveness of medical and surgical procedures in the treatment of certain long-term complications of the disease (e.g. antihypertension therapy in renal disease and laser beam photocoagulation for proliferative retinopathy)

I wish today to direct your attention especially to three additional accomplishments related to the control or "normalization" of blood sugar levels which offer exciting new opportunities to reduce the complications of diabetes:

- Development of insulin infusion systems which "normalize" elevated blood sugar levels in both humans and animals
- Demonstration in animals that "normalization" of blood sugar levels prevents and/or reverses the complications of diabetes
- Demonstration in human diabetics that "normalization" of blood sugar levels for short periods of time can improve and correct

some of the functional defects of the disease (e.g. perinatal mortality and retinal capillary leakage)

The recent development of the new insulin delivery systems provides clinical investigators, for the first time, with the ability to control blood sugar level on a 24 hour basis for days or weeks at a time. It will now be possible for the first time to assess the clinical impact of "normalyzing" blood sugar levels in human diabetics. Short-term trials appear to be immediately feasible to examine the effectiveness of this "normalization" on both the early and late stages of many complications of diabetes. The development of clinical trials to define the effectiveness of "normalization" on the long-term evolution of these complications is more complex, but planning for such trials should be initiated and should include studies to test the feasibility of maintaining metabolic normalization during long-term clinical trials. The Board believes that the development of both short-term and long-term clinical trials to evaluate the therapeutic consequences of "normalization" should be given high priority.

In addition to the above clinical trials, a number of other research directions appear most promising and should be vigorously pursued. For example:

- Advances in the biology of insulin gene structure and expression offer both the conceptual and methodological framework needed to explore the fundamental mechanisms involved in the genetic factors causing diabetes and to provide ways of correcting these defects

- Exciting observations implicating viral and immunological factors in the development of some forms of diabetes should be followed to develop new strategems not only for the treatment but also the prevention and cure of this illness

- Better understanding of the fundamental processes involved in insulin secretion and action provides the opportunity for developing pharmaceutical drugs to correct the specific molecular events which are altered in the diabetic

- Advances in immunogenetics and immunology should be expanded to resolve the problems of transplant rejection and apply the technique of pancreatic islet transplantation - and its demonstrated ability to cure the diabetic state - to the human diabetic

Continuation and optimal exploitation of these diabetes research advances is critically dependent on an adequate supply of research manpower, particularly physician-scientists trained both in the basic and clinical sciences. Since 1966, there has been almost a 50 per cent decrease in the total physician-scientist pool in this country and the influx of young talent into clinical investigation has been severely curtailed. For example, new clinical investigators supported through NIH research training programs have declined from 4,600 in 1971 to 1,800 in 1977.

The diabetes research progress made during the past five years reflects predominantly the efforts of established investigators who either were already identified with the field of diabetes or were attracted to the area by the availability of new research funds. New policies as well as adequate funds are needed promptly to reverse the present downward trend in the training of new investigators and to correct the many disincentives which currently make a career in clinical investigation so unattractive. The Board's last report addressed this problem in considerable detail and our forthcoming report will again provide specific policy recommendations. For example, we recommend that Federal training stipends be adjusted annually to compensate for increases in the cost of living. The payback requirement for training stipends should also be eliminated and several new training award programs are needed to encourage medically-trained persons to pursue research careers.

The Board believes that individual investigator-initiated research forms the major backbone of an innovative biomedical research effort.

However, supporting resources in the form of centers and multidisciplinary research programs which facilitate individual investigator efforts and enhance the cooperative and effective interaction of diverse basic and clinical scientists also play an important role in the diabetes program. The following types of special programs and centers have been developed.

- Diabetes Research and Training Centers (DRTC) - NIAMDD
- Diabetes-Endocrinology Research Centers (DERC) - NIAMDD
- Major Research Programs on Diabetes in Pregnancy and Infants of Diabetic Mothers (MRP) - NICHD
- Peripheral Neuropathy Center - NINCDS
- Centers for Diabetes Vision Complications - NEI

The Board has been impressed with the significant role which these centers have played in stimulating innovative multidisciplinary and collaborative research in many areas which previously had not received adequate attention. The DRTC concept has provided a particularly unique training experience in which diabetes health care providers are exposed to investigators at the cutting edge of diabetes research. These centers have served as training units for health professionals not only within their immediate locality but also for personnel involved in other Federal diabetes initiatives - such as the Model Care Program of the Indian Health Service. They have also provided an opportunity to involve specialists in the social sciences (e.g. education, sociology, psychology) who are needed to develop and evaluate new techniques for improving diabetes control, health care, and education programs. The Board has provided in its proposed budget for a reasonable increase in the numbers of diabetes centers over the next five years.

The Board wishes to take special note of the General Clinical Research Center (GCRC) program, a non-categorical activity supported by the Division of Research Resources (DRR). Over 80 per cent of the clinical research related to diabetes is carried out in hospital research facilities supported by GCRC funds. This program has been particularly susceptible to inflationary pressures in recent years since it deals almost exclusively with hospital costs. The modest annual increases in appropriations have not kept pace with actual costs so that the total number of beds supported by the program has decreased from 1051 in 1968 to about 670, with similar reductions in personnel. The Congress and the Administration must accord a higher priority to the vigorous development of these general resources for clinical research. As pointed out previously, the Board believes that the initiation of clinical trials to assess the therapeutic effectiveness of metabolic normalization in the diabetic merits the highest priority and these studies will require adequate GCRC facilities. The Board's budget recommendation for the DRR will insure essential resources for clinical research efforts in diabetes and permit an expansion of the successful Clinical Associate Program which has made significant contributions to the development of clinical research manpower.

The Board believes that a significant opportunity exists to reduce diabetes morbidity and mortality through improved application of known treatment measures. For example, current evidence concerning the potential benefits of "normalization" of blood sugar levels warrants more vigorous efforts to educate diabetics and health care professionals as to the importance of seeking this goal through known treatment strategies. The effective transfer of current diabetes information to the community is an extremely complex task which requires considerable planning and coordination to be successful. The Board is pleased to report that a joint Federal-state program is now developing the essential framework upon which future reductions in death, illness, and disability can be achieved.

The Center for Disease Control (CDC) has begun a program of community based diabetes control projects on a demonstration basis in 12 states. Eight additional states will begin planning similar projects in FY 1980. Despite resource limitations, this agency has created imaginative and needed community demonstration projects as a first step toward a national

diabetes control program. CDC has the expertice to systematically apply public health concepts of disease control to improve the quality, accessibility, and effectiveness of diabetes health care. Unfortunately, the absence of adequate resources for the program has severely hindered its full development within the initial states and delayed expansion to additional areas in need of this program. The Board has provided appropriate budget and personnel recommendations for this imaginative and well planned program.

The Board has been particularly concerned that very little attention was being directed toward a better understanding of the well recognized association between diabetes and behavioral and psychosocial aspects of the disease. We are pleased to report that the National Institute of Mental Health (NIMH) and four institutes of NIH have recently announced their interest in receiving research applications related to this problem. The Board encourages these institutes to continue and expand these new activities and has included appropriate budget recommendations for this purpose.

In summary, the American public and the diabetes community of patients, health care personnel, scientists, and voluntary health organizations should gain increased hope that the challenges of diabetes will be met. Although considerable additional effort is required, significant first steps have been taken. However, it is essential that the exciting opportunities now emerging be fully exploited through vigorous Federal diabetes programs. The Board's third annual report will include a five year budget. We are providing today budget and personnel recommendations only for FY 1981. We urge the continued support of this committee for these essential programs.

Budget and Personnel Recommendations
of the National Diabetes Advisory Board for FY 1981

Agency	($ in thousands) Diabetes Budget	New Personnel Positions
National Institutes of Health:		
NIAMDD*	$91,700	15
NHLBI	18,200	5
NEI	23,000	5
NICHD	10,800	4
NINCDS	6,500	3
NIAID	3,600	2
NIA	2,900	2
NIDR	2,300	2
NIGMS	1,600	
NIEHS	200	
DRR**	12,200	3
Subtotal	173,000	41
Alcohol, Drug Abuse, and Mental Health Administration:		
NIMH	1,000	4
Center for Disease Control	8,000	8

* The Board's recommendations for NIAMDD excludes diabetes-related activities in other NIAMDD programs.

** The Board recommends $76 million in FY 1981 for the total General Clinical Center Program of DRR. This table relfects an estimate of diabetes-related activities within this noncategorical program.

CYSTIC FIBROSIS

Senator SCHWEIKER. Why don't we interrupt your sequence one minute and let a member of the Child Health and Community Development panel—Cystic Fibrosis—go ahead.

Mrs. TULCIN. Thank you.

Cystic Fibrosis is the No. 1 genetic killer of young people in America. Each year over 30,000 years of life are lost to cystic fibrosis, years in which children born with this disease could have been productive citizens if only we knew how to control it.

You know that research works and we hope that research will work for us. This year, we are asking for $3.9 million, excuse me, $3.9 billion, a 14-percent increase for the NIH budget.

I am really making a plea for biomedical research per se. I think I am going to deviate from my text because of time and not tell you about cystic fibrosis, but tell you about those of us that will suffer if research dollars are cut back.

You said in your remarks to the other panel that the Congress is thinking of a 10- or 13-percent cut. I would like to address what it would mean to a disease like ours to suffer a 10-percent cut in program.

Senator SCHWEIKER. I didn't say the Congress, I said the President was saying that his cut might be 10 or 13 percent if he went ahead with it. The figure was right.

Mrs. TULCIN. I am sorry. I stand corrected.

Senator SCHWEIKER. Responsibility for where the cuts are coming from to where they were.

Mrs. TULCIN. However, a 10-percent cut in our programs would mean no programs for us because we have just begun to attract scientists in our field of endeavor. Because of the funds that Congress has so prudently allocated to our programs in the last 3 years, we have just begun to get off the ground.

A 10-percent cut in those programs would mean a wipeout for us because priority scores would dip so low that we would not be able to compete with the other diseases for funding.

So we are really facing a very severe problem. We are looking at our 25 years of being in business; a very unhappy 25 years because what we have really done is extend life. We haven't done anything more than that. That is a partial success story for a disease like ours, which is chronic and catastrophic at the same time.

CYSTIC FIBROSIS BREAKTHROUGH

We are on the verge, we believe, of two very major breakthroughs in our disease. One, we hope to have a carrier test available to us within the next year or so. This will mean an expensive clinical trial to make sure it will work, because we will be testing the Caucasian population. We are also at a major breakthrough in a very severe bacterial infection called Pseudomonas which, if we can get a handle on it, will mean a great deal for the treatment of other diseases.

That will be an expensive procedure. Without dollars and research, we will not be able to do this.

So I am here asking for money for the biomedical research community in NIH because if there is money for the whole, those of us that need it will be able to get some of it.

Senator SCHWEIKER. I just want to comment on the—well, I will withdraw that and get back to it.

We appreciate your going out of turn. Sorry about the problem. You are free to stay here as long as your time permits.

Mrs. TULCIN. Thank you very much for considering it.

PREPARED STATEMENT

Senator SCHWEIKER. Your prepared statement will be inserted in the record at this point.

[The statement follows:]

Statement of the Cystic Fibrosis Foundation

The Cystic Fibrosis Foundation is pleased to have this opportunity to comment on the Labor-HEW Appropriations Bill for Fiscal Year 1981. During the 25 year life of our Foundation, we have been privileged to share in considerable progress in the fight against cystic fibrosis. Unfortunately, we still have no cure for cystic fibrosis, we still have no control for cystic fibrosis, and half the children born this year with cystic fibrosis will not live past their teens.

In our testimony, there are three programs that we would like to discuss. Our first priority, of course, is for continued health research at the National Institutes of Health. In addition, we would like to address the Genetic Services program and the Pediatric Pulmonary Centers program.

What is Cystic Fibrosis?

Cystic fibrosis (CF) is the number-one genetic killer of children in America. The CF gene is carried by about five percent of the Caucasian population, and between 1,500 and 2,500 children are born each year in this country with CF. Despite recent advances in treatment, the average life span for those affected remains less than twenty years.

CF is an inborn error in metabolism that causes cells to secrete excessive amounts of thick, sticky mucus. This mucus clogs the lungs, making breathing difficult. It also interferes with the flow of digestive enzymes from the pancreas to the intestines, preventing the digestion of food. The risks of lung infection and diabetes are substantial, and the heart and lungs are placed under tremendous strain.

Lengthy and painful treatments are required on a daily basis merely to allow the patient to breathe. Many afflicted with CF are forced to take 60 or more pills a day containing enzymes and antibiotics. Frequent hospitalization is necessary during particularly severe bouts of the disease. And the disease is never outgrown; it only gets worse.

Yet, aside from their "hidden handicap," many people with cystic fibrosis are actually over-achievers in society. The disease does not affect their motor skills (except that many are underweight), and there is no impairment of intelligence, speech, or learning ability. The victims of CF want desperately to have the chance to live full lives and continue to contribute to society for a long span of years. Our goal in the Cystic Fibrosis Foundation is to give them that chance.

What is the Impact of Cystic Fibrosis?

On a national level, we estimate that there are between 13,000 and 30,000 people with cystic fibrosis. Through our national system of treatment centers, we currently provide services to over 12,000, and we know that there are many we do not see.

The average direct cost of treatment for CF is between $10,000 and $20,000 per patient per year. Overall, the annual cost in treatment alone is at least $150,000,000 per year.

To this must be added the impact on the people involved, which is not measured in dollars but which cannot be overlooked. The disease requires continuous attention, and parents must devote incredible amounts of time to therapy. One common procedure, called "clapping," involves literally hitting the child's chest to break up the mucus -- after years of this, a parent's hands can become deformed. Social activities and time together for husbands and wives become increasingly rare. The financial strain is overwhelming, yet extra income is lost because the burden of care does not permit both parents to work full time outside the home.

The pain of growing up without a future is hard enough for a young person, but the requirement for self-care is an additional burden that also interferes with academic pursuits and a social life. Depression and despair threaten the instinct for survival.

For the minority who live into their twenties, the fight for life continues without pause. The hidden handicap of CF can mean job discrimination and difficulties in social development. Questions of whether to marry, whether to have children, whether to pursue a career, and how to secure financial independence are much more difficult for these people than for the average young American.

Why Cystic Fibrosis Research? Why Now?

The 1978 report by the Cystic Fibrosis Foundation to the Congress, entitled "Cystic Fibrosis: A Plea for a Future," helps to answer one of the most important questions this Subcommittee faces each year: How should funds be distributed within the National Institutes of Health to properly balance various worthy health concerns?

Three criteria have been suggested to answer this question.

1. What is the potential return on our investment?

   We think the potential return for cystic fibrosis research is great. As explained earlier, the financial burden of CF is at least $150,000,000 in direct care costs alone, yet NIH is only spending about $9,000,000 on research. We believe there is a strong potential for additional research to reduce patient care costs for those who have contracted the disorder, perhaps by advances in drug or nutritional therapy, or to create the knowledge to prevent the disease from birth. Either development could reduce the size or growth of the treatment cost figure and pay for the research many times over.

   More importantly, in our eyes, long-term control of CF will permit those who have the disease, or who will be born with it in years to come, to live full, productive lives. The investment that society now pays for their education and health care would be repaid in full through their contributions to society. Much of our Nation's health effort is devoted -- and properly so -- to the care of those who have lived long lives before falling ill to cancer or heart disease or any of a number of other problems. CF victims do not now have that chance for fifty or sixty or seventy years of life, but an additional research effort could give them that opportunity.

2. How many people are affected, and how seriously?

   The simple answer to this question is deceptive. There are between 13,000 and 30,000 people with cystic fibrosis, and it is universally fatal at a young age. On a "head count" basis, however, CF has a greater impact.

   - There are a large number of genetic disorders affecting cell metabolism, but of them CF is uniquely able to serve as a research model for the group. To state it differently, what we learn about the genetic basis of CF will help unlock the doors to problems affecting many thousands of other people.

   - There are many immune deficiency diseases, and research into the underlying defect in the CF lung could benefit those who suffer from the related diseases as well.

   - Victims of asthma, chronic bronchitis, and emphysema would all stand to benefit from new knowledge about the control of obstructive lung disease.

- Additional studies into the most effective way to correct enzyme deficiency or imbalance would increase the quality and extent of life in patients affected by other diseases characterized by similar enzyme problems.

- Finally, chronic diseases such as cystic fibrosis create serious psychosocial problems for both patients and their families, and comprehensive treatment must address the impact on the entire way of life of those affected. Work with the treatment of CF patients would help those with other chronic diseases including diabetes, hypertension, and kidney failure.

Thus, there are many areas of common concern between CF and other health problems, and research in almost any aspect of CF will produce a valuable spill-over to benefit related disorders. An expanded CF program will not be limited in its impact only to the CF population.

3. Can the Money Be Used Well?

The Cystic Fibrosis Foundation is very concerned about this problem. We do not want to see the future of those with the disease destroyed because of blind alleys, duplication, or sloppy research. In our 1978 report to Congress, we discussed five major areas that need additional research in cystic fibrosis, and where the ability to do good work exists. These include metabolic defects in CF and the search for markers, the secretory process in CF, respiratory aspects of CF, digestive and nutritional problems, and the standardization of tests and improvements of diagnostic techniques. The research effort must include substantial basic research in most of these fields in addition to CF-specific research.

Cystic Fibrosis Research Recommendations

The direction and pace of health research in the National Institutes of Health is primarily determined by three things: the funds appropriated by Congress, the program direction indicated both by Congress and by the NIH's planning, and the strength of the scientific community addressing a particular problem. Over the past two or three years, cystic fibrosis has been blessed with support in all three of these areas. Except for last year's appropriation for NHLBI, the Institutes which support CF research have been generally well funded, and this Committee, in its report, has indicated strong support for continued efforts in CF. The NIH leadership has shared this concern, supporting a number of conferences, program announcements, and other efforts designed to focus scientific attention on CF and the opportunities for progress there. We are pleased that the scientific community has responded with a three-fold increase in CF-related grant applications to the NIH. A number of researchers who would not otherwise have worked in this field are now seeing it as a promising area of endeavor.

The result has been that between Fiscal Year 1977 and 1979, the amount of CF research supported at NIH grew from about $4.5 Million to over $9 Million. Early estimates for Fiscal Year 1980 are that CF research will be in excess of $10 Million. These figures are in line with recommendations in our 1978 report to Congress.

For Fiscal Year 1981, we hope that this effort will continue, and that cystic fibrosis research will grow to $14 Million across NIH.

Because there is no specific program or line item for CF in the budget, we make the following recommendations for the specific Institutes that support CF research. These recommendations will allow strong, balanced research efforts in health in all the areas relating to CF.

- For the National Heart, Lung, and Blood Institute, $610 Million. Last year, NHLBI received a budget increase of less than 4% -- the smallest of any of the Institutes. As a result, the Institute is funding a smaller fraction of its approved research applications

than at any time in its history. NHLBI has a strong record of progress in all the areas that it is responsible for, and has long provided important funding to the fight against CF. With the funds requested, NHLBI will be able to continue funding of specialized centers of research (SCORs) in CF, and will be able to expand its research grant activities in this field.

- For the National Institute of Arthritis, Metabolism, and Digestive Diseases, $395 Million. NIAMDD is responsible for conducting research into most of the major chronic diseases that currently make up so much of our national health bill. Because of the large number of diverse but important health problems that this Institute addresses, NIAMDD requires continued substantial support in its funding. In addition to the report on CF and the growth of interest in this field, NIAMDD is also being asked to respond to increased scientific interest in diabetes, arthritis, digestive diseases, kidney diseases, and other areas as well. About half of all CF research is funded by NIAMDD, and the plans outlined in the President's Budget do not provide for the continued growth that is necessary.

- For the National Institute of Allergy and Infectious Diseases, $250 Million. Research into the control of lung infection, one of the most deadly symptoms of CF, is supported by NIAID, and recent research indications that immune defects may play an important part in the long-term deterioration of CF patients should increase the role of this Institute in CF research. Again, the increases that have been requested will allow this Institute to maintain its program activities and to continue to exploit scientific opportunities.

The Cystic Fibrosis Foundation is a member of the Coalition for Health Funding, and we endorse the recommendations of the Coalition with regard to the National Institutes of Health.

Genetic Information and Counseling

The best long-term strategy for controlling genetic diseases is to learn how to detect them before birth and to provide information and counseling to parents who could have children with genetic diseases. Because genetic counseling is a relatively new area of medicine, there are many parts of the country where quality services are not available. Congress attempted to address this problem in the Genetic Diseases Act, but limited funding has allowed programs to be established in less than half the states. An expansion of this program to a level of $21 Million would allow 45 states to participate in the program at a level of funding sufficient to initiate state-wide systems.

Genetic screening and pre-natal diagnosis of cystic fibrosis have been the subjects of a number of major scientific papers in recent months. While no method is yet available for general clinical use, we are confident that procedures will be in use within a very few years. With every new scientific advance, the need for and value of a genetic information and counseling program becomes more apparent. We hope that this Subcommittee will continue its strong support of this program.

Pediatric Pulmonary Centers

The Cystic Fibrosis Foundation has been urging Congressional support of the Pediatric Pulmonary Centers program for over a decade. Approximately one out of every six children in the United States suffers from chronic pulmonary disease, and yet the number of health professionals, especially non-physicians, trained to care for children with cystic fibrosis and other lung diseases falls far short of the need. The training and care programs carried on by the Pediatric Pulmonary Centers are working to address this shortage.

At the present time, there are twelve Pediatric Pulmonary Centers with a total budget of slightly more than $3 Million per year. This total has not increased significantly in a number of years, and the Centers have therefore been unable

to maintain their programs in the face of inflation. We believe that an increase in funding of this program to $5 Million a year would allow for several additional Centers to be created and for more adequate funding to be provided to the existing Centers. We would also urge this Subcommittee to direct the Health Services Administration to conduct a review of the Pediatric Pulmonary Centers program and to prepare recommendations on means for improving the operations of the program with regard to its goal of providing training for health professionals in the context of high-quality, regionalized care of children with lung diseases.

We are concerned that there are still major areas of the United States which do not have any Pediatric Pulmonary Centers. We would urge the Committee to recommend in its report that, when future competitions are held for Pediatric Pulmonary Center grants, either because Center grants are expiring or because new Centers are being created, qualifying institutions from all areas of the country be allowed to compete. Further, we would urge that Center grant applications be independently peer reviewed, so that grants will only go to those institutions which will provide the greatest overall benefit from their program. We believe that the grant approval process should include geographic distribution, population density, professional needs in the area, and the academic and care quality of the specific program.

Conclusion

Cystic fibrosis remains one of America's most serious child health problems. As a disease which takes the lives of our Nation's youth, it affects all of us. Continued Federal support of research, care, and education programs are our only hope of finding the ultimate answer to cystic fibrosis.

ARTHRITIS, METABOLISM AND DIGESTIVE DISEASES

Senator SCHWEIKER. We will let the panel go ahead. Who is next?

Dr. SESSIONS. Perhaps I can start. First I would like to thank you for the support you gave the proposals last year. We consider it a privilege to be here today to testify. I'm the first of four panelists that represent a coalition of digestive disease organizations. Extended testimony which deals with——

Senator SCHWEIKER. I wonder for the record, will all other witnesses, since we have names which have been substituted, state your names, please, for the reporter.

Dr. SESSIONS. I will submit extended testimony that deals with research accomplishments.

Senator SCHWEIKER. We will place all the extended testimony in the record so everybody knows their full statement is included.

GASTROENTEROLOGICAL RESEARCH

Dr. SESSIONS. I'm going to deal with very specific bottom lines, you might say, telling you what we need and why.

The Congress appointed a commission that studied digestive diseases and came up with rather startling data as to the severity of the problem for the American public. The recommendations were submitted to the Congress last year. Unfortunately because of the timing there wasn't the opportunity for a full appropriations process. The recommendations requiring authorization, have been acted on favorably by the House and are part of the proposed Kennedy bill for the NIH, so we are confident we will have all of the authorizing legislation in hand in time for the appropriations process this year.

We would like to ask——

BUDGET REVISIONS

Senator SCHWEIKER. Let me say, we are not sure of that either, because in addition to the problem with the President resubmitting a whole new budget, we have reached the congressional spending ceiling on the present budget. Any new bill that comes out of committee now, if it goes 1 penny over the ceiling, which apparently all of them do, the bill is subject to a point of order raised by any Member unless we rectify the fact we are now over the current spending ceiling.

So no new spending bill of any kind whatsoever may now go through the House or Senate floor. I bring this out because it is something that has never happened before. It presents a real parliamentary and physical dilemma for us.

In addition to this bill we have the higher education bill, we have other health manpower bills and still others that will be held up over that point of order threat. So it's mainly due to interest rates, inflating to the point where all of our expenditures in Government are up.

Excuse my interruption but you should understand that the whole ball game has changed in the last 2 weeks.

Dr. SESSIONS. We appreciate your explaining that.

Senator SCHWEIKER. One of the reasons we don't have any business on the floor right now is we can't bring a bill up that isn't subject to a point of order on the spending limit.

Go ahead. I want to give you all the bad news now. It makes our problem in the committee probably 10 times more difficult than it normally is.

RECOMMENDATIONS

Dr. SESSIONS. Assuming for the moment that the bills have passed authorization in the House, and get favorable action in the Senate, we would like to offer as first priority items three points.

One is that there be established a National Digestive Disease Advisory Board. This, of course, was one of the recommendations of the commission. It follows the pattern of other commissions, for arthritis and so forth, and the cost is minimal, $300,000.

A second recommendation is that there be established a national digestive diseases educational and information clearinghouse. The Congress showed sufficient interest in this point that NIMDD and the Institute has set aside some funds to start this activity this year. We want this to be continued and expanded into the pattern that was planned for it. This again calls for $300,000.

Finally, while the Digestive Disease Commission, in a very conservative appraisal, recommended 23 items with an increased spending of $25 million, we have scaled this down to a prioritized list with a $10 million price tag. These programs are outlined in the materials submitted to the committee for study and critical review.

I don't have time to say anything about research opportunities or accomplishments, but this will be in the extended testimony. I believe the committee has had some benefit of the materials passed on earlier.

Senator SCHWEIKER. I don't want to say that we have discussed this bill in conference, it was with another bill as you well know and didn't get through. I want to assure you that I am supportive of the National Digestive Disease Advisory Board and clearinghouse. Our problem is to find the parlimentary means to make sure it passes safely. Hopefully we can get this particular item and all of them resolved. I think there is a sincere desire with respect to the Health Committee to help get it through. That has to be resolved for other bills as well. So I think there is some hope we can get it resolved somehow.

Dr. SESSIONS. Thank you. We will leave with light hearts.

Senator SCHWEIKER. Yes; we wanted to give you all the bad news.

PREPARED STATEMENT

Senator SCHWEIKER. Your prepared statement will be inserted in the record at this point.

[The statement follows:]

Statement of Dr. John T. Sessions

Mr. Chairman, I am John T. Sessions, Jr., M.D., Professor of Medicine, Division of Digestive Diseases and Nutrition, University of North Carolina in Chapel Hill, and I am here representing the American Gastroenterological Association.

I have appeared before you now for a number of years, speaking in support of appropriations for research and training in digestive diseases. As in past years, I have prepared for you a report on the accomplishments that have occurred in research in digestive diseases made possible by the money and by the bill report language provided by this subcommittee, and also suggest specific areas where support during the upcoming year would increase research opportunities.

However, before I speak specifically about research accomplishments and opportunities, I would like to indicate to you our concerns about the underfunding of those recommendations made by the National Commission on Digestive Diseases last year.

As you will recall, about three years ago Congress passed a law establishing a National Commission on Digestive Diseases and requested that Commission to survey the field of digestive diseases to determine where we have been, where we are now, and where we are going in terms of research and care in the field of digestive diseases. That Commission, with over 400 gastroenterologists and lay persons concerned about the disease, and other medical and lay specialists as well, participated in hearings throughout the United States. A comprehensive report was made to Congress last year at about this time. We were very hopeful that the twenty-three recommendations would be implemented by various Federal government agencies, and we had hoped that funding would be made available by this Committee to support those recommendations.

To digress just a moment, I would like to indicate to you that the House Committee on Interstate and Foreign Commerce moved rapidly to put into law those provisions which required new authorization. Three specific recommendations were dealt with by that Committee, including a National

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Digestive Diseases Education and Information Clearinghouse, a specific program dealing with education and training programs in digestive diseases in schools of health, and the establishment of a National Digestive Diseases Advisory Board. That bill was agreed to by the House of Representatives last year. Action is now pending on similar legislation before Senator Kennedy's Subcommittee on Health in the Senate. Additionally, in the current legislation, HR 6522, pending before the Interstate and Foreign Commerce Committee, dealing with the biomedical research needs, language supporting both the Clearinghouse and the Advisory Board has been included.

Because the legislation for these three programs has already cleared the House, and there is no question that a program similar to that legislation will be enacted into law, we request that this Committee specifically indicate that for the National Digestive Diseases Advisory Board for fiscal 1981, there be included at least $300,000 (which is the authorized figure in the House legislation), and at least $300,000 to carry out the work of the National Digestive Diseases Education and Information Clearinghouse. (The NIAMDD has indicated that it is willing to move forward on the National Digestive Diseases Education and Information Clearinghouse, using its general Public Law, Section 301 authority, because it understands the very great interest that the Congress has in this proposed program. They have set aside this year approximately $200,000 for the carrying out of that program, which will permit them to begin to start up the Clearinghouse, and so a specific appropriation of $300,000 would provide continuity and rapid movement in this area.)

We are hoping that this Committee will also appropriate a sum of $450,000 for the upcoming fiscal year, which is the sum authorized under Section 440 (c), the Education and Training Programs in Digestive Diseases, in House bill HR 1650, which passed the House last year.

However, Mr. Chairman, these are only three of the twenty-three recommendations made by the National Commission. I attach for the record a copy of page 53 drawn directly from Volume I of the National Commission's report, which lists the recommended digestive disease programs for NIAMDD. As you will study this list, you can see that there are a large number of

opportunities now available in the field of digestive diseases for rapid forward movement. Also for the record, I would like to insert also a copy of the 4-page summary statement made by the National Commission on Digestive Diseases, indicating the wide-ranging nature of the opportunities now available within that institute.

We all recognize that this is an extremely stringent year regarding funding increases, and therefore I recognize that it is probably not possible to make the major increases in funding that are indicated in the proposal by the National Commission. Therefore, for your consideration, I offer to you those suggested opportunities that would be made available if this Committee indicated in its bill report or in the actual bill itself, that up to $10 million or up to $20 million could be expended in the field of digestive diseases in the NIAMDD this upcoming fiscal year.

Mr. Chairman, we have a superb opportunity now to move forward in research on digestive diseases. The entire field has shown its great interest in the National Commission's work, and many people are anxious to assist in moving the whole field forward, and we feel that we would be remiss in not calling all of this to your attention at this time.

Now, Mr. Chairman, I would like to describe five areas of specific accomplishment over the past year and research opportunities for the near future. These areas are selected from many important possibilities.

(1) Bleeding from the upper gastrointestinal tract, which may present as the vomiting of blood or the passage of tarry black stools, continues to be an important medical problem, accounting for at least 150,000 hospital admissions each year in the United States. When the bleeding continues and arises from peptic ulcers of the stomach or duodenum, surgery is usually required to stop the bleeding. The surgical mortality in these patients, many of whom are otherwise healthy and many of whom are elderly, is unacceptably high. If these patients could be treated effectively medically, surgery could be avoided or at least postponed until the patient was best able to tolerate an operation.

Instruments (endoscopes) have been developed that allow the physi-

cian to look directly into the digestive tract to see where bleeding is coming from. Endoscopy has helped physicians decide when and where to operate for recurrent or intractable bleeding but until recently there was nothing that could be done through the endoscope to stop the bleeding. Now, as a result of basic research supported by this Committee, a number of investigators, and particularly the group at the University of Washington in Seattle, have developed techniques for stopping bleeding by transmitting energy through the endoscopes. Experiments establishing the effectiveness of laser beams and the electrocoagulation by radio frequency electrical currents have been completed in experimental animals and patients. It is now essential that we have clinical trials of these two forms of treatment to determine in a conclusive manner which of these approaches is most effective, the relative costs and the frequency as well as severity of complications associated with the treatment. Detailed studies indicate that a multicenter, cooperative trial, will be necessary to secure enough patients for an early and conclusive answer to these questions. An ample number of highly qualified clinical centers has expressed a desire to participate. A successful clinical trial is the logical culmination of this research that you have chosen to support through the years and should have an important impact on the health of the American public. Additional funds will be needed to adequately support studies in this area, the estimated cost being $1,000,000 a year for about three years.

Prevention of peptic ulcer formation is the ultimate goal. Increased understanding of genetics, biochemistry and physiologic factors in peptic ulcers encourages expanded research in this area. An additional figure of $750,000 is requested to further study basic mechanisms of peptic ulcers.

(2) Gallstones are responsible for about 500,000 operations and about 5,000 deaths each year. Yet we know that gallstones are often present without causing symptoms. We need to know how frequently gallstones exist with and without symptoms, how likely gallstones are to eventually cause symptoms, and just how dangerous these stones are. The development of ultrasound techniques now allows us to detect gallstones

without exposing patients to x-ray. By adding an ultrasound examination to the National Health Survey, we could determine safely and relatively inexpensively how frequent gallstones are in the general population, what people are most frequently affected, and at the same time, learn what proportion of these people have symptoms. This survey would cost about $250,000 a year for several years.

While gathering this information, we should increase our knowledge of factors that cause gallstones, as a basis for preventing their development. A study of the medical treatment for gallstones that is presently underway may be helpful, but even more important is a growing body of knowledge of factors contributing to cholesteral gallstone formation. Examples are changes in the composition of bile that occur with obesity, with pregnancy, and with the administration of certain sex hormones commonly used as contraceptive agents. People with sickle cell disease have an increased frequency of gallstones made from bile pigments. The knowledge and techniques acquired in studying cholesteral gallstones should now be applied to pigment stones with the goals of preventing their formation or dissolving them. An addition of $500,000 during the coming year for work in this area can be expected to yield important advantages.

(3) Cirrhosis of the liver is the seventh most common cause of death in the United States. While the disease is commonly due to excessive drinking of alcohol, there is increasing evidence for significant liver injury by industrial toxins and various pharmaceuticals. Further knowledge of toxicology and immunology as it bears on cirrhosis should provide additional means for the prevention and treatment of cirrhosis. Appropriation of an additional $750,000 is recommended for this area.

(4) Crohn's disease and ulcerative colitis are tragic disorders that are causing chronic and disabling disease with increasing frequency. The importance of these diseases is amplified by the fact that they usually attack young people during their periods of most rapid development and productivity. Basic research and workshops supported by the Senate have pointed increasingly toward a viral or bacterial infection as a principal cause of these diseases but we have not yet succeeded in establishing this

as a fact or identifying the specific agent responsible for such an infection. It is the opinion of the scientific community that our most sophisticated, modern techniques should be applied to research in this area because if an infectious cause can be found, an effective treatment seems far more likely. There currently exists laboratories with an interest in these inflammatory bowel diseases who are equipped to pursue the virologic, bacteriologic and immunologic research required to further elucidate a possible infectious basis for these diseases. Your continuation and expansion of research in this area can be reasonably expected to sustain these laboratories and recruit others with a view toward gaining greater control over Crohn's disease and ulcerative colitis during the next decade. An additional appropriation of $750,000 for research in this area during the coming year should prove to be extremely useful.

(5) The digestive tract has been described as "the sound board of the emotions" and approximately 20% of patients visiting physicians for a digestive disease have such a functional disorder. Recent research on the nervous system and a workshop held in the past year revealed new opportunities for the study of these problems. A variety of new substances have been identified that are released by nervous tissues and influence digestive tract functions. Hormones that are present in the gut have now also been found in the brain. Substances called endorphins that have some of the actions of morphine have been found to occur in the normal intestine. A workshop that brought neuroscientists together with gastroenterologists identified many promising opportunities for fruitful research. With more knowledge, we may be able to diagnose these disorders directly, avoiding the expense and discomfort of ruling out other possible explanations. New knowledge should also increase the specificity and effectiveness of treatment for these patients. Research in this field should grow rapidly during the next few years and we request $700,000 for support during the coming year.

$10 Million Allocation

National Commission on Digestive Diseases Recommendation	(Dollars in Thousands) FY 81
1. Establish a National Digestive Diseases Education and Information Clearinghouse	$ 300
3. Strengthen Professional Education in Digestive Diseases	95
4. Standardize Terminology and Diagnostic Criteria	13
9. Support Training Programs in Digestive Diseases Research	500
10. Expand Applied (Clinical) Research in Digestive Diseases	5,000
11. Expand Basic Research in Digestive Diseases	2,500
14. Determine Epidemiological Patterns of Digestive Disease	400
15. Investigate the Toxicity of Environmental and Industrial Pollutants to the Digestive Tract	400
16. Study the Influence of Nutrition on Susceptibility to Digestive Diseases	500
21. Establish a National Digestive Diseases Advisory Board	292
TOTAL	$10,000

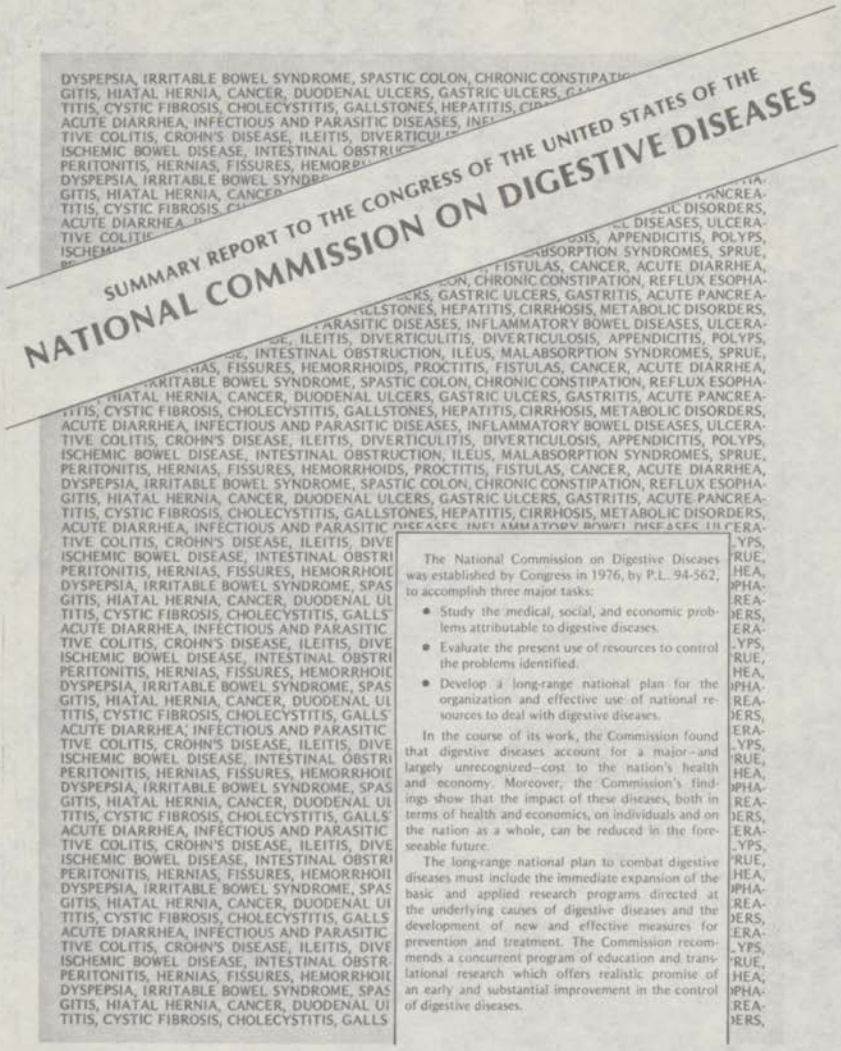
$20 Million Allocation

National Commission on Digestive Diseases Recommendation		(Dollars in Thousands) FY 81
1.	Establish a National Digestive Diseases Education and Information Clearinghouse	$ 750
2.	Establish Standards in Training of Physicians	50
3.	Strengthen Professional Education in Digestive Diseases	150
4.	Standardize Terminology and Diagnostic Criteria	13
5.	Aid Physicians in Constructing Sequences of Diagnostic Tests	70
6.	Expand Health Care Delivery and Translational Research	750
9.	Support Training Programs in Digestive Diseases Research	700
10.	Expand Applied (Clinical) Research in Digestive Diseases	9,500
11.	Expand Basic Research in Digestive Diseases	4,500
12.	Support Cooperative Research	750
13.	Expand Intramural Research at the National Institutes of Health	250
14.	Determine Epidemiological Patterns of Digestive Diseases	500
15.	Investigate the Toxicity of Environmental and Industrial Pollutants to the Digestive Tract	500
16.	Study the Influence of Nutrition on Susceptibility to Digestive Diseases	1,000
17.	Study Continuing Medical Education and Assess Manpower Needs	225
21.	Establish a National Digestive Diseases Advisory Board	292
	TOTAL	$20,000

SUMMARY OF PROPOSED BUDGETARY INCREMENTS BY RECOMMENDATION
(Dollars in Thousands*)

Recommendation	Fiscal Year 1980	1981	1982
1. Establish a National Digestive Diseases Education and Information Clearinghouse	$ 1,259	$ 1,449	$ 1,564
2. Establish Standards in Training of Physicians	99	107	–
3. Strengthen Professional Education in Digestive Diseases	499	687	1,026
4. Standardize Terminology & Diagnostic Criteria	58	63	–
5. Aid Physicians in Constructing Sequences of Diagnostic Tests	408	567	748
6. Expand Health Care Delivery & Translational Research	8,459	12,878	16,851
7. Strengthen Digestive Diseases Programs in the Department of Defense	233	252	272
8. Encourage the Role of the Veterans Administration in Digestive Diseases Research	583	630	680
9. Support Training Programs in Digestive Diseases Research	2,935	5,245	7,115
10. Expand Translational and Clinical Health Services Research in Digestive Diseases	18,177	24,121	32,544
11. Expand Basic Research in Digestive Diseases	7,996	11,483	15,275
12. Support Cooperative Research	4,666	5,039	5,442
13. Expand Intramural Research at the National Institutes of Health	759	1,311	1,946
14. Determine Epidemiological Patterns of Digestive Diseases	2,938	6,043	8,439
15. Investigate the Toxicity of Environmental & Industrial Pollutants to the Digestive Tract	3,762	5,732	8,470
16. Study the Influence of Nutrition on Susceptibility to Digestive Diseases	2,881	4,434	4,857
17. Study Continuing Medical Education and Assess Manpower Needs	670	1,008	986
18. Provide Health Insurance Coverage for Patient Education	–	–	–
19. Provide Health Insurance Benefits for Catastrophic Diseases	–	–	–
20. Facilitate Progress in Digestive Diseases by Administrative Changes	–	–	–
21. Establish a National Digestive Diseases Advisory Board	292	315	340
22. Ensure Representation for Digestive Diseases on Three Institute Advisory Councils	–	–	–
23. Provide Identity and Visibility to Digestive Diseases within the National Institutes of Health	–	–	–
Total	$56,674	$81,364	$106,555

*Includes 8 percent per annum inflation, except for training awards, which are in constant dollars.



The National Commission on Digestive Diseases was established by Congress in 1976, by P.L. 94-562, to accomplish three major tasks:

- Study the medical, social, and economic problems attributable to digestive diseases.
- Evaluate the present use of resources to control the problems identified.
- Develop a long-range national plan for the organization and effective use of national resources to deal with digestive diseases.

In the course of its work, the Commission found that digestive diseases account for a major—and largely unrecognized—cost to the nation's health and economy. Moreover, the Commission's findings show that the impact of these diseases, both in terms of health and economics, on individuals and on the nation as a whole, can be reduced in the foreseeable future.

The long-range national plan to combat digestive diseases must include the immediate expansion of the basic and applied research programs directed at the underlying causes of digestive diseases and the development of new and effective measures for prevention and treatment. The Commission recommends a concurrent program of education and translational research which offers realistic promise of an early and substantial improvement in the control of digestive diseases.

FINDINGS OF THE COMMISSION

While digestive diseases vary in severity from brief, self-limited illnesses to chronic, disabling, and some universally fatal conditions, their total social and economic impact is enormous. Measured in terms of morbidity, mortality, and cost, they constitute *the third largest component of the total economic burden of illness in the United States*, being outranked only by circulatory diseases and by the combined category of accidents, poisonings, and violence.

Digestive diseases collectively represent:

- 10 percent of the total economic burden of illness in the United States, as defined by the National Center for Health Statistics.
- The primary reason for major surgery.
- The leading cause of hospitalization.
- 15 percent of all hospital utilization (43.4 million hospital days each year).
- The second most prevalent cause of disability among the employed.
- 20 million chronically ill individuals.
- 14 million persons who suffer acute episodes of illness each year.
- 190,000 deaths each year (counting only those for which digestive diseases are identified as the *immediate* cause of death).
- $17 billion in direct health care costs.
- $35 billion in total annual economic loss, or approximately 1.5 percent of the gross national product (1978 projection).

Digestive diseases are highly detrimental to Americans in their peak years of productivity and responsibility. Seventeen of every 100 individuals between the ages of 45 and 64, most of whom sustain family income in whole or in part, have some form of diagnosed digestive disease. At the same time, the absolute importance of digestive diseases as causes of serious illness, hospitalization, and death is highest among the aged.

Digestive diseases abound in all strata of our society and in all parts of the United States. Their diagnosis and treatment often depend upon the ready availability of sophisticated instruments and highly trained personnel. Thus, the burden of digestive diseases can be expected to fall more heavily on our rural population, where the low population density cannot support expensive equipment and specialists, and where physical distances between physician and patients are often great.

The figures cited above, however, fail to convey the social and financial devastation experienced by people afflicted with the most severe and chronic forms of digestive diseases. For these people, frequent consequences may be prolonged debility, malnutrition, unemployment, denial of insurance protection, and lifetime medical expenses as high as $500,000 for an individual patient.

In contrast to the magnitude of these problems, *efforts to control digestive diseases have been tragically inadequate* and needlessly fragmented. This is due in part to public attitudes and to minimum public awareness of preventive measures and the consequences of neglect. The digestive tract and its functions are viewed through veils of ignorance, embarrassment, taboo, and inappropriate humor.

Efforts of concerned voluntary organizations which have worked hard and long to increase patient and public understanding of digestive diseases are noteworthy. They have demonstrated over the years that changes in public attitudes through education are both possible and vitally necessary.

As a subject of academic concern, digestive diseases are underrepresented on the faculties of medical and other professional schools, and the number of active researchers in the field is not only relatively small, but is also declining. The decline is related to current limitations on the level and the stability of support for digestive disease research, which has discouraged talented young physicians and scientists from pursuing research careers in this field. Meanwhile, established investigators have left research in the digestive diseases and are not being replaced.

Despite the relatively low level of research support, significant advancements have been made in the state of knowledge about a number of common digestive diseases, their treatment, and their prevention. Major benefits have been achieved for patients with hepatitis, peptic ulcers, gallstones, infectious diarrhea, diseases of absorption, reflux esophagitis, gastrointestinal bleeding, aspirin-induced stomach injury, and colonic polyps, as well as for patients requiring parenteral nutrition and major surgical intervention. Much work remains to be done, however, in terms of both prevention and treatment of these disorders, and there are still many diseases for which effective modes of diagnosis and treatment are entirely lacking.

THE NATIONAL PLAN

The National Commission on Digestive Diseases strongly believes it is time for the nation to mount a vigorous and well-coordinated attack on digestive diseases. The national plan presented in Volume I of the report of the National Commission on Digestive Diseases includes a series of interrelated goals and strategies. They incorporate the most promising leads in research and needed new directions in health care delivery and education. All components of the plan can and should be implemented without delay, with the expectation that benefits to the public will be

evident and measurable in varying stages in one to 10 or more years.

Since so much remains unknown about the causes, mechanisms, and factors influencing digestive diseases, the essential foundation of the long-range plan is a well-coordinated, expanded research endeavor. Research offers the surest and most cost-effective means of substantially reducing the suffering and the economic burdens resulting from digestive diseases. In the meantime, as research progresses, the immediate needs of patients with digestive diseases must not be overlooked; these needs are addressed directly in the long-range plan.

The Commission has developed the long-range plan to achieve two major goals:

- Reduce the suffering of all Americans afflicted with digestive diseases.
- Reduce the costs associated with digestive diseases.

In an era of escalating health care needs and limited resources, only a well-organized, detailed, cost-effective program directed at a clearly identified social goal can justify sustained public support. The long-range plan developed by the Commission, we believe, is such a program. Minimum budget increments to implement these programs are proposed.

The recommendations listed below have been carefully considered for their feasibility, cost, and expected benefits. They represent, in essence, the Commission's conclusions in terms of: (1) immediate action that promises early and lasting benefits, (2) programs that are imperative for the public good in the long-range effort to combat digestive diseases, (3) proposals that are not aimed solely at problems related to digestive diseases but are inclusive of other major national health needs, and (4) steps essential to the coordination and organization of the long-range plan.

THE SCOPE OF DIGESTIVE DISEASES

The digestive tract, which includes the esophagus, stomach, intestines, gallbladder, liver, and pancreas, is affected by a wide range of acute and chronic diseases, including infections, cancers, intoxications, and diseases of unknown origin. Digestive diseases are disorders of any of these organs. Some of them are commonly known, such as ulcers, hepatitis, and gastrointestinal cancers; others, such as biliary atresia, cystic fibrosis, inflammatory bowel diseases, and pancreatitis, occur less frequently but with devastating long-term effects.

RECOMMENDATIONS OF THE COMMISSION

The National Commission on Digestive Diseases recommends that Congress and concerned agencies, public and private, take the following actions immediately to provide early and continued benefits in the national effort to combat digestive diseases.

Measures to improve the provision of information and training to patients, health care personnel, and the public:

1. Establish and fund a National Digestive Diseases Education and Information Clearinghouse to improve wide distribution of available knowledge in prevention and control of digestive diseases.
2. Promote the establishment of standards for the education and training of specialists in digestive diseases.
3. Strengthen and, where necessary for this purpose, fund educational programs in digestive diseases in American medical schools.

Measures to improve medical care of patients with digestive diseases:

4. Standardize the nomenclature, diagnostic criteria and methodology, and guidelines for measuring disability caused by digestive diseases.
5. Develop guidelines for the sequence of performing diagnostic tests in the digestive diseases.
6. Increase funding for the study of risk-benefits and cost-benefits related to health care services for patients with digestive diseases, and for translational research—the translation of known medical knowledge into effective treatment.
7. Expand programs in digestive diseases in the Department of Defense.
8. Expand clinical research in the digestive diseases and programs for the treatment of these diseases in the Veterans Administration.

Measures to promote research in needed and promising areas:

9. Enlarge and strengthen Federal training programs in research on digestive diseases to increase the number of teacher-researchers and to encourage the interest of larger numbers of young scientists in this vital area of research.
10. Increase funding for applied (clinical) research on such topics as adverse drug reactions, alcoholic liver disease, cirrhosis, colonic disorders, functional gastrointestinal diseases, gallstones, gastrointestinal bleeding and vascular disorders, gastrointestinal surgery, hepatitis, infectious

diarrheas, inflammatory bowel diseases, maldigestion and malabsorption, malignancies (cancer) of the digestive organs, pancreatitis, pediatric digestive diseases, peptic ulcer, reflux esophagitis and esophageal motility disorders.

The Commission recommends that simultaneously with the actions in Recommendations 1 through 10, Congress and the respective concerned agencies take the following specific actions to ease the national burden caused by digestive diseases in the foreseeable future and to establish a long-range, national program of continuing and coordinated research in digestive diseases:

11. Increase funding for basic research in digestive diseases to lay firmer foundations for their prevention, diagnosis, and treatment.
12. Fund cooperative research in digestive diseases when scientifically necessary and cost-effective.
13. Expand the intramural digestive disease research programs at the National Institutes of Health.
14. Determine epidemiological patterns of digestive diseases to formulate a comprehensive understanding of their impact on the population's physical, emotional, and financial well-being.
15. Study the effects of environmental and industrial pollutants on organs of the digestive system.
16. Fund research on the critical role of diet as a cause of digestive diseases.

The Commission recommends that the Congress or appropriate agencies undertake the following steps with regard to diseases in general, but with specific emphasis on digestive diseases:

17. Survey manpower requirements for the prevention and treatment of digestive and related diseases and study the cost-effectiveness of various forms of professional training.
18. Assure that the cost of educating patients about their digestive diseases is a direct reimbursable expense by Federal and private insurance programs.
19. Enact legislation to provide catastrophic health insurance coverage for all citizens.
20. Exempt from the Office of Management and Budget clearance procedures those medical and behavioral research projects which are conducted in accordance with specified protocols which are approved under DHEW regulations for the protection of human subjects, and which call only for voluntary participation; and exempt the digestive diseases workshops recommended in this report from the DHEW policy which reduces the number of conferences.

The Commission recommends that the Congress and/or appropriate Federal agencies, in order to organize and coordinate the long-range plan outlined in this report, take the following actions:

21. Establish a National Digestive Diseases Advisory Board responsible to the Congress and the Secretary of Health, Education, and Welfare.
22. Appoint knowledgeable representatives concerned about the problems associated with digestive diseases and the implementation of solutions to those problems to the Advisory Councils of the National Cancer Institute, the National Institute of Allergy and Infectious Diseases, and the National Institute of Alcohol Abuse and Alcoholism.
23. Enhance the status of digestive diseases within the National Institutes of Health by forming a Division of Digestive Diseases within the National Institute of Arthritis, Metabolism, and Digestive Diseases.

For further information, write to:

NIAMDD Information Office
Building 31, Room 9A04
National Institutes of Health
Bethesda, Maryland 20014

LIVER FOUNDATION

Ms. THIEL. I am Thelma Thiel, executive director of the Liver Foundation. I have also served on the National Commission for Digestive Diseases. I'm here as a representative of all our affiliates and chapters throughout the country to ask your support for the recommendations of the Commission.

I recently spoke to the mother of a 14-year-old child—alive today because of a liver transplant 10 years ago. My son would have been 14 years old today had he had the chance to have a liver transplant. He died 9 years ago from a childhood liver disease that caused cirrhosis and made his 4 years of life on earth 4 years of pain and suffering.

Cirrhosis of the liver alone is the seventh leading cause of death in America today and accounts for 75 percent of all deaths from alcoholism. Hepatitis can also lead to cirrhosis. About a half million cases occur each year in the United States and the numbers are increasing at an alarming rate in the adult population. One in every 200 Americans is a carrier of hepatitis B, who could transmit the disease to you or me by such simple acts as sharing a cigarette, dental work, kissing, or other intimate contact. Out of any 100 people who receive a blood transfusion, 5 to 10 will develop hepatitis; 2 will develop hepatitis leading to cirrhosis of the liver. There are a half-million gallbladder surgeries performed each year with 6,000 deaths related to such therapy.

NATIONAL CLEARINGHOUSE

The American Liver Foundation and Coalition of Digestive Disease volunteer organizations are attempting to fill the information void. It's an enormous task which we cannot accomplish alone. The National Clearinghouse is vital to launch an effective, aggressive public education program. And coordination of the efforts of the voluntary agencies and National Clearinghouse are essential if we are to accomplish the goal of public education in the most cost-effective manner possible.

We are ready and willing and able to work with NIH but we need your commitment to sufficiently fund the Foundation's program clearinghouse. The impact of the devastating problem of digestive diseases is so widespread and costly that I urge you to act now to approve funds for all the recommendations including the clearinghouse.

An increase of $10 million for the digestive disease section of the NIMDD would barely begin to meet some of these needs. A $20 million increase would effect a significant number of the needs spelled out in the Commission report. I just want to reiterate that we understand the problems but we really feel this is very, very important.

Thank you.

PREPARED STATEMENT

Senator SCHWEIKER. Your prepared statement will be inserted in the record at this point.

[The statement follows:]

STATEMENT OF THELMA KING THIEL, R.N.

Good afternoon Mr. Chairman and members of the subcommittee. I sincerely appreciate the opportunity to meet with you and to make a few brief comments.

I am Thelma King Thiel, R.N., executive director of the American Liver Foundation. I am here as a representative of all our affiliates and chapters throughout the country to ask your support for the recommendations of the Commission: For basic research, clinical research, improved professional education in digestive diseases, the Advisory Board, and particularly for the Education and Information Clearinghouse.

I have just learned from a trip around the country meeting with men and women whose lives have been shattered by liver diseases * * * breadwinners who can no longer support their families and are forced to go on welfare * * * mothers and fathers of children with incurable liver diseases who ask, "What research is being done to save my baby? Where can I go for answers?" Members of the subcommittee * * * there are no answers to most of these dreadful diseases—over 100 of which attack children and adolescents.

Cirrhosis of the liver, alone, is the seventh leading cause of death in America today, and accounts for 75 percent of all deaths from alcoholism. Most of us consume some alcohol and believe we are not at risk. But studies indicate that some individuals who consume only small amounts of alcohol develop cirrhosis. Could you or I be one of them and not know it? Research alone can give us the answers.

Our emphasis in the past has been "after the fact." Wait until you get sick and then seek help—a very costly practice in dollars and human suffering. We can no longer afford the luxury of ignorance. The most cost-effective method of health care is through personal involvement in prevention. Americans want to participate in their own health care but they need to know how. We cannot afford the waste of lives or the estimated $35 billion yearly cost of digestive diseases.

The Commission report indicated that 55 percent of all Americans will suffer from a digestive disease during their lifetime. Will you be one of that 55 percent?

Thank you Senator Magnuson and members of the subcommittee for giving me this opportunity to share my concerns with you.

GASTROINTESTINAL ENDOSCOPY

Senator SCHWEIKER. Thank you. Next.

Dr. OVERHOLT. Mr. Chairman, I am Bergein Overholt, a practitioner—physician in practice—and I treat patients. Today I represent the American Society for Gastrointestinal Endoscopy, a group of about 2,500 physicians and surgeons who specialize further beyond their ordinary training in the use of flexible fiber optic instruments.

These instruments are relatively new in the field and are used with their flexibility with considerable ease and comfort for the patient and physician to examine the inside of the stomach, intestine, and colon very rapidly and effectively. The advancements in these instruments over the last 10 years have been so significant that since their introduction they have changed the practice of digestive diseases in such a way that it far excels the advances that any other single technique has been able to achieve.

For example, the removal of polyps from the colon can be accomplished with these instruments avoiding the necessity for surgery. These advances that I am speaking of have been accomplished in great part with Federal support. That is just one of the reasons that the American Society supports the Commission's recommendations.

If these appropriations requests are indeed supported by your committee and the Congress, continued advances in the area are highly probable. And I point specifically toward duodenal ulcer with gastrointestinal bleeding. With these instruments and improvements we are able to shine laser beams inside and hopefully put down clotting substances and tissue glues to stop bleeding.

These are lifesaving tools used on a day-to-day basis, highly important, but that need to be developed with Federal support. We urge your support for the Commission's request.

I might close on somewhat of a personal point. As a low-level elected official, of a small metropolitan city, we are faced with budget cuts. I certainly sympathize with what you have to go through. We certainly appreciate your sincerity in keeping the United States strong and sensitive to the needs of its people. It's those needs that I am speaking to.

Thank you.

Senator SCHWEIKER. We appreciate your empathy. The real frustration here is we all held hearings on the basis of a projected budget and what we thought was feasible.

Now it looks like the whole thing will be thrown back to square 1 and every assumption that we held a hearing on and took into consideration will have to be changed. In that changing process we all have our own individual preferences about what ought to be changed and what shouldn't. So it's going to make for a rather protracted, I guess, prolonged situation.

You would understand that.

Dr. OVERHOLT. Yes, sir.

PREPARED STATEMENT

Senator SCHWEIKER. Your prepared statement will be inserted in the record at this point.

[The statement follows:]

Statement of Dr. Bergein F. Overholt, American Society of Gastrointestinal Endoscopy

Mr. Chairman, I am Bergein F. Overholt, M.D., speaking on behalf of the American Society of Gastrointenstinal Endoscopy.

We in the Society have supported the National Commission for Digestive Diseases recommendations wholeheartedly. Many of the members of our Society participated in congressional visitations last year in support of those recommendations, and will do so again this year. We fully support the increased levels of funding called for by Dr. Sessions, Ms. Rosenthal, and Ms. Thiel.

It would take a considerable amount of time to detail the extraordinary advances that have occurred in the use of endoscopy in the last few years, and the pain, money, and lost work it has saved. This field of medicine is now creating so many opportunities that the NIAMDD has targeted a number of research programs that it would like to undertake. A consensus conference to deal with the most proper and timely use of endoscopic procedures is planned. Research is planned for the study of effective control of upper gastrointenstinal hemorrhage, such as occurs in bleeding ulcers (one new technique, which has been tested in animals, and based on the directed spraying of the hemorrhage site with blood clotting factors such as thrombin and a plasma concentrate, is believed by the administrators of the NIAMDD to be so important that they have included it in their justification to the Congress for the proposed budget this year--I have included a copy of that justification with this short statement).

There are many other examples I could give, but time does not permit. We who work in the field, however, see these opportunities to help our patients, and know that the research dollar is vital. But also vital are the dollars that would be spent at the NIAMDD for the education of patients and the public to help them prevent digestive diseases, and if not prevent them, to help the public seek the best and most advanced care possible.

Thank you for the opportunity to appear, and I will be pleased to answer any questions you may have.

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DIGESTIVE DISEASES AND NUTRITION

Purpose and Method of Operation

Basic, applied, and developmental research are fostered in the two major program areas of this activity through the use of investigator-initiated research grants, center grant awards, research career development awards, and research and development contracts. National Research Service Awards support the training of individuals for full-time careers in research and/or teaching.

The 1981 budget estimate of $57,366,000 for this activity represents an increase of $4,973,000 over the 1980 estimate. The program plans for 1981. are as follows:

Digestive Diseases

NIAMDD will continue to support research into the causes, treatment, diagnosis, and prevention of disorders of organ systems associated with the gastrointestinal tract, including salivary glands, esophagus, stomach, pancreas, liver, gallbladder, and the small and large intestines. Specifically the Institute will support research to determine the causes and treatment of specific diseases such as esophagitis, peptic ulcer, pancreatitis, ulcerative colitis and regional ileitis (Crohn's disease), malabsorption syndrome, gallstones, and cirrhosis, among others.

The Institute will take additional steps within the bounds of available resources, to implement the recommendations of the National Commission on Digestive Diseases, presented in a five-volume report to the Congress on January 31, 1979. The Commission report contained 23 separate recommendations including the significant request for a National Digestive Diseases Education and Information Clearinghouse. In direct response, NIAMDD will establish such a clearinghouse to coordinate the wide distribution of available knowledge in prevention and control of digestive diseases.

NIAMDD plans to pursue further studies of improved treatment for the effective control of upper gastrointestinal hemorrhage, which often occurs in bleeding ulcers, a major health problem. One new technique, tested in animals, and based on directed spraying of the hemorrhage site with blood clotting factors such as thrombin and a plasma concentrate of fibrogen, is promising and will see further [illegible]

NIAMDD will also complete a long-term clinical trial of the dissolution of cholesterol gallstones through the oral administration of chenodeoxycholic acid (CDCA). The use of CDCA and possibly ursodeoxycholic acid, a closely related bile acid, may lead to major alternatives to gallbladder surgery. Some 500,000 gallbladder operations are carried out in the U.S. each year at a cost of more than $1 billion, and there are 6,000 deaths related to such therapy annually.

The American Society for Gastrointestinal Endoscopy (ASGE) is a society of over 2,500 physician and surgeon members who have taken additional training in gastrointestinal endoscopy. ASGE is the primary professional national organization concerned with education of physicians and assurance of quality care delivered to patients relative to gastrointestinal endoscopy. Demonstration of these concerns is shown by ASGE work on (1) "Guidelines for Training in Gastroenterology"; (2) "Guidelines for Practice in Gastroenterology"; (3) development of criteria for utilization of endoscopy in various digestive diseases including esophagitis, duodenal ulcer, colon polyps and others, and (4) a statement on cost effectiveness of gastrointestinal endoscopy. In addition, national/regional post graduate education courses are a major function of ASGE. A complete description of the ASGE and its activities is available upon request.

The application of fliexible fibre optics to gastrointestinal instruments began in the late 1950's. The incorporation of small flexible glass fibres (7 - 12 microns) into long instruments allows the transmission of light down to the instrument tip and the transmission of a image back to the observer's eye. Wires running through the instrument and attached at the tip and at the handle allow easy four-way control of the instrument tip, thereby providing precise control over the direction the inserted instrument travels. Accessory channels traverse the instrument length and allow for passage of probes for direct biopsy, cytology, injection of materials, and polypectomy when indicated. Another channel allows instilling of water for lens cleansing and insufflation of air to distend the intestinal lumen. Visual image reproduction is excellent.

Advances have been rapid in gastrointestinal endoscopy. Now by utilizing flexible fibre optic instruments, direct visual inspection of the esophagus, stomach, duodenum, small intestine, (limited amount) and colon is readily accomplished. Through injection of radiocontrast die, indirect examination by X-rays of pancreas and bile ducts, is available. The endoscopist also may visualize the surfaces of the liver, spleen, abdominal wall and intestine, with instruments inserted through the abdominal wall (laparoscopy).

Endoscopic examinations by a trained, experienced physician-endoscopist is a safe, rapid, and reliable procedure extremely well tolerated by patients (mild sedation is typically used). Results are accurate, generally accepted to be more reliable than X-ray examination, although X-rays and endoscopy actually complement one another. In certain situations, therapeutic endoscopy adds another dimension to improved diagnostic capabilities, saving hundreds of thousands of dollars by reduced costs and morbidity in procedures such as esophageal stricture treatment,

pancreatic sphincterotomy for extraction of common bile duct stones, and most importantly in colonoscopic polypectomy, and in the earlier diagnosis of cancer of the colon.

The results of the utilization of flexible fibre optic endoscopy in digestive diseases is clear--no other single advance in the last 20 years has so greatly and positively influenced the diagnosis and treatment of digestive diseases. Federal funds have played a major role in the development of this field.

It is because gastrointestinal endoscopy has assumed so important a role in digestive diseases that ASGE is interested in the Digestive Diseases Commission and its recommendations.

First, physician and surgeon members of the ASGE believe that endoscopy is only a tool to use to assist in the diagnosis and management of digestive diseases and that the main impact of these procedures will be their use by trained physicians, and surgeons who use endoscopy appropriately as only one alternative for the diagnosis and treatment of digestive diseases.

Second, ASGE believes that future advances in patient care rest with the continued advancement of training and education of physicians, clinic and basic research, and clinical application of what is learned, not simply in the field of endoscopy where advances in patient care are important, but in the field of gastroenterology where such advances are absolutely vital considering the enormity of the financial, physical and mental burden of digestive diseases at a national level.

Therefore, we have actively participated in the development of, and actively endorsed, the Commission's recommendations to support (1) the establishment of funds for the Clearinghouse on information, (2) establishment of the Advisory Board on digestive diseases, and (3) the allocation of at least $10 million for training, research and education in digestive diseases, above the President's recommendation.

The future related to the relief of the burden of digestive diseases is bright relative to gastrointestinal endoscopy if such support is granted. For example:

1. The Clearinghouse will be able to provide information to the public and to physicians on the role of endoscopy in the treatment and diagnosis of digestive diseases. The consensus programs are just one example that should provide information as to the correct sequence of diagnostic events in the evaluation of a patient with a digestive disease. This should help to create cost savings, along with informing patients and the public.

2. The Advisory Board should be able to direct future efforts of the Federal government in areas related to gastrointestinal endoscopy to points of clinical importance and in research areas. An example is the investigation of gastrointestinal bleeding and its management. Current research protocols require large number of patients and demands central coordination for maximal and best utilization of Federal and other dollars to best study techniques such as laser treatment, electrocoagulation, tissue glue or clotting factors in the management of duodenal ulcer bleeding.

3. As previously testified to by the public and by physicians in all areas of medicine, education and research training in medicine and particularly in our case in gastroenterology is vital in order to allow continued advancements in research and in areas of clinical importance. Support of education and training is absolutely critical to achieve continued improvements in gastrointestinal endoscopy.

NATIONAL FOUNDATION FOR ILEITIS & COLITIS

Senator SCHWEIKER. Who's next?

Ms. ROSENTHAL. Suzanne Rosenthal. I'm here today, listed on your schedule as speaking on behalf of the concerns of the National Foundation for Ileitis & Colitis; I have spoken before you many times for the Foundation. But I'm taking the opportunity today instead to represent the very broadest range of all digestive diseases.

I'm here to represent the new Coalition for Digestive Diseases which grew out of the concerns unfolded during the life of the National Commission on Digestive Diseases. We have 12 national lay voluntary health agencies and also various medical and scientific organizations concerned with digestive diseases which make up the membership of the Coalition.

We all share basic, common goals: Prevention, early diagnosis, improved treatments and medical management, and finally, causes and cures of digestive diseases. A complete list of the Coalition's organizations is attached to my testimony. The Coalition is deeply concerned about the implementation of the recommendations of the Commission. Having served as chairman of the public information education committee, I have firsthand knowledge of the Commission's activities. The Coalition is deeply concerned that the Commission's entire apparatus and 2 years' work, costing close to $2 million, not turn into one enormous exercise in futility. We wonder, were parents and victims unnecessarily paraded before the Commissioners to spill their guts and one by one reveal their tragic tales of physical and emotional suffering—tales incidentally of suffering coupled with stories of personal bankruptcy that resulted from financing the persistent costs of chronic digestive diseases?

Are thousands of patients' testimony and thousands of pages of investigative research prepared by the committee to go to waste? Are we not to develop and implement a long-range national plan for the organization and effective use of national resources to deal with the digestive diseases?

You have heard what the Coalition has suggested; the speakers before me have emphasized the priorities. We hope the Government will continue in its partnership with the private sector to respond to the cries of the hundreds of people who have revealed their tragic stories.

Will the Government merely apply token first aid by applying a bandaid to heal the deep and aching wound in the Nation's digestive tract, or will it respond affirmatively and decisively?

Gentlemen, it's time to show real concern for the 20 million chronically ill sufferers of digestive diseases. We understand what the priorities are. We have listed them, share them with you, and are available to address additional concerns or questions you have in terms of the priorities that we have designated in the testimony.

PREPARED STATEMENT

Senator SCHWEIKER. Thank you. Your prepared statement will be inserted in the record at this point.

[The statement follows:]

STATEMENT OF SUZANNE ROSENTHAL, FOUNDATION FOR ILEITIS AND COLITIS

What has the Coalition of Digestive Disease organizations come here to suggest regarding the FY 1981 NIAMDD budget?

We believe an additional $10 million, above what the President has recommended for the 1981 budget for the Digestive Disease and Nutrition section of the NIAMDD, can be effectively used to begin to fulfill some of the Commission's recommendations.

Primary to the Commission's determinations is the establishment of a National Digestive Diseases Education and Information Clearinghouse. Too little information has been given to the public, too little information is available to the non-specialist physician and to other health specialists.

The NIAMDD has allocated $200,000 for FY 1980 for the start-up funds for the Clearinghouse. A minimum of an additional $300,000 or a total of $500,000 will be required for FY 1981 if the initial operations are to be effectively capitalized.

Professional education must be strengthened and training programs in digestive disease research increased if our plans for future research efforts are to be realized. An additional $600,000 can be effectively used.

Basic research must be expanded with nutritional and environmental considerations investigated. $3,500,000 allocated here above last year's research investment is an imperative.

Applied clinical research programs to help our digestive disease victims now must be additionally funded with a minimum of $5 million.

And to provide intelligent direction and surveillance of all these programs a National Digestive Diseases Advisory Board must be established requiring approximately $300,000.

The Commission recommended this concurrent program of education and training and basic and translational research which can offer a realistic promise of an early and substantial improvement in the control of digestive disease.

Thank you for allowing us this time to address our concerns.

You may contact me, Suzanne Rosenthal at the offices of the National Foundation for Ileitis and Colitis at 295 Madison Avenue, Suite 519, New York, N.Y. 10017 (212) 685-3440 or any of the representatives listed on the attachment and here today to witness these proceedings.

1980 COALITION FOR DIGESTIVE DISEASE ORGANIZATIONS

American Association for Study of Liver Disease
James L. Boyer, M.D., President
Yale University School of Medicine
Department of Internal Medicine
333 Cedar Street
New Haven, Ct. 06510
(203)436-8140

American Celiac Society
Ms. Anita Garrow
45 Gifford Avenue
Jersey City, New Jersey 07304
(201)432-1207

American College of Gastroenterology
Warren Nugent, M.D.
Lahey Clinic
605 Commonwealth Avenue
Boston, Massachusetts 02215
(617)262-4900 Ext. 354

American Liver Foundation
Thelma Thiel, R.N.
Executive Director
30 Sunrise Terrace
Cedar Grove, New Jersey 07009
(201)239-4139

American Society for Parenteral and Enteral Nutrition
Karen Kight
Acting Director
6110 Executive Boulevard
Suite 810
Rockville, Maryland 20852
(301)881-4626

Center for Ulcer Research and Education Foundation
Mr. Richard Sessions,
Treasurer
V.A. Center, Building 115, Room 217
Los Angeles, California 90073
(213)478-3711 Ext. 2204
Ext. 2246

Cystic Fibrosis Foundation
Mr. Richard Vodra
Washington, D.C.
(301)881-9130

Dean Thiel Foundation
(same as American Liver Foundation)

National Foundation for Ileitis & Colitis, Inc.
Suzanne Rosenthal
295 Madison Avenue
Suite 519
New York, New York 10017
(212)685-3440

North American Society for Pediatric Gastroenterology
Harry Greene, M.D., President - John Watkins, M.D., President-Elect
Vanderbilt Hospital
Nashville, Tn.
(615)322-7363

Society for Gastrointestinal Assistants
Susan E. Sweny,
President
19 Jacqueline Road
Apartment "C"
Waltham, Massachusetts 02154
(617)893-4297 - Home
(617)492-3500 Ext. 1452
Ext. 1526

United Ostomy Association

1. Mr. Louis Raffio
120 Locust Drive
Westwood, Massachusetts 02090
(H) (617)762-6860
(O) (617)743-4100

2. Mr. Lloyd Boyd
5013 North 33rd Street
Arlington, Virginia 22207
(H) (703)536-8243
(O) (202)343-5471

JUVENILE DIABETES FOUNDATION ACCOMPLISHMENTS

STATEMENT OF RICHARD ASZLING, CHAIRMAN, BOARD OF DIRECTORS

ACCOMPANIED BY ALICE BROWN, PRESIDENT, NORTHERN VIRGINIA CHAPTER

Mr. ASZLING. Mr. Chairman, as you know, the Diabetes Foundation greatly appreciates the opportunity afforded us today. I'm Richard Aszling, chairman of the board of directors of the Foundation. To Senator Weicker, if he hadn't had to leave, I would have pointed out that I come from Greenwich, Conn. I am accompanied by Alice Brown, president of our Foundation's Northern Virginia chapter and a member of the Foundation's Government Relations Committee. Copies of our full statement will be filed with the committee.

The Juvenile Diabetes Foundation is an international voluntary health organization dedicated to supporting and furthering research and education in diabetes. Today, we appear before you on behalf of our board of directors and our entire membership and their families in over 119 chapters throughout the United States.

At the 5-year point in our long-range plan, it seems appropriate to stop and look back. How far have we come in 5 years? Has the Federal diabetes initiative been a productive one? Has the diabetes research initiative yielded substantial dividends?

JDF believes that the answer is a resounding "Yes." Research funding in more than a half dozen institutes within NIH has been augmented substantially. The National Advisory Board has been operational 3 years; the intracommittee has been established; and National Diabetes Data Group and Clearinghouse are operational.

There are now eight diabetes research and training centers funded by JDF, conducting research and training positions for allied personnel. Twenty States are developing community-based diabetes control demonstration projects. Indian Health Services is implementing five model health care projects on reservations. Major research programs of the National Institute of Child Health and Human Development have been initiated in four States; two State diabetes registries have been established.

Clearly the Federal dollars have enhanced State and community organizations' diabetes research and control programs. When we appeared before the committee a year ago, we were excited about a research breakthrough funded by the NIH: The production of human insulin utilizing recombinant DNA techniques, a development which may ultimately guarantee an ample supply of pure human insulin. In the interim, federally supported diabetes research projects have resulted in four other major breakthroughs: The discovery of a causative or triggering virus which could lead to the prevention of diabetes; development of a mechanical pancreas; transplanting in animals of healthy pancreatic cells.

RECOMMENDATIONS

In general, we support the appropriations recommended by the National Diabetes Advisory Board. However, we feel the administration's

budget—you have to know I wrote this before all this we heard here today, just as you held your hearings awhile ago, we did our writing. The administration's budget we think is completely unsatisfactory and a deterrent to the progress we have made in combatting the third leading cause of death in the United States—diabetes.

Senator SCHWEIKER. Wait until Thursday night.

Mr. ASZLING. All right. It provides for no growth in research—that is in terms of research grants to be funded—provides for no new training support or manpower programs and no new clinical trials. Almost every witness has pointed out today how critically needed manpower training is if we are going to get all the jobs we need done. We think this no-growth approach will stunt programs such as the diabetes effort and undo a lot of the good done in the last 5 years. We are fully aware of the cost study atmosphere which permeates the Congress, although I have to admit I know a lot more about it now than I did a couple hours ago. But we also believe that this balance-the-budget movement is geared toward elimination of waste and excessive bureaucracy and other counterproductive uses of public moneys. It can't be turned into a movement against biomedical research.

The Federal Government's commitment to biomedical research within NIH is about $3 billion or about one-half of the entire Federal budget. Diabetes, the third leading killer in the United States, the leading cause of new blindness in the United States, a major cause of heart disease, kidney disease, stroke, represents about one-fifth of 1 percent of the Federal budget. To tamper with the apparatus we have constructed would possibly save a few dollars now at the definite expense of the Nation's health in later years.

We believe that it is imperative to appropriate adequate funds for diabetes; our lead institute, NIAMDD; and to the National Heart, Lung, and Blood Institute. We recommend that the needed support for research on the interrelationship of diabetes and artherosclerosis be approved. Likewise, appropriate funding for the NINCDS and also for the National Eye Institute.

Our detailed recommendations on appropriations for the Institute and our justifications will be found in the full statement.

I would like to ask Ms. Brown to conclude our oral statement, if I may.

Senator SCHWEIKER. All right.

TRAINING FUNDS

Ms. BROWN. Thank you.

As a parent of a child with diabetes, a disease which spans almost all of the institutes of NIH, I live with the profound fear that today's research advances will not be translated to a cure or even better treatment for lack of qualified investigators to conduct the necessary research.

JDF is dedicated to the belief we must foster a fund in which today's scientists, physicians and medical students will seek out a career in biomedical research. To this end, JDF itself has funded $1½ million in fellowships in the past 4 years.

Accordingly, we endorse the recommendations of the National Board as stated in its third annual report, regarding the increase of the number of and quality of physicians and scientists entering the field of diabetes research.

All of the components for successful attack on diabetes are now available. NIH is supporting meritorious research. Research, advances in the treatment, prevention and cure of diabetes are exploding. Biomedical researchers are eager to conduct research if the funds are only available. The cost in terms of human suffering, premature death, lost wages, productivity, social security payments, is far too great not to promote and encourage diabetes research today.

How we wish we could tell you diabetes would be eradicated within a short period of time. How we hope we could tell our children they will lead a normal life, a full life free of the insulin syringes. You have made these hopes more tangible than the illusions they once were. You and your committee created the National Commission on Diabetes. The research which you have funded has built upon this foundation. The National Conference has provided the Congress and diabetes community with a masterful dividend for research, training, education, and control.

To you, Senator Schweiker, goes our deepest gratitude. We will miss you on the other side of this witness table. You have listened and you have responded year after year. You have even become a household name in the home of every American diabetic. You are an example for all of the Congress and for all of JDF and the diabetic population. I thank you. We have come a long way together; there is still a long way to go.

My son is now 9 years old. He's already had diabetes for a very long 3½ years, but in light of what has happened in the last 5 years, I continue to think—in my strongest and most sincerest terms—that I now have more hope for the life of my child than I have ever had before. It's because of what you have done. Thank you.

Senator SCHWEIKER. Well, thank you very much. It's sort of ironic that the one time the administration has increased NIAMDD's budget to any significant extent, they have decided to change their minds and start from scratch. So, we are going to have to still do some battles in that respect.

PREPARED STATEMENT

Senator SCHWEIKER. Thank you. Your prepared statement will be inserted in the record at this point.

[The statement follows:]

STATEMENT OF DR. RICHARD ASZLING, CHAIRMAN, BOARD OF DIRECTORS, JUVENILE DIABETES FOUNDATION

The Juvenile Diabetes Foundation is an international voluntary health organization dedicated to supporting and furthering research and education in diabetes.

In 1975, Congress created the National Commission on Diabetes (P.L. 93-354) and charged it with the responsibility of developing a Long Range Plan to Combat Diabetes. The Commission developed such a plan and submitted it to Congress and the President on December 11, 1975. As one of its primary recommendations, the Commission urged Congress to substantially increase funding to the multitude of Federal agencies which support research, education, training and control programs in diabetes.

For the past few years, we have come to this Committee and asked you to create a broad mandate to NIH, to the Center for Disease Control, to the Indian Health Service, and to other component-entities of the Federal diabetes effort, and you have answered our prayers. You, Senator Magnuson, Senator Schweiker, Senator Bayh, Senator Burdick, Senator Mathias, and Senator Weicker, and other distinguished members of the Congress took on the challenge and responsibility for implementing the unique Long Range Plan to Combat Diabetes. You sponsored an attack on a disease that had become a major and devastating public health problem facing our Nation.

Five years ago, prevention and cure of diabetes and its complications were mere pipedreams in the minds of the parents of diabetic children. Five years ago, the recommendations of the National Commission on diabetes were merely thoughtful and insightful ideas committed only to paper. Today, the Nation's ten million diabetics and their families have more than a glimmer of hope. They <u>know</u> that progress is being made -- in giant steps.

The National Commission on Diabetes set forth a dynamic five-year plan of action, a proposal which would have remained just another government document without this Committee's vision and commitment to the Nation's diabetic population.

Additional initiatives are: The Indian Health Service is implementing five model diabetes care projects on Indian reservations; diabetes has a prevalence rate of as high as 60% among some Indian tribes. Major research programs (MPRs) of the National Institute of Child Health and Human Development have been initiated in four states and are investigating the aspects of diabetic pregnancies and the infant of a diabetic mother. Two state diabetes registries have been established which would provide valuable epidemiologic, mortality, and morbidity data. And voluntary health organizations, such as the Juvenile Diabetes Foundation, which cooperate with various established programs, have chapters in every state in the Union. Clearly, the Federal dollars have enhanced state and community organization diabetes research and control programs.

Federally supported diabetes research has resulted in four other major breakthroughs since we last testified before this Committee. In the past eleven months;

-- Researchers and scientists have demonstrated that several common human viruses are capable of producing diabetes in laboratory animals, a discovery which could lead to a means of preventing diabetes.

-- Researchers and scientists have developed a miniature battery-powered pump, worn externally, which feeds a continuous supply of insulin to the diabetic.

-- Researchers and scientists have devised in laboratory animals a way to transplant insulin-producing islet cells and overcome rejection by the body's immune system. If this process should work in man as it does in laboratory animals, such transplants could provide a natural insulin supply to diabetics.

-- Researchers and scientists have located possible genetic markers for diabetes which may make it possible to identify some high-risk candidates before they develop the disease.

The Federal diabetes effort, an infant program just five years ago, has borne fruit! The research support that you

and your colleagues in Congress have provided has resulted in breakthrough after breakthrough. The interest in conducting diabetes research continues to accelerate; the National Institutes of Health are literally swamped with approved diabetes research grant applications. And the success of the Federal diabetes effort is even recognized by the same Administration which seeks virtually no increase in -- and a cutback when inflation is factored in -- diabetes research funding. As Dr. Donald Fredrickson, Director of the NIH, stated in a January 7, 1980, letter to NDAB Chairman, Dr. David Kipnis;

> "I am impressed and encouraged by the very substantial progress that is being made in diabetes research on a very broad front. It is noteworthy that, while on the one hand, many of these advances reflect the successful application to diabetes of new knowledge generated from basic research, at the same time, diabetes research has also advanced knowledge in broad areas of science fundamental to biomedical research in general and to an understanding of other disease processes . . ."

The research results of the past year indicates that "targeted" diabetes research funding has been one of the most successful Federal research initatives in history. Because diabetes spans virtually every body system, it is clear that the Congress' investment in basic diabetes research will, as Dr. Fredrickson noted, yield advances for nondiabetic Americans suffering from heart disease, stroke, eye problems, and a multitude of microvascular, cellular and metabolic disorders.

RESEARCH RECOMMENDATIONS

JDF's detailed appropriations recommendations are included in the attached table. However, we wish to highlight several priority areas. Our priorities represent our opinion regarding the appropriate direction for diabetes research during this decade. Our resource in years past has been the Long Range Plan of the National Commission on Diabetes. But there is a new reference available to the diabetic, to the Congress, and to the Administration -- a magnificant reference, a blueprint for diabetes research in the 1980s. I refer to the comprehensive assessment of the Long Range Plan conducted by the National Diabetes Advisory Board -- the National Conference on Diabetes: Current Status and

Future Directions, a symposium which brought together the world's top diabetes researchers to participate in seventeen workshops directed toward a broad range of diabetes-related problems. The recommendations of this Conference, as adopted by the NDAB, provide a diabetes research strategy for the 1980s.

I have a diabetic child, as do hundreds of thousands of our members. We pray for a cure for diabetes and we hope for improved treatment of this disease. But JDF has an obligation to the millions of Americans who will be afflicted with diabetes some time in the future -- our friends, and yes, our children's children. Prevention of diabetes and its complications is our number one priority. We believe that the fastest means of so doing is to fund research through the National Institutes of Health. And the diabetes virus breakthrough is just one of the many signs that the promise of prevention grows with the success of the diabetes effort. I believe I am quoting you, Senator Magnuson, when I state that "research is the first step towards prevention."

In general, we support the recommendations of the National Diabetes Advisory Board. However, the Administration's budget is completely unsatisfactory and a deterrent to the progress in combating the third leading cause of death in our country -- diabetes.

The Administration's budget provides for no growth (in terms of the number of research grants to be funded) in research. This budget provides for no new training support. This budget provides for no new manpower development programs, and no new clinical trials. This "no-growth" approach will stunt the growth of maturing research programs such as the diabetes effort.

The budget which is reported out of this Committee must be based on the premise that greater funding for the National Institutes of Health will serve as an investment to accelerate and stimulate research advances. If sufficient funds are available in basic research, clinical trials, and training grants, researchers will enter the field. There are areas of prime voids such as neuropathy, eye, vascular complications, stroke, and mental health. It is with these views in mind that we outline our recommendation

that $192.0 million be appropriated for diabetes research and training in FY 1981.

If all of the Federal support for biomedical research and training were eliminated today, it would make only an infinitesimal dent in the overall Federal budget. To tamper with the delicate biomedical research apparatus will save a dollar now at the expense of the national health later.

If you, as we pray you will, and the Congress, work to appropriate for diabetes every dollar we have recommended for research, you would barely increase the Federal budget. What this Committee would really do is provide an essential impetus for a cure, and hopefully, prevention of a disease which afflicts 5% of our population. What this Committee would do is pay a miniscule price to wipe out a disease which drains the American economy of over $7 billion annually.

The following represent several of our priority concerns:

National Institue of Arthritis, Metabolism, and Digestive Diseases

NIAMDD is the cornerstone of the Federal diabetes research and training effort. Under the leadership of the Associate Director for Diabetes, Dr. Lester Salans, this Institute is finally demonstrating a substantial commitment that recognizes diabetes as the horrendous problem it is. We recommend that $97.0 million be appropriated to NIAMDD for diabetes research and training in FY 1981. This allocation would enable the Institute:

(1) To begin to implement the vital research recommendations of the National Conference on Diabetes regarding: the regulation of carbohydrate and lipid metabolisms; hormone biosynthesis, secretion, and actions; the relationship of obesity and various nutritional factors to diabetes; and islet cell transplantation, to name just a few;

(2) To expand NIAMDD's research manpower development programs, including Research Career Development Awards, Special Emphasis (Diabetes) Research Career Awards, and New Investigator Research Awards in Diabetes;

(3) To continue the Institute's intramural research program, including the Phoenix field research station that conducts diabetes research related to the American Indian population; and

(4) To provide expanded support for the National Diabetes Data Group, the National Diabetes Information Clearinghouse, and the Diabetes-Endocrinology Research Centers.

NIAMDD is responsible for supporting kidney research; we urge that this Committee mandate increased funding for diabetes research related to kidney disease. The Federal government spends almost $1 billion of American taxpayers' contributions to the Social Security Fund for the End Stage Renal Disease (ESRD) program each year. The SSA reports that there are presently 40,000 dialysis patients and that the program is processing the claims of more than 200 new patients per month. This drain on the American economy is devastating and growing. The NDAB states in its Third Annual Report that at least one of every five dialysis patients is diabetic and that diabetes is one of the most common causes of renal failure. It is conservatively estimated that the Federal government will pay by 1984 $750 million per year in care for the diabetic-uremic patient.

Hardly a month goes by without HEW publishing in the FEDERAL REGISTER changes in the ESRD program designed to cut costs. The surest means of effectuating substantial costs savings is to eliminate the cause of kidney failure -- through diabetes research.

We recommend as well that the Diabetes Research and Training Centers, funded by NIAMDD, be expanded to include as many as qualified in FY 1981. DRTCs have conducted research that have led to some of the diabetes breakthroughs noted above, and they have participated in collaborative programs for the Indian Health Service for the training of health personnel in its new model diabetes care program. The Centers are regionally located so that professionals in various areas throughout a region can be trained at these centers and go back to their practice better equipped to deal with their patient population. The eight

Centers currently in existence serve as resources to assist State Health Departments in the development and implementation of the CDC-supported diabetes control program. All in all, DRTCs offer a unique resource for interaction between traditional biomedical research and health care delivery, the result of which has been and will be the expedited transfer of diabetes research "from bench to bedside."

National Heart, Lung, and Blood Institute

In no Institute has there been a more conscientious, aggressive, and innovative campaign against diabetes than that waged by the National Heart, Lung and Blood Institute. And this comprehensive research and training effort has been spearheaded by one of the biomedical research community's most dedicated and brillant leaders, Dr. Robert Levy.

Why is the work of NHLBI so important to me? Because I, like millions of parents of diabetics, live with the fear that my child will be stricken down by heart disease related to his diabetes in the prime of his life -- just as it struck down your friend and ours, Congressman William Steiger. Diabetes is one of the four major risk factors of cardiovascular disease in the United States. The diabetic is twice as prone to coronary heart disease as a nondiabetic, twice as susceptible to stroke, and five times as likely to develop arterial diseases of the limbs.

The National Conference on Diabetes recommended that the NHLBI conduct: research on the therapeutic effects of drugs that alter platelet behavior; clinical trials on the interaction of insulin and hypoglycemic agents on high density lipids; autopsy studies to relate the pathology of atherosclerotic lesions to the age of onset of diabetes, the type of diabetes care, and other variables; and research to develop and use non-invasive methods for studying the progress of atherosclerosis in the diabetic. The Juvenile Diabetes Foundation recommends that $22.0 million be appropriated to the NHLBI in FY 1981 to begin to accomplish these laudable objectives.

National Eye Institute

We believe that it is imperative that Congress augment its support for the activities of the National Eye Institute. Diabetes is the leading cause of new blindness in the United States. There are thousands of diabetics already blind and countless more with substantially impaired vision. The cost of blindness in terms of pain and suffering to the diabetic is devastating. The diabetic is incapacitated. He suffers from a disease which affects all of his body systems, a disease which causes other debilitating complications that aggravate or are aggravated by his blindness. If the diabetic suffers from diabetic neuropathy, he may be unable to learn to read in braille. The blind diabetic may be unable to transport himself to a rehabilitation center. He has difficulty in measuring his insulin requirements and then accomplishing injection of the substance. The diabetic, who has a tendency towards obesity, and hence cardiovascular disease, must exercise; yet his blindness hampers his ability to do so. The emotional consequences are substantial as well. The diabetic is not born blind; diabetic retinopathy generally develops after the diabetic has suffered from diabetes from ten to fifteen years. He can be thrust into a world of darkness and must adjust emotionally from a life of productivity to a life of incapacity, greatly dependent upon his family and society for his physical, psychological, and financial well-being.

And what is the cost in financial terms? Hundreds of millions of dollars are spent each year directly by the Social Security Administration and by State welfare agencies in payment assistance to those classified as blind or disabled. Many more millions are spent by Federal and State governments in the form of tax benefits to the blind. And what is spent by the Federal government each year on diabetes-related eye research? Less than $18 million dollars.

We recommend that $26.0 million be appropriated to the National Eye Institute so that it may implement the recommendations of the National Conference on Diabetes. After all, one research dollar that leads to the prevention or arrest of dia-

betes' visual complications will save the taxpayer manyfold dollars in the costs of rehabilitating and supporting the blind diabetic.

National Institute of Neurological and Communicative Disorders and Stroke

Serious diabetic neuropathy afflicts 25% of the diabetic population, and is the most common type of neuropathy in the United States. All diabetics have some form of neuropathy. The diabetic with neuropathy may have impaired sensation of the hands and feet, which can lead to ulcerated tissue and amputation. He suffers severe muscle pain, impaired mobility, and impotence.

We applaud the NINCDS for its support of a specialized research center to coordinate multidisciplinary research on the cause of and possible treatment for diabetic neuropathy. We are encouraged as well by NINCDS-supported research which indicates that meticulous metabolic control does improve the functional abnormalities in the diabetics' peripheral nerves. Dr. Donald Tower is to be commended for his efforts to increase NINCDS' activity on diabetes and stroke.

We believe that Congress should appropriate $9.5 million to the NINCDS in FY 1981 to augment its research and training support for activities regarding the relationship of diabetes and stroke, the identification of central nervous system pathways which process information relating to metabolic status, and the assessment of interaction between psychological and physiological variables which affect the diabetic state. The National Conference on Diabetes demonstrated that there is much that can be done if the monies are made available.

Research Manpower Training

One of our greatest concerns, and one which has been supported by virtually all of the NIH Advisory Councils, the National Academy of Sciences, and the Nation's health care community is the need to increase biomedical research training support. As a parent of a child with diabetes -- a disease which spans almost all of the Institutes of NIH -- I live with the profound fear that today's research advances will not be translated into a cure for lack of qualified investigators to conduct the necessary re-

search. The Juvenile Diabetes Foundation is dedicated to the belief that we must foster a climate in which today's scientists, physicians, and indeed medical students, will seek out a career in biomedical research. To this end, JDF itself has funded over $1.5 million in fellowships over the past four years.

The problem is aggravated by many factors. Federal funds for support for NIH research have not grown sufficiently in recent years. Federal support for research training has declined significantly. Since 1966, there has been almost a 50% decrease in the total physician-scientist pool in this country and the influx of the young talent into clinical investigation has been severely curtailed. For example, new clinical investigators supported through NIH research training programs has declined from 4,600 in 1971 to 1,800 in 1977.

The shortage of support for research manpower training into the areas of prevention, complication, and cure will curtail the growth of all research efforts in diabetes. To take care of today with no thought of tomorrow is a disastrous path to follow. We must put new minds in areas of expanding research such as in fields of eye, heart, neuropathy, stroke, blindness, allergy, and infectious disease.

Accordingly, we heartily endorse the recommendations of the National Diabetes Advisory Board, as stated in its Third Annual Report, regarding the increase of the number of and the quality of physicians and scientists entering the field of diabetes research. Our recommendations for NIH research, as included in the attached table, include funding for biomedical research training.

CENTER FOR DISEASE CONTROL

Under the capable and innovative leadership of Dr. William Foege, Director, CDC, and Dr. William Flynt, the Center for Disease Control has spearheaded a number of very significant accomplishments designed to implement a Long Range Plan to Combat Diabetes.

CDC has commenced a program of community-based diabetes control projects on a demonstration basis. Ten states have now

completed the initial planning activities and have begun to implement specific, carefully designed interventions and related activities. Two other states began initial planning activities last year and it is anticipated that an additional eight states will be awarded planning funds in FY 1980, thus extending this program to at least twenty states. These centers have already evaluated and improved local patient education resources; sponsored workshops and conferences for over 2,200 physicians, nurses, dieticians, and other members of the diabetes health care team; designed systems to identify and assimilate data on high-risk diabetic population groups; provided surveillance of diabetes health care services; and supported the establishment of two state diabetes registries.

The Center for Disease Control has established reasonable long-term goals for this program, goals which we wholeheartedly support -- reduced diabetic hospitalization, reduced lower extremity amputation, reduced deaths associated with diabetic coma, and elimination of perinatal mortality associated with pregnancies of diabetic women.

The CDC's programs are unprecedented. The Federal contribution has been minimal -- $4.6 million in FY 1980. But its dividend has been massive. We are now witnessing the establishment of a successful Federal program which is causing a dynamic ripple effect into the states, private agencies and industry. The payoff for all chronic diseases promises to be great. Accordingly, the Juvenile Diabetes Foundation recommends that Congress provide $11 million in FY 1981 to expand CDC's diabetes control demonstration projects to 25 states.

STAFFING RECOMMENDATIONS

Developing new research manpower is a necessity. But how can we move this diabetes program forward without the necessary arms, legs, and minds? We need sufficient staff positions to manage and coordinate this great effort.

In order to accommodate the needs of a Federal diabetes effort, we believe the following numbers of staff positions should be allocated to the diabetes research and related programs: NIAMDD-

15 slots, NHLBI-5 slots, NEI-5 slots, NICHD-4 slots, NINCDS-3 slots, NIAID-2 slots, NIA-2 slots, NIDR-2 slots, DRR-3 slots, NIMH-4 slots, CDC-8 slots, and the Indian Health Service-25 slots.

CONCLUSION

You created the National Commission on Diabetes, whose Long Range Plan became the foundation of the Federal diabetes effort. The research which you have funded has built upon this foundation. The National Diabetes Advisory Board, through its National Conference on Diabetes: Current Status and Future Directions, has provided the Congress and diabetes community with a masterful blueprint for research training, education, and control. We can now continue to build our diabetes structure, and from the top, there will emerge a panoramic view of a healthier America -- free of diabetes and its devastating complications.

Within this decade, we pray that we at JDF will be able to write the book on how diabetes was cured. This book will be dedicated to you, the members of this Committee, who had the vision and patience to ignore what might have been politically expedient and to do what you knew in your hearts was right.

Thank you.

DIABETES APPROPRIATIONS RECOMMENDATIONS
(in millions of dollars)

AGENCY	Proposed FY 1981 JDF Recommendation
National Institutes of Health	
National Institute of Arthritis Metabolism and Digestive Diseases	97.0
National Eye Institute	26.0
National Heart, Lung, and Blood Institute	22.0
Division of Research Resources	13.5
National Institute of Child Health and Human Development	11.0
National Institute of Neurological and Communicative Disorders and Stroke	9.5
National Institute of Allergy and Infectious Diseases	4.5
National Institute of General Medical Sciences	2.0
National Institute of Dental Research	3.0
National Institute of Aging	3.5
Total NIH	192.0
Center for Disease Control	11.0
National Institute of Mental Health	2.0
Indian Health Service	2.2
	207.2

AMERICAN DIABETES ASSOCIATION

Senator SCHWEIKER. I guess we haven't heard from the American Diabetes Association yet.

Dr. ARKY. I am Ronald Arky, president of the American Diabetes Association, professor of medicine at Harvard.

During the last 6 months, I have had the opportunity to visit approximately half of the States of this country, and visit in some of the facilities that have been supported by the efforts of this committee, the NIH, and other Federal agencies in the last 5 years.

I guess I can from a firsthand point of view tell you that there is some good news. I think that this has, as my colleagues have pointed out, been a particularly good year in terms of basic investigation and research. Those in the areas of virology, immunology, and genetics have already been expounded. But I think even more impressive is the fact that the diabetes research and training centers are fulfilling a major role in translating that information. If one visits in Michigan or Indiana, in Massachusetts or New York, it's apparent that the investigative work being done in those areas is readily being translated into patient care.

Of the 20 CDC centers that I have visited, I have visited 6—I can assure you that they, too, are achieving their design goals. There is no question that identifying areas in which there are shortages of personnel—areas in which specific care must be rendered—has taken place; certainly in Maine, Rhode Island, Georgia, and North Dakota. I think in the latter instance, the interaction with the Indian Service is again something to be acknowledged.

CDC PROGRAMS

Senator SCHWEIKER. I think we have to give a lot of credit to Dr. Foege at CDC. I recall the first time I had our bill stipulate that we start a program like this, they wiped out my small increase and used it to raise everybody's salary. I never forgave the then director for that. He later lost his job, but not for that reason.

He ran into something called the swine flu. But Dr. Foege really has done a great job with this program. I think what encourages me is that they are using it as a model program for dealing with chronic diseases. So not only does it benefit the diabetes community, but it basically is going to be used as a model for disease control programs in the future.

So we are sort of getting a double investment out of it. I think it shows the kind of thing that can be done. We are very much appreciative of what CDC's done with it. Sorry for interrupting.

Dr. ARKY. No, fine; I think it just corroborates another aspect of the CDC efforts. For example, in Rhode Island I think one can already see a cutting down of hospitalization. Both for accute problems and chronic problems. I have confidence, for example, that the high incidence in that particular State of individuals who have gangrene will be diminished by the type of care and defining of resources that are needed. These are just minor examples, I think, of what has been accomplished.

I am here primarily to strongly support my colleagues of Dr. Field and Dick Aszling in supporting the recommendations of the National Advisory Board. There is no question that the PAN approach or TRANS approach of all Institutes of NIH involved has already done a great deal in alleviating the problem, but also certainly in letting the public know that diabetes is a major health concern.

NEW RESEARCHERS AND TRAINING

I think there are two points I would emphasize. A year ago when I testified, I raised the points that others have raised today; as director of a training program, I am particularly disturbed by the figures that Jim Field has related to you. We have a problem. We do not have physician-investigators coming up from the ranks. We have got to develop some means of stimulating individuals to come into this field, not only to carry on the fundamental research that has been started and that has obviously had some effect, but to enter the clinical realm, and take the place of specialists who obviously, as time goes on, are not going to be there.

So we have to increase our stipends. Considering inflation, and certainly considering some of the points that you raised early on, Senator,

we must provide some security so that individuals know that there is going to be some funds available in future years.

I think the second point I would make relates to my role as chief of medicine at the community hospital. It is still disturbing to note that the second disease most often reported on discharge summaries is diabetes malady. That the individual coming in with renal disease, kidney disease, and blood vessel disease has diabetes as the precipitator of that problem. I think that we still have just scratched the surface in terms of educating our professionals, and in terms of the ravages of this disease.

I think one of the goals of appropriations, if at all possible, is to make sure that the HRA provisions be considered, because I think there is a great need for professional education that we have been neglecting over the years.

All of this is just to urge, even in these restrained times, that we make an effort to continue what I think has been an enormously successful program in the past 5 years. I think it is rather startling that results of the efforts, sponsored by this subcommittee and other legislators, the NIH particularly, and the Advisory Board, have already borne fruit. I think it would be a shame not to continue.

Thank you.

PREPARED STATEMENT

Senator Schweiker. Your prepared statement will be inserted in the record at this point.

[The statement follows:]

STATEMENT OF DR. RONALD ARKY, PRESIDENT, AMERICAN DIABETES ASSOCIATION

As you know Mr. Chairman, diabetes is a very severe chronic disease which has been estimated to be the third leading killer among diseases. Diabetes also produces complications which result in disability. Diabetics are more than twice as prone as non-diabetics to coronary heart disease and stroke, exhibit a 40-fold higher amputation rate than non-diabetics, and represent nearly 20% of all end stage renal disease patients entering hemodialysis programs. Diabetes is also one of the major causes of blindness in adults in the United States. In general, diabetics are hospitalized 2-1/2 times more frequently and have longer average hospital stays by 50% than non-diabetics. The estimated cost to the nation of this disease was $5 billion in 1975 and has been estimated by the National Diabetes Advisory Board to be approximately $7 billion in 1978.

The news with respect to diabetes is quite encouraging, however. Dr. Frederickson stated before this Subcommittee and the House Labor-HEW Appropriations Subcommittee that some very exciting developments were occuring in diabetes. To quote the National Diabetes Advisory Board: "Not since the discovery of insulin over a half a century ago, has the outlook for clinical advances in the treatment and ultimate prevention and cure of diabetes been so promising as today". Recently, an international meeting of some 200 experts from a broad spectrum of biomedical science related to diabetes was convened to evaluate the status of this field of research and that conference concluded, as did the National Diabetes Advisory Board, with enthusiastic optimism about future accomplishments in diabetes research.

Some of those accomplishments are the following:

- significant advances in the area of gene structure and recombinant DNA biology which portend an unlimited production of human insulin;
- the importance of genetic, viral and immunological factors in the development of diabetes;
- development of pancreatic islet transplantation techniques in animals which cure the diabetic state in animals;

- development of devices which would normalize elevated blood sugar levels in humans and animals;
- demonstrations that the normalization of blood sugar will prevent or reverse major complications in diabetics;
- documentation of the effectiveness of surgical and medical procedures such as anti-hypertension therapy and laser beam photocoagulation.

Also, the disease prevention programs being supported by the Center for Disease Control have had major success already. Those programs, which now operate in some 20 states, have produced substantial information regarding the incidence and effects of diabetes and have raised major possibilities with respect to programs for the control of the disease. Programs are now in place in a number of states to evaluate the effect of certain forms of service delivery.

I would also like to commend the leadership of NIH for its efforts in the diabetes field and the leadership of the Center for Disease Control. NIH has provided substantial support from the Office of the Director. Diabetes has been made one of the so-called "trans-NIH" priorities and major coordination has occurred between Institutes with regard to research and research training activity. Dr. Frederickson has lent substantial support to this coordination effort which has been chaired by the Associate Director for Diabetes, Dr. Lester Salans. Dr. Whedon has also lent support to these efforts in his role as Director of the NIAMDD. Dr. Foege at the Center for Disease Control has been a staunch advocate of the diabetes control program and Dr. Flynt who manages the program has been a tireless and effective worker in implementing this model chronic disease control activity.

I would now like to turn to our budget recommendations for fiscal year 1981.

1. NIH Research and Research Training

We would like to put ourselves on record as supporting the priority attached to the so-called investigator initiated awards which are the project research grant programs administered by NIH. At the same time, we believe very strongly that the NIH

must support a balanced program of biomedical research and a balanced program involves all of the following components: investigator initiated projects; intramural research; contract research; the support of Research & Training Centers; and research training. If any one of these elements is not adequately supported the research program in any major area will suffer. For example, if the emphasis is upon investigator initiated awards to the exclusion of other support, a research hypothesis that is indicated by animal research but needs to be tested in a clinical setting might not be followed up on because clinical trials in the diabetes program are managed and financed through the contract device and contracts are not investigator initiated awards. Likewise, the diabetes Research & Training Centers are major sources of clinical trials and offer a vehicle to translate research information into the hands of practitioners. Beyond that, Research & Training Centers attract a nucleus of top researchers, who, working together, produce the kind of synergism that often makes research effective. It goes without saying, that the intramural research program in diabetes headed by Dr. Roth is one of the best intramural programs at NIH and one of the best research programs in the country. Also, without adequate support for research training, the new investigators who are needed in biomedical research to keep ideas fresh will not be attracted into the field. The cuts in research training proposed by NIH, particularly the substantial cut in research training at the National Institute of Arthritis, Metabolic and Digestive Diseases, represents a major set-back for biomedical research. Our research proposals for NIAMDD and the other Institutes that include diabetes research activity represent our commitment to this balanced program of research in the biomedical field.

Our recommendations are as follows for the diabetes programs within each of the Institutes that support diabetes.

N I H

National Institute of Arthritis, Metabolism & Digestive Diseases

The President's budget for fiscal year 1981 includes approximately $80.3 million for diabetes and diabetes-related

research in the National Institute of Arthritis, Metabolism and Digestive Diseases. This represents an increase of $5 million over the current spending level with that increase devoted entirely to investigator initiated awards. We support a level of spending of $91.7 million for the diabetes program within this Institute with the additional $10 million over the President's budget being used to increase the training program to about $6 million, to provide approximately $2 million of additional funding for diabetes Research & Training Centers bringing that level to $13 million, and providing an additional $5 million for contract research and investigator initiated awards. Research activity to be expanded would include further work with respect to the transplantation of pancreatic islet cells, further development of instruments which delivery insulin and are implanted in the system, further research with respect to the impact of nutrition on diabetes and the relationship between obesity and diabetes.

National Heart, Lung & Blood Institute

The present level of spending is $15 million, and that is the presumed level for fiscal 1981. We recommend $18 million to expand research done with respect to atherosclerosis and diabetes and other studies recommended by the National Diabetes Advisory Board.

National Eye Institute

The present spending level is $17.5 million and that is expected to be the level in fiscal 1981 under the President's budget. We recommend a $5.5 million increase bringing the level to $23 million to support further research with respect to diabetic retinopathy as suggested in the Third Annual Report of the National Diabetes Advisory Board.

National Institute of Child Health & Human Development

The present spending level is about $7.8 million and that is the level presumed under the President's fiscal 1981 budget. We recommend a $3 million increase bringing the total level to $10.8 million. This increase would provide additional support to the major research programs and investigator initiated research in such areas as the refinement of test procedures to monitor fetal development in the diabetic mother and further basic studies of the metabolic events occurring in diabetic women during pregnancy, and other research recommended by the National Diabetes Advisory Board.

Diseases and Stroke

The present spending level is about $5 million and that is the presumed level in fiscal year 1981. We recommend a level of $6.5 million. These funds will assist in supporting the research center on peripheral neuropathy and increase specialized training programs to expand the participation of neuro-scientists in the unresolved problems of neurological complications of diabetes.

Research Manpower

We think that additional funds added to the NIH budget for diabetes should be targetted heavily on research training in order to restore research training funds cut in the President's budget and make some additions. Research training and research manpower are extremely important to the diabetes effort and we are quite disturbed by the cuts in the President's budget in these areas. NIAMDD in particular has suffered among the worse

cuts receiving about a 25% cut in its research training program. It is noteworthy that a pool of physician-scientists in diabetes and other fields is rapidly decreasing. Yet, physician-scientists are very important not only to the research effort but to the application of knowledge through clinical trials. Imaginative new manpower development programs have been developed by NIH. A new special emphasis, Research Career Award, has been developed and jointly sponsored by NIAMDD and 3 other Institutes, the NHLBI, NICHD, and the National Institute on Aging. These innovative activities need further support. Also, increases are necessary in order to adjust upward the Federal training stipends to compenstate for cost-of-living increases.

General Clinical Research Centers

In fiscal year 1980, approximately $56 million is expended on the GCRCs. 75 centers receive support for some 677 clinical beds. In 1970, 93 centers received support and 904 beds were provided. Without these centers as major resources, clinical trials will not be able to be supported in the numbers necessary in many areas of NIH research activity. We therefore recommend that $76 million be provided for the General Clinical Research Centers. With that amount of money, approximately $12 million would be devoted to diabetes beds for clinical trials compared to the present $9 million level.

Other Recommendations With Respect to NIH Including Specialized Support in 5 Other Institutes is Included in the Chart Attached to This Testimony

Center for Disease Control

The Center for Disease Control program now supports 20 projects in 20 states. 12 of these projects are now in the implementation stage while 8 will be in the planning stage in fiscal year 1980. These programs are designed to significantly reduce the high morbidity and mortality presently associated with diabetes by applying currently available technology, knowledge and resources to this problem. In the first stage, each state must analyze the effects of diabetes and the resources that might be available to deal with the problems discovered. In the second phase, the state supports activity to deal with the particular problems of diabetes found in that state such as the high rate of amputations found in one state. The activities which are being conducted by the states in the implementation stage include the development of and improvement of patient education programs, training of health care professionals in the treatment of diabetics -- 2200 of such professionals have participated in training projects already, support for new outpatient programs and reformed third party reimbursement to support such programs. The present level of support in the Center for Disease Control is $4.6 million for the 20 states. In order to move all 20 states into the implementation stage in fiscal year 1981 and to support 8 new positions, an additional $3.4 million is

necessary. This additional funding would also enable the Center for Disease Control to compile and analyze the data which it is receiving from these 20 states. This information will provide substantial insight into the problems of diabetics and the method of intervening in their care to reduce morbidity and mortality.

National Institute of Mental Health

In fiscal year 1980, the National Institute of Mental Health spent approximately $800,000 on research related to the behavioral and psychological aspects of diabetes. About that same amount is recommended for fiscal year 1981 in the President's budget. We would recommend continuation of that program and support at approximately $1 million. NIMH and 4 of the Institutes of NIH supported a major new program dealing with behavioral studies in fiscal year 1980. National Conference on Behavioral and Psycho-Social Issues in Diabetes was sponsored in May. Some additional research is necessary in the areas specified in the National Diabetes Advisory Board Report and the funding recommended should enable research in those areas to be carried out.

Health Manpower Training and Health Care Delivery Experiments

As we are learning more and more through basic biomedical research and the data being collected by the Center for Disease Control, it is becoming very apparent that the Government should devote some effort to improved application of knowledge to the care of the diabetic. As the National Diabetes Advisory Board indicated in its Report; "It is evident that the health status of the patient is closely linked to the level of skills and knowledge as well as the attitudes of health care professionals". The majority of diabetics receive health care from general practitioners and other health care personnel who, in the opinion of the National Diabetes Advisory Board and others, often do not have adequate exposure to appropriate methods of treating diabetes including the most advanced information derived from research. These practitioners are in areas throughout the United States and therefore some effort is necessary to improve the training of health professionals throughout the United States in order to improve care and reduce mortality and morbidity. It is very clear that improved education of professionals can make a major dent on the $7 billion cost of diabetes derived essentially from its complications. We would therefore recommend that at least $1 million be earmarked for the training of health care professionals in methods of treating diabetes and related endocrine and metabolic problems. We would recommend that this money be made available under the special project funding

authorized in Section 788(d) of the Public Health Service Act and administered by HRA. We would also recommend that the Center for Health Services Research in HEW be provided an additional $1 million earmarked for research with respect to improved methods of service delivery for the diabetic including experimentation with methods of patient education. The health manpower training program would involve grants to medical schools and other health professional schools to provide student education and continuing education programs. These educational activities are far different from the short-term activities that might be conducted by a state with a CDC grant. The program to be established by the National Center for Health Services Research would involve grants to non-profit health care providers to experiment with the latest methods in organizing and delivering care to the diabetic. This experimentation should provide information with regard to the most effective methods of delivering care.

Mr. Chairman, this ends our testimony. We realize that this is a very difficult budget year but the programs that we are recommending, incremental increases in the biomedical research program and approximately $6 million in the way of increases to provide improved care, are very important in dealing with diabetes and should provide substantial cost savings for the Government in the form of reduced disability support.

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Table 1

BUDGET RECOMMENDATIONS FOR DIABETES BIOMEDICAL RESEARCH

FY 1981-85
($ in millions)

Agency	FY '80(est)	FY '81	FY '82	FY '83	FY '84	FY '85
National Institutes of Health:						
NIAMDD *	75.3	91.7	108.0	124.0	141.0	169.0
NHLBI	15.1	18.2	21.7	25.4	29.4	34.5
NEI	17.5	23.0	25.8	27.9	30.2	32.6
NICHD	7.8	10.8	12.3	13.9	15.6	17.5
NINCDS	5.1	6.5	7.2	8.0	9.0	10.2
NIAID	2.9	3.6	4.7	5.5	6.3	7.3
NIA	2.4	2.9	3.5	4.2	5.0	6.0
NIDR	1.2	2.3	2.6	3.0	3.4	3.8
NIGMS	1.5	1.6	1.8	2.0	2.2	2.4
NIEHS	.1	.2	.4	.5	.6	.8
DRR **	9.2	12.2	15.9	19.7	23.9	29.0
Subtotal	138.1	173.0	203.9	234.1	266.6	313.1
Alcohol, Drug Abuse, and Mental Health Admin:						
NIMH	.8	1.0	1.2	1.5	1.8	2.1

* NIAMDD estimate for FY '80 includes $3.7 million of diabetes-related activities supported by other NIAMDD programs. Recommendations for FY '81-'85 exclude diabetes-related activities in other programs.

** Board recommendations include $76 million in FY '81 for the total General Clinical Research Center Program of DRR. This budget table reflects an estimate of diabetes-related activities within this noncategorical program.

ARTHRITIS FOUNDATION

Senator SCHWEIKER. All right. The Arthritis Foundation.

Dr. FELTS. Yes, sir, Mr. Chairman, I am William Felts, associate professor of medicine at George Washington University. I have the pleasure of appearing on behalf of the Arthritis Foundation and National Arthritis Advisory Board.

I would like to relate a bit of an overview to you, rather briefly, from my own background—which has been involved in patient care of individuals with arthritic disorders for more than 20 years, involvement in research and training, organizational work in a voluntary capacity with the Arthritis Foundation.

I have had the honor to be a member of the Arthritis Commission and National Arthritis Advisory Board, the Institute of Medicine and a past president of the American Society of Internal Medicine. I would

like to second the observations of other panelists that we are most appreciative of the dilemma confronting the Congress and administration with respect to our inflation and to other socioeconomic problems.

Nonetheless, we have to view these problems from our own perspective, and I would like to relate a few observations that I perceive occurring in our national approach to chronic disease, particularly since the passage of the Arthritis Act in 1974.

We have viewed arthritic conditions as being models for many of the problems that perplex our society—diseases of unknown origins and conditions that we don't know how to cure. These conditions serve as great models in this capacity for all form of research. We must recognize that until basic research breaks occur, we still, as physicians and as other health care providers, are confronted with caring for the individuals who are afflicted by these conditions.

RECOMMENDATIONS

The figures that our two groups have prepared through separate processes are, we believe, very reasonable. In view of the constraints under which this committee must work, I would ask you to indulge me in presenting our particular figures with perhaps the suggestion that at least the percentages that they represent in any process that evolves may be helpful to the committee in making appropriate adjustment.

For one thing, we believe that the research budget as proposed by the President, should be increased by at least $12 million. The models of arthritic disorders, rheumatoid disease and lupus are very well funded and are being investigated. But the other problems, such as those represented by osteoarthritis, arthritis of childhood, spondylitis, systemic sclerosis, and other connective tissue disorders are lagging behind and need to be improved.

I would also like to point out that the arthritis program in the NIMADD lags behind other categorical programs and has only partially been corrected by funds allocated in other programs authorized under the Arthritis Act. We would hope the committee can further act to correct the disparities between authorizations and funding, as resources may allow.

One of the major advances has been the creation of multipurpose arthritis centers. These now number 24. But they have been significantly underfunded. Some of their tasks include the evaluation of interventions and their cost effectiveness; expansion of patient education via nursing; allied health personnel and patient advocacy groups; and development of uniform data modules and data systems to assess outcome; and the identification of significant factors to be applied in screening and evaluation efforts.

Because these efforts are very vital to health care services, it is the considered opinion of the Foundation and NABB that $5 million should be added to the President's original proposed budget for centers in 1981.

Epidemiology also requires specific action. The problems of a lagtime in the cause and effect evaluations often requires decades to assess. This necessitates meticulous action for protocols and program development

and also requires a continuity of resource support. New initiatives should seriously be considered and funded in epidemiology and, parenthetically, in data support.

Findings from these endeavors could well save billions in future health care cost. The recommended initial designation of $2.5 million for this purpose is included. We have critical concern about next year's appropriations and need to reverse the administration's recommendation of diminished resources to training. We believe this would almost destroy the basic research community in the next decade if it is not reversed.

We need more established NIAMDD clinical investigator awards and we need an initiated program in new investigator research awards.

I would like to assure you that our mutual objective remains the attainment of a balanced national program. Actions by the Arthritis Foundation and other private sector groups, the Congress, the NIAMDD, various Federal agencies, National Arthritis Advisory Board, and programs that have been implemented, represent tangible actions. A number are cited in the written material submitted, and I would like to have included, sir, the third annual report of the National Arthritis Advisory Board.

Thank you very much for the opportunity to express these views.

[CLERK'S NOTE.—The third annual report of the National Arthritis Advisory Board was submitted and inserted in the subcommittee files.]

PREPARED STATEMENT

Senator SCHWEIKER. Your prepared statement will be inserted in the record at this point.

[The statement follows:]

STATEMENT OF DR. WILLIAM R. FELTS, JR., ARTHRITIS FOUNDATION

INTRODUCTION

During the last five years, since the passage of the National Arthritis Act, there have been significant changes in the approach to problems posed by chronic diseases in this country. Many of these changes have been stimulated by the Arthritis Act and the new programs which it has brought into being: Multipurpose Arthritis Centers; a National Data System in arthritis which is being used as a model by the National Institute on Neurological and Communicative Disorders and Stroke for its new data system on stroke and coma; and a National Arthritis Clearinghouse which is attempting to collect information on ongoing and past research in arthritis; professional, public and patient education programs; therapeutic approaches to the modern management of the arthritis patient; community outreach programs; and evaluation mechanisms for measuring the cost effectiveness of chronic care programs.

The synergistic effect of the Arthritis Act upon other chronic diseases is due to the fact that the arthritic diseases are excellent models for almost all chronic diseases of unknown cause with which our society is trying to cope.

Yet, until etiologies and cures are identified through a sustained program of basic research, we will continue to be confronted by newly-recognized problems resulting from these diseases and largely frustrated in our attempts to cure them.

So basic and clinical research, and the preparation of individuals for research careers, is the first stanchion upon which our bridge of hope for a brighter future in chronic diseases is based. This stanchion must constantly be shored up against the ever present threat of being eroded by political waters which are looking for short cuts to success. There are, unfortunately, no short cuts in biomedical research.

At the same time we must do a better job of preparing a host of health professionals -- physicians, surgeons, physiatrists, nurses, allied health professionals -- to help improve the condition of the nation's 31 million arthritis patients of whom nearly 7 million are partially or totally disabled. This second stanchion, education, also is faced with increasing pressure from many directions -- questions of how many, how much training, what kind of training, who should be trained, generalists vs. specialists, etc. In arthritis the team approach is often the most successful. This is being looked at carefully in the Multipurpose Arthritis Centers.

And, lastly, the third stanchion -- demonstrating improved methods of care to health professionals, patients and the public.

In all of these, the Multipurpose Arthritis Centers now have and will continue to have an important role to play. The Centers provide a major mechanism by which a critical mass of trained manpower can be brought together to share their expertise in addressing the varied problems attendant to the chronic diseases. Despite this potential, Arthritis Centers are grossly underfunded. To date, appropriations have barely exceeded one-third of the authorizations.

The development of a balanced program to combat chronic diseases should be our cherished goal. In the following discussion of advances and needs, I have tried to depict the striving for a sense of balance. The major imbalance is the gap between the limited availability of funds and constantly expanding needs. I hope that this Committee may be able to address this problem in the face of pressures to achieve other kinds of balances which may not be the most appropriate ones with respect to resolving our long-range needs in chronic care.

ARTHRITIS RESEARCH

As indicated in the enclosed analysis of the impact of the National Arthritis Act on the Arthritis Program of NIAMDD, arthritis extramural research grants have barely managed to keep apace of inflation since 1976; the same number of grants having been awarded in FY 1979 as in FY 1976. The National Arthritis Commission's Plan, submitted to Congress in April, 1976, called for a doubling of arthritis research in order to attack many of the areas not then being investigated and to expand other areas which were underfunded.

Since that report was issued there have been several major breakthroughs in arthritis research. One has been in the area of genetics where arthritis researchers have led the way in demonstrating associations between chronic disease and histocompatibility antigens. Genetic markers have been identified in several major forms of arthritis — spondylitis, juvenile rheumatoid arthritis, adult rheumatoid arthritis and systemic lupus erythematosus (SLE).

Major advances have also been made with respect to measuring immune complexes which may lead to the discovery of the factors which initiate arthritis. The investigation of how cells initiate and control immune responses have shown that abnormality in cell function can lead to abnormality in immune responses. For example, studies of patients with SLE have shown that abnormalities in cellular immunity may result from a loss of suppressor T-cell function. This field of immunologic inquiry is expected to continue to bear fruit if properly nurtured.

Virology may also play an instrumental role in unearthing the causative factors of arthritis. Models of infectious arthritis induced by certain bacteria are providing important clues to the possible isolation and characterization of microbial agents in persons with arthritis.

This basic research needs to be complemented by enhanced clinical research into the improvement of current therapeutic techniques and the facilitation of technology transfer, and by upgrading the capability of research institutions to attract prospective young scientists into research careers.

The Foundation proposes that the President's recommended level of funding of Extramural Research Grants next year be elevated from $24,190,000 to $36,184,000, a $12 million increase, to provide expansion in the following areas: immunology, genetics and infectious agents. Inflammation, structure and function of connective tissue, and developmental and cell biology should also receive special emphasis.

Research should be directed at identifying the various cell subtypes, and the soluble factors produced by them, that either "suppress" or "help" the body's immune response in the rheumatic diseases. Animal models should be used to study the role of viruses or bacterial debris in initiating or perpetuating inflammation of joints. The metabolism of collagen, mucopolysaccharides, and other molecules needs to be investigated to understand how cartilage is destroyed in inflammatory arthritis.

While research on systemic lupus erythematosus and rheumatoid arthritis is highly active, much more research needs to be carried out in juvenile arthritis, the spondylitic diseases, degenerative joint disease, systemic sclerosis, the arteritides, and psuedogout.

Coordinated with genetic investigations, new research should take advantage of the associations between genes in the major histocompatibility loci and the rheumatic diseases; B locus antigens in spondylitis and its varients, and D locus antigens in rheumatoid arthritis and systemic lupus. These provide genetic markers for disease predispositions to several forms of arthritis. Coordinated

with these investigations should be searches for environmental causative factors, including microbes of various sorts.

Epidemiologic studies need to be initiated in the spondylitic group, rheumatoid arthritis, lupus and juvenile polyarthritis. These areas will be discussed at a Workshop on Rheumatic Diseases Epidemiology to be held by NIAMDD in September, 1980. The Workshop will be chaired by Leon Gordis, M.D., Professor and Chairman of the Department of Epidemiology, School of Hygiene and Public Health, Johns Hopkins School of Medicine; and Warren Winkelstein, M.D., M.P.H., Dean and Professor of Epidemiology, University of California at Berkeley.

TRAINING

The Administration's tack of diminishing research training opportunities in order to increase research opportunities is analagous to taking food from expectant mothers in order to feed their children who are already born. This starvation policy with respect to research training can only result in the diminution of the future research community and an eventual cataclysmic drop in research capability. The Foundation trusts that Congress has already seen through this myopic approach to providing a "stable" research budget and intends to reverse this policy by restoring the training funds in their entirety plus adding such sums as may be necessary to provide an adequate number of training opportunities.

The Foundation is hopeful that Congress may see fit to increase somewhat the funding for a new program in arthritis -- Clinical Investigator Awards, provide for new leaders in academia by expanding the Research Career Development Awards program, and maintain the Research Service Awards apace with inflation.

In 1979, the relatively new Clinical Investigator Awards program was supporting 10 prospective arthritis researchers at a stipend of $25,000 plus $20,000 in equipment and supplies. The Institute is adding two to three new Clinical Investigator Awards each year. This program was begun in FY 1977 with four M.D.'s who had already completed some arthritis research training and were aiming at an academic career. These CIA's are regarded as providing a "bridge" in the early careers of aspiring M.D.-researchers who need encouragement to enter research and limited support until such time as they can effectively compete with more senior researchers for a regular research grant or can achieve NIH support through a Research Career Development Award. Of the seven awardees during the first two years of the program, one has successfully competed for an arthritis research grant and has thus been dropped from the Clinical Investigator program. It is expected that one or two others may join their colleagues in the competitive research ranks this year.

One of the missing links in the Arthritis/Bone/Skin "cluster" at NIAMDD is that there has not been sufficient research funds to be as flexible as the other "clusters" of the Institute and offer New Investigator Research Awards as another means of providing biomedical research opportunities for young researchers.

The Institute was supporting 17 Research Career Development Awards in arthritis in FY 1979 which were going to 13 Ph.D.'s and four M.D.'s. This five-year support program is designed to provide a stable financial base for the most capable of the young researchers who are expected to be in leadership positions later in their careers as independent investigators. The primary areas of investigation being undertaken by the 17 current recipients of RCDA's in arthritis include cartilage, collagen and connective tissue. The RCDA stipend is $30,000. One of the weaknesses of this award is that it does not automatically carry with it an assurance of research support. Unlike the Clinical Investigator Award, the RCDA recipient is adjudged more competitive and thus capable of obtaining research support from the regular peer-review process. Unfortunately, this does not always work out and on occasion the

Department Chairman under whom the RCDA-investigator is working may need to provide the laboratory support necessary to enable the researcher to carry on his or her tasks.

With respect to the National Research Service Awards (NRSA's), there were 12 individual Fellowships awarded in arthritis in FY 1979, mostly Ph.D.'s, and there were 22 institutional awards in which 65 Fellows were participating. This three-year training program is producing about 25 new researchers each year. It is not expected to grow much beyond this despite the fact that the manifold research opportunities in arthritis would dictate that a 50 percent increase could easily be absorbed by the research community.

CENTERS

The concept of arthritis centers is not new. The National Foundation/March of Dimes began underwriting a handful of National Arthritis Clinical Research Centers in the early 1960's based upon the belief that arthritis as a "hands-on" disease could best be studied in a clinical setting where patients could be observed over a long period of time. The Arthritis Foundation took over the "support" of these Clinical Research Centers in the mid-1960's and is still continuing the program. The "support" level, however, is minimal and is mainly a token recognition of the achievement of excellence rather than program sustenance. The Multipurpose Arthritis Centers program, on the other hand, begun in FY 1977, provides substantial funds to enable a major expansion of activities with respect to education, research and community programs.

Of the 24 federally-funded Arthritis Centers now in place nearly all initiated new educational programs for medical students, interns, residents, nurses, allied health professionals, patients and the public. New educational materials are being developed which are being made available to other teaching institutions. One group whom the National Arthritis Commission had hoped would benefit from the educational impetus of the Arthritis Act were prospective researchers. However, as yet, Centers funds provide no research stipends. Of particular need is a stimulus for nurses and allied health professionals to engage in arthritis research.

Perhaps the major impact of the Centers has been in health services research. Prior to the advent of the Centers, few studies had been undertaken in this area. Currently eight Centers are engaged in case finding and epidemiologic studies. Six Centers have developed model team-care demonstration projects and another six have outreach clinics served by Center staff. Studies assessing the socio-economic impact of arthritis on communities are under way in nine Centers.

Centers are also beginning to define the needs of individual communities, planning responses which relate to specific levels of care, studying patterns of care and cost of care, and developing interesting instruments to measure the outcome of intervention by providers in multiple settings.

NIAMDD is providing modest supplemental grants to many of the Centers for "development and feasibility studies" to look at prospective research areas. Much of this activity which involves young investigators has already been extremely productive. The annual scientific meeting of the American Rheumatism Association Section of the Arthritis Foundation in June, 1979, saw 34 percent of its research papers emanating from the 24 Multipurpose Arthritis Centers. With respect to the Arthritis Health Professionals Section meeting, the influence of the Centers upon research was even more remarkable. Sixty-seven percent of papers presented came from the MAC's. This concentration also shows that the Centers are highly attractive to allied health professionals who wish to receive specialized training in the rheumatic diseases.

In conclusion, the emergence of federal support for Center-oriented activities with respect to arthritis has been highly significant. These Centers need to be sustained and allowed to experience moderate growth in concert with a continuing evaluation of their impact upon research, education and community health services.

EPIDEMIOLOGY

As I have noted in my discussion of arthritis research, it has been recently discovered that certain persons posses genetic markers which cause them to have a predisposition for certain types of arthritis. This discovery needs to be elaborated upon through epidemiological studies of these persons at high risk. Variables such as sex, age, environment, response to disease, response to treatment, etc. need to be measured to determine why some persons with these genetic markers become afflicted with arthritis while others do not.

The mandate of the Center for Disease Control in Atlanta, Georgia, has been broadened to include chronic diseases. Yet, there is to date no program in arthritis despite language in the FY 1980 Report of the Senate Appropriations Subcommittee on Labor-HEW that such a program be initiated. Thus, even though there is an Arthritis and Immunological Disease Section in CDC's Bureau of Epidemiology, and even though there was an epidemiologist assigned to arthritis for a short time in 1979, financial limitations and lack of specific personnel slots for arthritis have severely hampered the Center's willingness to undertake epidemiological studies in arthritis.

There have been some spot studies by CDC at the request of State and local health departments. Lyme arthritis in Connecticut, for example, was investigated with respect to its virological implications, and the possible association of systemic lupus in dogs and humans in the same household was studied. However, the surface has not even been scratched.

The Foundation, therefore, requests that this Committee provide funding for six staff persons at CDC to work on arthritis epidemiology studies, and to earmark an additional $2.5 million for CDC's 1981 budget for these studies and in developing arthritis control and surveillance programs in cooperation with State health departments.

These studies in cause and effect will require a long term commitment by Congress since evidence must be carefully weighed and measured over successive years, following a significant number of patients. Yet, the results of these studies could well change the course of treatment of millions of persons threatened with disability because of arthritis and save billions of dollars.

DATA

The National Arthritis Data System, located at Stanford University, developed from a concept of a Computer Work Group formed by the Arthritis Foundation in 1974. The technology employed by the Arthritis Data System is based upon the American Rheumatism Association Medical Information System (ARAMIS), a product of the Foundation's efforts of 1974-75.

ARAMIS has become a collaborative project, drawing data from several sources to be stored at the Stanford central computer facility. More than 44,000 arthritis patient visits have been recorded for 12,000 patients. Specialized data banks are now being developed for orthopaedic surgery performed on arthritis patients, for juvenile arthritis which has had a number of separate data banks in various institutions specializing in arthritis in children, and for systemic lupus erythematosus (SLE).

An NIAMDD grant of $215,000 in FY 1980 is being supplemented by a grant of $146,000 from the National Center for Health Statistics to "assess the technological aspects of data base research."

The excellence of the ARAMIS system and the justification for its continued support can be demonstrated by the fact that the National Institute on Neurological and Communicative Disorders and Stroke is adopting it as a model for its new data bank on stroke and coma.

AN ANALYSIS OF HOW THE VARIOUS COMPONENTS OF THE ARTHRITIS PROGRAM OF NIAMDD HAVE FARED SINCE THE PASSAGE OF THE NATIONAL ARTHRITIS ACT OF 1974

FY 1977

The FY 1977 budget for the Arthritis Program of NIAMDD reflected in part the recommendations to Congress by the National Arthritis Commission of April 1976. The Program received a hefty 31.5% increase from a very low base of $17,709,000 in 1976 to $23,296,000 (+$5,587,000).

Of this increase, $2,500,000 was "earmarked" for initiating the Multipurpose Arthritis Centers program. It was awarded later that year to the first nine Centers.

To resuscitate a nearly moribund training program suffering from the demise of the institutionally-awarded Research Training Grants and the agonizingly slow start-up of the so-called "Weinberger" research fellowships (National Research Service Awards), $1,339,000 was added to the Arthritis Program Training budget ($453,000 for Research Career Development Awards and $856,000 for NRSA's) which had fallen to a low of $368,000 in 1976.

The Cooperative Clinical Drug Trials in arthritis were also revived with $822,309 after several years of dormancy. This important program had had an 18 year history of consecutive support by NIAMDD before it was halted in 1975 to allow for a reorganization of the program which had experienced some administrative problems. This major program is one of the few truly independent drug investigative programs in the country with respect to the "double-blind" testing of anti-rheumatic drugs.

And, Arthritis Intramural Research Program was increased by $700,000 or 21.3%.

Meanwhile, Extramural Research funding was saved from going under completely by a Supplemental Appropriation which enabled $351,000 to be added to the program, an increase over FY 1976 of 2.6% ($14,100,000 vs. $13,749,000).

Thus, the first appropriations year following the issuance of the Report to Congress in April 1976 by the National Commission on Arthritis and Related Musculoskeletal Diseases which had recommended a doubling of arthritis research, was disastrous with respect to research funding. Yes the Centers program was begun with an appropriation which was less than 15 percent of the authorization, but why was arthritis research penalized?

FY 1978

In FY 1978, The Centers program continued to grow. An additional $2,704,000 was provided to the program for a total of $4,149,000, an increase of 110% over FY 1977. This enabled the Institute to fund an additional 13 Centers for a total of 22.

Training received another shot in the arm with a 25.4% boost from $1,679,000 to $2,106,000 (a $427,000 add-on for RCDA's and NRSA's combined).

Yet, while the Arthritis Program in its entirety rose by 19.8%, from $23,296,000 to $27,906,000, Extramural Research Grants increased by only 9.4%, from $14,100,000 to $15,426,000 (+$1,326,000).

FY 1979

In FY 1979, Arthritis Research Grants were finally given some badly needed pump priming. Research grew almost as fast as the Program itself, +18.7% vs. +20.6%. An additional $2,884,000 was allocated to Research which enabled 44.7% of approved grants to be funded. Yet, the total number of arthritis grants funded by NIAMDD in FY 1979 was the same -- 187 -- as were awarded in FY 1976.

The Centers program received another boost of $1,873,000, or a 36.4% increase over 1978. This enabled two additional Centers to be funded, for a total of 24, and for Supplemental Grants to be awarded to most of the Centers.

FY 1980

The FY 1980 budget for the Arthritis Programs of NIAMDD reflects a leveling off trend for the Centers program, caused by the need to upgrade Research Fellowship stipends, and a modest sustenance of Extramural Research -- from $18,310,000 to $20,152,000 (+10.1%) -- which is expected to allow approximately 35% of approved research grant applicants to be funded, a sizeable drop from 1979. The entire Arthritis Program growth is being slowed this year by a drop in the share of Institute funds allocated to the Program. While the NIAMDD budget rose by 12.9% this year, the Arthritis Program is experiencing only a 10.8% increase.

This represents a "shortfall" of $984,426 in the Arthritis Program budget this year -- money which was taken from the Arthritis Program to enable the Institute to boost Research Fellowship stipends in other program areas. This current assault by the Institute on the Arthritis Program greviously compounds the neglect shown the arthritis research program over the past four years.

In fact, since 1976, although the Arthritis Program has grown substantially, primarily because of the advent of the Centers program, in reality it has grown only slightly faster than the Digestive Disease program (+$19,481,000 vs. $14,970,000), which has had no separate authorizing legislation, and considerably slower than the Diabetes program (+$19,481,000 vs. $54,084,000). Even the Kidney/Urology program has grown by $14,297,000.

CONCLUSION

There has obviously been a complete lack of resolve on the part of Congress and the Administration to assure that the National Arthritis Act of 1974 was implemented, and that recommendations of the National Arthritis Commission and the National Arthritis Advisory Board were adhered to.

The millions of Americans who are threatened with severe disability by arthritis have not been well served, The federal government continues to finance by many billions of dollars the results of arthritis disability through Social Security Disability Insurance, Veterans' benefits, Medicare, Medicaid and Vocational Rehabilitation and loss of tax revenues from persons no longer able to work because of arthritis, but neglects to give proper credence to the investment in a greatly expanded biomedical research program which would lessen the government's financial burden for this disease and the toll it exacts on its victims.

HOW DOLLARS ARE SHARED BY THE TEN PROGRAM AREAS OF
THE NATIONAL INSTITUTE OF ARTHRITIS, METABOLISM, AND DIGESTIVE DISEASES (NIAMDD)
FY 1976 - FY 1980

PROGRAM AREA	FY 1976	%	FY 1977	%	FY 1978	%	FY 1979	%	FY 1980	%
DIABETES	$14,672*	8.5	$36,267	17.2	$53,169	21.3	$61,071	21.0	$68,756	21.0
METABOLISM	33,611	19.5	35,041	16.6	38,151	15.3	41,505	14.3	47,628	14.5
DIGESTIVE DISEASES	26,176	15.2	27,662	13.1	31,816	12.7	36,826	12.6	41,146	12.5
ARTHRITIS	17,709	10.5	23,296	11.0	28,370	11.3	33,753	11.6	37,190	11.3
KIDNEY/UROLOGY	21,410	12.4	25,081	11.9	26,946	10.8	32,161	11.0	35,707	10.9
ENDOCRINOLOGY	23,827	13.8	25,060	11.9	27,195	10.9	31,812	10.9	36,705	11.2
HEMATOLOGY	11,966	6.9	12,651	6.0	14,679	5.9	15,121	6.2	20,164	6.1
NUTRITION	9,645	5.6	10,437	4.9	11,838	4.7	13,942	4.8	15,862	4.8
ORTHOPAEDICS	8,133	4.7	9,411	4.5	10,878	4.4	12,613	4.4	14,379	4.4
DERMATOLOGY	4,832	2.8	6,111	2.9	6,578	2.6	8,785	3.0	9,955	3.0

*Figures in thousands of dollars.

National Institute of Arthritis, Metabolism, and Digestive Diseases

Arthritis Program

Regular Research Grants

	1975	1976	1977	1978	1979
Number of Competing Applications Eligible for Award	107	89	133	162	166
Number awarded	59	43	36	57	74
Noncompeting awards	107	144	123	101	113
Total eligible for award (Lines 1 + 3)	214	233	256	263	279
Total awarded (Lines 2 + 3)	166	187	159	158	187

NATIONAL INSTITUTE OF ARTHRITIS, METABOLISM AND DIGESTIVE DISEASES

ARTHRITIS PROGRAMS PROJECTION FOR FY 1981

(Figures in thousands of dollars)

	Research Grants	Centers	RCDA's	Research Service Awards	Epi-demio-logy	Comm. Demon. Projs.	Data	Nat'l. Info. Clear-ing-house	Contracts	Total Extra-mural	Intra-mural	Total
FY 1979	18,310	7,022	1,062	1,271	0	0	190	146	1,220	29,021	4,304	33,525
FY 1980	20,152	7,686	1,062	1,985	0	0	350	154	1,286	32,675	4,458	37,133
Administration's Proposed FY 1981	24,190	7,885	825*	1,200*	0	0	400	250	1,240	35,990	4,819	40,809
FY 1981 Budget Proposed by NAAB and AF	36,184	13,000	1,551	2,207	2,500	0	750	250	2,065	58,507	5,226	63,733

TOTAL NIAMDD BUDGET
(in thousands of $'s)

1978	1979	1980	Administration-Proposed 1981	Foundation-Proposed 1981	"Coalition for Health Funding"-Proposed 1981
$260,246	$302,743	$341,939	$365,711	$426,000	$395,000

*NOTE: Administration proposes reduction of arthritis training by $1,002,000

DIABETES ADVISORY BOARD

Senator SCHWEIKER. Yes; we don't include the whole report in the record but we will file it. We will include your whole statement.

Let me just say that as one who pioneered the Diabetes Advisory Board, I did include the Arthritis Advisory Board in the bill that finally passed. I believe all the disease categories should be treated fairly and equitably and I plan to support the Digestive Diseases Advisory Board as well.

While we may have a technical problem right now of getting it through, as far as I'm concerned it's something we badly need to do to get fair representation. I think it's been helpful to NIAMDD to have these advisory inputs and let the consumers have their say about where this program ought to be going and directed.

I had quite an argument when it first went through. I was accused of tearing NIH out brick by brick if I had ever put one of these advisory boards into effect. NIH is still standing. The bricks are all there.

We have a lot more citizen participation in the kind of research that frankly benefits them. So I want to make clear I do believe we should get the third panel in place to get fair and equitable representation in the NIAMDD group. I think it's very important.

ENTITLEMENTS AND BUDGET CUTS

I do want to come back to the budget thing because this is the all-consuming problem before us. I think we are going to devise a way to measure what benefits we get from some of our entitlement programs. Health is always put in a squeeze because we have never had the magic legislative formula of entitlements.

This committee has not looked with favor on entitlements because they make it difficult to determine what is a good program and what is a bad program. Up to now it's never become an issue. With the President's proposals pending it may well be an issue.

If we are going to cut up budgets in the future based on what is an entitlement and what isn't, and cut back nonentitlement programs and don't cut back entitlement programs, we may want to define what entitlements are and bring into scrutiny what kind of programs get sacred treatment and what kind don't. I don't think that health research benefits can be anywhere near as effective if they are not going to have the same kind of growth rates as our so-called entitlement programs.

Many of the entitlement programs are in areas where we are not getting our return on investment. So I think one thing that the whole coalition of health groups has to look at is a new definition of what an entitlement is and what our health programs are. Otherwise we are going to get really unfairly treated in the proposals that are made and coming forth very soon; and up until now it hasn't been an issue because nobody's decided to go back and do these things this way.

But I can see if this is to be the pattern for this year, it is going to be the pattern for future years. It puts the pressure on us as Senators to ask who do we give the entitlement programs to and why?

I believe our subcommittee strongly agrees with the representations here. And having some research background myself, I strongly feel that you can't possibly have a bona fide program without training. So we are going to fight to get our training back in in spite of the President's position and NIH's position, which I find very much outside of scientific thinking. I find it somewhat of an anomaly.

We thank the panel for being here.

NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT

STATEMENTS OF:

JAMES MURPHY, PEDIATRIC RESEARCH GROUP

PHYLLIS MAGRAB, DR. ROBERT STEMPFEL, DR. IRVIN EMANUEL, AND SELDON TODD, AMERICAN ASSOCIATION OF UNIVERSITY AFFILIATED PROGRAMS

DR. CARL HAYWOOD, VANDERBILT UNIVERSITY, PEABODY COLLEGE

HOWARD BRINKLEY, SOCIETY FOR THE STUDY OF REPRODUCTION

Senator SCHWEIKER. We will call our final panel today: Programs Affecting the National Institute of Child Health and Human Development.

I might say, we don't have some of the written statements. Some gave verbal statements. We would like to include a complete written statement in the record, so you have until March 14 for those who don't have written statements who would like to file them with us. We will be glad to include them, the whole statements.

We have already heard from the Cystic Fibrosis Foundation. Do you have an order of preference?

All right. You press the buttons. Make sure you introduce yourselves.

MENTAL RETARDATION

Mr. TODD. I'm Selton Todd. Our concern is mental retardation. There are 6 to 7 million mentally retarded nationally, as you know. Our concern is research.

We have a very distinguished panel I would like to introduce. Dr. Carl Haywood, Director of the Mental Retardation Research Center, Peabody College, Vanderbilt University. Dr. Haywood is also the president of the association of the 21 mental retardation research centers. He's speaking on behalf of his experience and also for the group.

Dr. Magrab is director of the university-affiliated facility at Georgetown. She is also past president of the Association of University Affiliated Facilities. She is the lead staff person working with the Secretary of HEW on how the Head Start program can be expanded to deal more effectively with the handicapped.

Dr. Emanuel, who is Director, Mental Retardation Research Center——

Senator SCHWEIKER. That is out West somewhere, isn't it? That's a good location to be from.

Mr. TODD. Finally we have Dr. Robert Stempfel of Miami. Dr. Stempfel has one of the first and best known UAF programs. He also is a leader in the development services, also a service leader in terms of services to children.

Dr. Haywood will commence.
Senator SCHWEIKER. We have a few other people there.
A VOICE. We will follow this major panel.

MENTAL RETARDATION RESEARCH CENTERS

Dr. HAYWOOD. My name is Carl Haywood. I am a professor of psychology and of neurology at Vanderbilt University, and director of the John F. Kennedy Center for Research on Education and Human Development.

The Kennedy Center in Vanderbilt's George Peabody College is 1 of the 12 national mental retardation research centers constructed and established under the provisions of Public Law 88–164, the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963.

In the testimony that I present to you I am representing the 12 national mental retardation centers in my capacity as chairman of the center directors and administrators. I am representing also, as its president-elect, the American Association on Mental Deficiency, an organization of approximately 12,000 professional persons in the field of mental retardation service, education, and research that has since 1876, been the world's primary source of professional concern for better understanding, care, development, treatment, training, and rehabilitation of mentally retarded individuals.

I appreciate very much, as do those whom I represent, the opportunity to appear before this committee and to share with you our conviction that continuing support of the 12 national mental retardation research centers is demanded by considerations of economy and the public purse, as well as by considerations of humanity and human rights.

One of the major goals of Public Law 88–164 was to provide for increased knowledge of the causes, social correlates, and treatment of mental retardation, and through such an increase in knowledge to reduce the social problem and the human suffering associated with mental retardation. In other words, that landmark legislation constituted recognition of a widespread national problem that affects some 6.5 million Americans directly, and up to 50 million Americans indirectly; and a conviction that we could, through collective action, do something about that problem.

As a significant part of the solution, the 12 national mental retardation research centers were created with a 20-year bilateral commitment. In order to receive construction funds, the host universities for these centers had to commit themselves to a minimum of a 20-year program of research on mental retardation and related aspects of human development, with the clear implication that the Federal Government would support that commitment throughout the 20-year period.

At the same time, and with great foresight, the Congress created the University Affiliated Facilities, UAF's, for the Developmentally Disabled, with primary missions in services and training. This historic linking of the knowledge-generating function with the knowledge-use functions of training and service through the UAF's has paid off in truly remarkable fashion.

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We are now approximately at or just beyond the midpoint of this historic bilateral commitment, with most of the 12 centers having been in operation now for at least 10 years.

Mental retardation directly affects over 50 million persons, or almost one in every four in the United States, including over 6 million retarded persons, their families, their extended families and close associates, and those who work with them. The average cost to the public purse is over $1 million over the lifetime of each retarded individual, and the cost in human suffering and lost human resources is incalculable. Because of research done in these centers, we are on the threshold of further advances.

The centers deserve and need your continuing support for research that is focused on prevention of the human and economic costs of mental retardation. The directors of the research centers and supporting professional associations that I represent ask you to help us to preserve this historic partnership between the Federal Government and these research institutions in order that we may continue for at least the remainder of our 20 years commitment to devise further ways to prevent the human suffering and economic loss associated with mental retardation.

RECOMMENDATIONS

And specifically we recommend the following four actions. First, to reaffirm the commitment of this committee and subsequently of the Congress to finish the course. That is, to support the work of the 12 national mental retardation research centers for the remaining years of the original 20-year commitment.

Second, to increase the funds available for the mental retardation research program of the National Institute of Child Health and Human Development to a total of $37 million for core support, which is to say center grants for 12 individual centers, and the remainder for research training grants and meritorious research projects and program projects both in the 12 centers and in other excellent institutions.

Third, to protect the funds so allocated by restoring the mental retardation research centers funds to special item status in the NIH budget, a status that was enjoyed until about 2 years ago.

And fourth, to recognize the mutually beneficial relationship of the research centers and the UAF's by continuing and extending support for the maternal and child health research and training associations and support of the developmental disabilities assistance program. Funds that you invest in this manner will be returned many times over through prevention of mental retardation and its associated long-range costs.

If in the next year our research prevented only 37 cases of retardation, that would have required long-term institutionalization, we would have paid back fully the funds that we are requesting today to support that research. I assure you we will do much better than that.

Thank you, Mr. Chairman.

PREPARED STATEMENT

Senator SCHWEIKER. Your prepared statement will be inserted in the record at this point.

[The statement follows:]

STATEMENT OF DR. CARL HAYWOOD

In many ways, these 12 centers stand as a prime example of the carrying out of a congressional mandate. Within a short time after the enactment of Public Law 88-164, the centers had been constructed and were at least minimally equipped, staffed, and in operation. Even before moving into the newly constructed facilities, scientists in these centers were producing new knowledge, challenging old concepts, training the next generation of workers in this field, and relating in mutually beneficial ways to clinical and service systems that have responsibility for many aspects of the lives of mentally retarded persons and their families. Universities proceeded boldly to recruit faculty scientists for work in these centers, and to commit themselves to tenured and tenure-track appointments for these investigators, often obligating the universities to employ these faculty scientists for as long as 30 or 40 years, on the strength of the actual or implied commitment of the federal government to support the centers on a continuing basis. Not relying completely on funding from the National Institute of Child Health and Human Development, the particular institute within the National Institutes of Health that was given primary responsibility for these centers, mental retardation scientists in the centers have competed vigorously and with a high degree of success for research funds from other sources, including state agencies, private foundations, other institutes within the National Institutes of Health, and other federal agencies. In the center that I direct reliance on NICHD for funding of our research has declined from approximately 85% of our annual research budget in 1971 to approximately 38% of our total research budget today. Scientists in these centers have made substantial contributions to our basic fund of knowledge about the nature and causes of mental retardation and some mechanisms by which it can be modified, and the knowledge that they have produced has already been translated in many cases into applicable programs of prevention, treatment, education, community integration, and long-term habilitation of mentally retarded persons. The quality of the contributions of these scientists has been recognized throughout the world in a variety of ways, including publication of their papers in the most prestigious journals in their primary disciplines, replication of their work by other scientists in other places, citation of their work in the writings of scientists in many fields, and extension of their work by students, other basic scientists, and applied by investigators who seek to identify the practicial applications.

In spite of these successes, I must tell you that at this mid-point in their history the centers are being systematically starved of the support that they must have in order to finish the course. In many ways, we are in sight of our goals that were so clearly envisioned by the 88th Congress and that have been shared by every Congress since that time. We shall not reach those goals to any full extent unless very significant shifts are made in the patterns of funding that have become established over the last 5 years with respect to these centers.

Specifically, the directors of these 12 national mental retardation research centers, regarding the centers as a national trust, urge you to assure the continued support of the centers at least through the original 20-year period envisioned by the 88th Congress by increasing the funds available to the National Institute of Child Health and Human Development, especially the funds allocated to the core support of the centers (center grants), and then to protect those funds for the specific use of the mental retardation research centers by restoring the "special item" status of of those funds in the budget.

Until 2 years ago, the core support funds for the mental retardation research centers had special item status in the NIH budget, and could be clearly identified, giving members of Congress an opportunity to monitor the allocation of funds within NICHD to the mental retardation research centers program. Two years ago, that special item status was dropped, and it is now quite impossible to identify the funds that support these centers in the NICHD budget, since the "centers" item in the current budget request of that agency includes not only the mental retardation research centers but population centers and Major Research Programs as well. The current

NICHD/NIH budget request includes a very substantial increase in the item identified as support for "centers," but the budget for core support of mental retardation research centers has been cut significantly. Mental retardation center directors have been notified recently that, contrary to our expectation that center core support grant funds would be increased to a total of $6,700,000, that fund has been administratively reduced to $6,200,000, and all center core support grants are to be cut in the next year of their support to a level that is 12% below the current level. In most cases this will mean that the core support for the mental retardation research centers will be about 20% below the level that had been approved for next year by review committees and by the National Advisory Child Health and Human Development Council. Clearly, the increase in support for "centers" that is in the current NICHD budget request is not destined for the mental retardation research centers. The point here is that such reductions in the support available to mental retardation research centers cannot be detected by members of Congress from an examination of budget proposals since their special item status has been removed. Restoration of that special item status will make it possible once again for Congress to monitor directly the extent of support of these important centers.

In recent years my predecessors have told you about selected important achievements of the mental retardation research centers, giving you, on each occasion, some examples of important additions to the fund of knowledge about mental retardation. I will not repeat a recitation of the advances that you already know about, but will instead identify some of the most recent scientific advances made through work in these centers that have already begun to have benefits in the prevention or amelioration of mental retardation.

Generally, the scientific program of these centers is characterized as both biomedical and behavioral, reflecting characteristics of the problem of mental retardation. In fact, one of the great strengths of the centers program is that it is multitisciplinary in concept and in practice. Scientists in most of these centers have only to walk across the hall to encounter experts in different but highly related disciplines with whom they can share expertise and discuss common problems. It is this blending of the biomedical and behavioral sciences that constitutes the source of several unique and important advances.

In two of the centers important work is being done in the area called behavioral teratology, referring to the long-term effects of various chemical and biologic agents upon the development of behavioral and social processes. Scientists in one of these centers have discovered long-term effects on behavior from certain chemicals, including common additives, that are not necessarily reflected in identifiable physiological or structural changes in the laboratory animals being studied. Similarly, in the other center one of the scientists has discovered that alcohol ingested by females during pregnancy produces long-term behavioral effects on their offspring that are likewise not necessarily reflected in measurable structural changes in the animals. Such work has two major effects: (a) It contributes to a better general understanding of the nature of teratogenic mechanisms, i.e., those mechanisms by which the development and ultimate functioning of children may be affected by drugs, alcohol, environmental chemicals, and even ingredients of supermarket food products. (b) Such studies may contribute quite directly to developing children of the use of such drugs and other agents during pregnancy.

Sometimes the important developments in the research centers occur in the area of technology as well as theory. A researcher from one of the centers has developed a method for transcutaneous monitoring of oxygen and carbon dioxide, known as the "Clark electrode," that can be used in newborn nurseries. This device is placed directly on the skin, and does not require taking blood samples or other intrusive or invasive methods for determining levels of oxygen and carbon dioxide. Either very low or very high levels of oxygen can cause permanent brain damage and lead consequently to lifelong mental retardation. With this monitoring device, nurses and physicians in neonate nurseries can know immediately when there are changes in the blood levels of oxygen and carbon dioxide in infants, and can institute remedial procedures in time to prevent brain damage. Because relatively minor changes in glucose levels are often associated with metabolic disorders that lead to

permanent mental retardation, the same researcher is currently perfecting a transcutaneous glucose electrode that will operate on similar principles and allow instantaneous detection of changes in blood levels of glucose. Early detection allows treatment measures that can forestall the mental retardation.

A scientist in another of the 12 mental retardation research centers has studied the economic effects of neonatal screening for metabolic disorders that are related to mental retardation. Taking phenylketonuria (PKU) as an example, she has found that the screening test costs 33 cents per baby, which means that with an incidence in her state of 1 case in 15,000 live births it costs approximately $5,000 to identify one PKU baby. If unidentified and untreated, this condition leads in almost 100% of the cases to mental retardation that is so severe as to require institutionalization. Following identification, through neonatal screening, a baby with PKU is treated in a clinic associated with the mental retardation research center at a cost of approximately $4,000 per year. Treatment includes a carefully controlled diet and medical management and is almost always successful in preventing mental retardation. Such individuals have been known by now to grow up with no intellectual impairment, to hold jobs, marry, graduate from universities, become parents, and in general assume the broad responsibilities that society expects of its citizens. By contrast, an untreated infant with PKU will spend many years, perhaps 40 or 50, in a residential institution, usually at public expense. A current conservative estimate of the cost of institutionalization of severely and profoundly retarded individuals is between $20,000 and $40,000 per year. If one calculates the cost of lifetime institutionalization, the likely earnings of a nonretarded person who might have been retarded without screening and treatment, and the actual cost of screening and treatment, not even considering such dimensions as lost taxes, it becomes clear that screening and treatment for such disorders as phenylketonuria lead to a net economic saving of at least $1 million, and perhaps as much as $2 million for each individual identified.

Clearly, it is to our economic benefit to continue these programs of research, and to support them adequately. Work is constantly going forward in these 12 centers to identify the specific disorders that lead to mental retardation, and to develop effective and cost-efficient methods of screening, followed by effective methods of treatment through which the mental retardation related to such disorders can be prevented. These detection and treatment procedures are then put in practice in our allied program, the University Affiliated Developmental Disabilities Training Facilities (UAFs), where they are incorporated quickly into the training of new clinicians. The clinic mentioned above with regard to the treatment of PKU is an example of the economy of continued high levels of funding for both the mental retardation research centers and the university affiliated facilities.

Prevention is clearly the emphasis of choice for both humanitarian and economic reasons. In fact, prevention of mental retardation is a superb example of that rare circumstance in which humanitarian and economic goals lie in the same direction and require the same action. For that reason scientists in these 12 centers have focused their research sharply on questions whose answers can lead to preventing the human suffering and the personal and public economic disaster that accompany mental retardation. Prevention takes a variety of forms. In the sense of primary prevention, we need to know what genetic circumstances are likely to lead to the birth of a retarded child, and much progress has been made in the centers on that front. Second, in cases in which primary conditions that often lead to mental retardation cannot be prevented, it is sometimes possible, as in the case of PKU, to devise treatments that foster normal mental and social development even though the physiological predisposing condition has not been eliminated. Finally, some mild mental retardation is associated with economic poverty, social and cultural disadvantage, poor education, and related social conditions. We know, largely through work done in these 12 centers, that carefully devised and applied programs of early identification, early education, parent training, pediatric management, and follow through in the school years can greatly reduce the number of persons in such circumstances who are ever diagnosed as mentally retarded. Prevention on all these levels is being pursued vigorously in these 12 centers, together with basic research on the fundamental processes and mechanisms that will make possible further advances in prevention of mental retardation. If every case of mental retardation that is prevented

as a result of the work of these centers ultimately saves the economy between $1 million and $2 million, the past and future public investments in the centers will have been returned many times over. The accompanying saving in human suffering will be incalculable!

In spite of everything we can do to prevent mental retardation, a substantial number of individuals are born with retarding conditions, so it is important that we continue to develop, evaluate, and disseminate methods for ameliorating the behavioral and social effects of mental retardation, for making the learning processes of retarded individuals more efficient, for increasing their integration into society, and for decreasing their dependence on institutions and on other presons. That is the primary focus of behavioral, social, and educational research that takes place in these centers. Psychologists and special educators in the centers have made quite significant advances in methods for teaching retarded individuals, including even those who are severely retarded, the necessary skills to care for their daily requirements, such as bathing, dressing, finding directions, eating without assistance, and in many instances, preparing food and caring for clothing. More capable retarded persons have been taught successfully to use public transportation, to work in sheltered workshops (and even in regular jobs), and to live relatively independently, caring for their own needs. Many of these training methods were direct results of basic research in behavioral psychology that started years ago in the animal laboratory as experiments on the learning mechanisms of pigeons. Several of the 12 mental retardation research centers are especially active in this kind of behavioral research. Through such research emphases, as well as our close alliances with university affiliated facilities, we are daily gaining in the ability to translate this fundamental behavioral technology into training methods that can be used successfully by a wide variety of persons, including parents and other family members. Widespread use of these training methods has already reduced substantially some of the costs of caring for retarded persons because they are able to do more for themselves and they require less constant attention.

Research on the early education of both mentally retarded children and children who are at high risk of becoming retarded because of economic and cultural deprivation is taking place in several of the 12 mental retardation research centers. An investigator in one of the centers has found a surprising long-term effect of early education. One group of children got two summers of preschool education when they were 4 and 5 years of age, with visits by teachers to their families during the winters, while a comparison group did not receive such treatment. Years later, during adolescence, some of the girls in both groups became pregnant and left school. There was no significant difference between the groups in the number who became pregnant, but there was a startling difference between these groups in the number who returned to school and completed their high school education following an adolescent pregnancy. The strong motive to return to school and complete that part of their education was about 8 to 1 in favor of the early education group. Thus, the primary effect that lasted over a period of almost 15 years after the end of the early educational treatment was a motivational effect, sending young mothers back to school to get additional education, which might have the long-term effect of interrupting the intergenerational cycle of poverty leading to socio-cultural retardation leading to further poverty.

In spite of the achievements so far of research in many dimensions of mental retardation, much remains to be done. We are confronted today with a variety of socio-political movements that have to do generally with securing the human rights of all individuals, including those who are mentally retarded. Such movements take the form of deinstitutionalization, mainstreaming, and otherwise attempting to change drastically the customary environments in which mentally retarded persons grow up, live, work, and spend their lives. As happens so frequently in our society, we are rushing into new ways of doing things without doing the necessary research to determine the characteristics and effects of such new ways. We have concluded that large, public, understaffed and overcrowded institutions are not good for the development of mentally retarded persons, and so we have started to place such individuals in alternative settings. It could be that retarded persons are going out of institutions and into environments that are no better for them. Further, there is no assurance that we are getting the most benefit out of the various arrangements that we are trying out. Anthropologists, sociologists, social

psychologists, educators, pediatricians, and others who are concerned with the development of retarded individuals must have the resources to do the necessary research to determine how to match individual needs and characteristics with particular settings in order to get the most benefits for every individual.

Similarly, much remains to be done in the biomedical sciences. We are annually discovering new applications of fundamental techniques developed in this field 20 years ago, such as prenatal diagnosis through amniocentesis and karyotyping, with new capability of diagnosing a wide variety of potentially retarding disorders. Such advances must be followed up with appropriate treatment methods in order to forestall the consequent mental retardation. Research on characteristics of cell membrane functioning and malfunctioning promises to shed new light on a wide range of behavioral developmental phenomena. Similarly, basic research on neuronal growth has reached a critical stage at which the promise of new understanding is great and the need for uninterrupted research is compelling. New research on brain enzymes, acting at the vital synaptic junction of neural cells, promises to provide an extremely important key to both the understanding of brain functions and the possibility of enhancing brain functions through biochemical intervention.

In the last 10 to 15 years we have opened the door to these and other important advances in the understanding of mental retardation and improvement of the lot of mentally retarded persons. If we are to step across the threshhold and capitalize on these advances in knowledge and the ones that must surely follow them, it is essential that support for the 12 national mental retardation research centers continue at a level that will at least keep pace with inflation and not actually go backwards in terms of the purchasing power of these centers.

This committee has expressed repeatedly its strong support of the mental retardation program, its appreciation of the considerable progress made in this program, and its wish that increases in funds recommended by this committee for the National Institute of Child Health and Human Development be used in part to extend the work of the mental retardation research program, through the 12 mental retardation research centers. With great sadness, I must tell the members of the committee that in recent years its instructions and wishes have not been carried out. The two principal mechanisms for the funding of the mental retardation research centers, center (core support) grants and program project grants, have been shrinking as a policy of NICHD. In the present year, NICHD's director informed the mental retardation research center directors that he had been able to come up with an increase in the total amount of money allocated for center core support grants, raising that fund for the first time to around $7 million for the 12 centers, including both direct and indirect costs. Four months after that statement, all the center directors have now been notified that, rather than getting increases, all of the center core support grants for the next grant year are to be cut to a level that is 12% below the funding level in the current grant year, which for many centers will mean, as I pointed out before, a 20% cut below the core support levels that were approved and recommended by the National Advisory Child Health and Human Development Council. We have been told that these cuts are necessary in order to take money from this source and use that money to fund more research project grants and program project grants. Since core support is the very essence of a research center, making the difference between programmatic interdisciplinary research in a center and isolated project research by unrelated individual investigators, such redistribution strikes at the very heart of the research centers concept. This is particularly unfortunate in view of the distinguished record of achievement of these research centers, often in areas where achievement might not have come as quickly, or indeed at all, without the special character of research centers with their multidiscipline staffing, their common-use facilities, their easy information exchange among investigators, and their mission orientation. In spite of some anticipated growth in the centers, core support for the 12 mental retardation research centers is significantly less, in terms of constant dollars, than it was in 1972. Table 1 below shows the trend of annual funds for core support of the mental retardation research centers from FY 1972 to FY 1979, both in absolute dollars and in constant dollars.

While we are being told that center grants must be cut in order to provide funds for project grants and for program project grants, it is also clear that funds for those research grants are severely limited. Table 2 below shows the

actual and constant dollars committed to the 12 mental retardation research centers in the form of program project grants since 1972.

More will be required than simply expressing the wish of this committee that funds provided for NICHD be used to supplement the funding of the mental retardation research centers program. The most urgent request of the mental retardation research centers directors and administrators is that the funds allocated for the support of the mental retardation research centers be restored to special item status in the budget, thus giving this committee and other concerned members of Congress the ability to determine whether funds allocated for that purpose are actually going to the support of the centers.

More specifically, we are requesting that the sum of $8 million be designated in the FY 1981 budget for core support grants to these centers, and that the total sum of $37 million for FY 1981 be designated within the budget of NICHD for support of the mental retardation program, including center core support grants ($8 million), institutional research training grants, and research programs of excellent merit both in the centers and in other outstanding facilities.

Ten of the 12 mental retardation research centers are directly linked to university affiliated clinical training facilities (UAFs) that were created under the same legislation that created the mental retardation research centers, and the other two are engaged in similar activities of clinical services and training of personnel for such services. That alliance is extremely important both to the research programs of the centers and to the quality of training and service to mentally retarded and other developmentally disabled persons. Indeed, it is this collaborative relationship between research and training, both of which are closely related to the delivery of excellent services, that has strengthened both the research program and the training programs. The mental retardation research center directors wish to encourage this continuing relationship by urging increased and correlated support for the Maternal and Child Health research and training appropriations and support of the Developmental Disabilities Assistance Program. If either component of this productive partnership is unable to survive because of lack of adequate funds, the other partner, either a mental retardation research center or a university affiliated facility, in the manner of a biological symbiosis will find its own health seriously imperiled.

The great humanitarian vision of the 88th Congress, expressed in the creation of the 12 mental retardation research centers and the university affiliated facilities, has been partially achieved. Great progress has been made, and even greater progress is in sight. The centers are facing a mid-life crisis in which our ability to bring about long-range and very substantial savings in human suffering and in public funds depends upon continued and sharply focused support that only you can provide. The choice is yours. In the words of a current television commercial, "You can pay now, or you can pay later" . . . and later, and later. And later costs more.

Table 1

NICHD Support of MRRC Core Grants by Fiscal Year, 1972-1979 (In Thousands)

	1972	1973	1974	1975	1976	1977	1978	1979
Absolute $	5,856	6,533	5,761	5,672	5,608	6,116	6,455	6,759
Constant (1972) $	Base*	5,994	4,841	4,363	3,977	3,971	3,842	3,693
Average Award, Absolute $	488.0	544.4	480.08	472.7	467.3	509.7	537.9	563.2
Average Award, 1972 $	-	499.5	403.4	363.6	331.4	330.9	320.2	307.8

*Constant dollars, calculated at a standard rate of 9% inflation.

Table 2

NICHD Support of Program Projects in MRRCs by Fiscal Year, 1972-1979 (In Thousands)

	1972	1973	1974	1975	1976	1977	1978	1979
Number of Awards	10	11	13	15	17	19	20	21
Absolute $	3,088	3,581	4,068	4,595	6,253	6,974	7,892	9,240
Constant (1972) $	Base*	3,285	3,418	3,535	4,435	4,529	4,698	5,049
Average Award, Absolute $	308.8	325.5	312.9	306.5	367.8	367.0	394.6	440.0
Average Award, 1972 $	-	298.6	262.9	235.7	260.9	238.4	234.9	240.4

*Constant dollars, calculated at a standard rate of 9% inflation.

SUMMARY AND RECOMMENDATIONS

Testimony to the Senate Labor-HEW Subcommittee on Appropriations (Warren G. Magnuson, Chairman) on behalf of the Twelve National Mental Retardation Research Centers. Presented by H. Carl Haywood, PhD, Director, John F. Kennedy Center for Research on Education and Human Development, George Peabody College for Teachers, Vanderbilt University; Chairman, Mental Retardation Research Center Directors and Administrators; President Elect, American Association on Mental Deficiency.

At approximately the half-way point in the 20-year program of research envisioned by the 88th Congress for the 12 national Mental Retardation Research Centers, the centers have made encouraging and occasionally spectacular advances in understanding of the mechanisms that underlie mental retardation and its behavioral deficits. In spite of these advances, and the compelling need to carry forward their research begun in the first half of the program of this national trust, support for the 12 centers through the NICHD budget has been declining significantly. That decline has been difficult to detect because of removal of the funds for these centers from"special item" status in the NIH budget.

The directors and administrators of the 12 national mental retardation research centers, with the support of the American Association on Mental Deficiency, the Division on Mental Retardation of the American Psychological Association, and the American Academy on Mental Retardation, recommend four actions to this committee:

1. Express the commitment of this committee, and subsequently of the Congress, to "finish the course"; i.e., support the work of the 12 national mental retardation research centers for the remaining years of the original 20-year commitment.

2. Increase the funds available for the mental retardation research program of the National Institute of Child Health and Human Development to a total of $37 million, including $8 million for core support (center) grants for the 12 individual centers, and the remainder for research training grants and meritorious research projects and program projects both in the 12 centers and in other excellent institutions.

3. Protect the funds so allocated by restoring the mental retardation research centers funds to "special item" status in the NIH budget.

4. Recognize the mutually beneficial relationship of the Mental Retardation Research Centers and the University Affiliated Facilities (UAFs) for the developmentally disabled by continuing and extending support for the Maternal and Child Health research and training appropriations and support of the Developmental Disabilities Assistance Program.

HUMAN DEVELOPMENT SERVICES

Senator SCHWEIKER. Thank you. Who's next?

Ms. MAGRAB. I'm next. The UAF's really expand the role of the application of research and translate it as quickly as possible into practice to benefit the quality and efficiency of service to handicapped individuals. There are several ways we bridge that gap. Through services and through promoting coordination of services and through training.

I have been before the committee many times. One of the things that seems to be the least understood about our program is that there is a very strong service component to it. We get viewed as primarily a training activity. Yet it's provided service to about 50,000 clients. In a way,

that is deceiving because these 50,000 clients are the most difficult to serve individuals, individuals who require very complicated degrees of service and they are individuals who could not obtain service in the normal mainstream of delivery.

It's really on behalf of these clients that we are speaking to you today. We have long recognized that every facet of life of these individuals is effected. This has compelled UAF's throughout, to work with other agencies. We have experience with other coordinating services such as working with Head Start in the handicapped effort, coordinating that handicapped effort with title 5 programs, and with various other programs that provide services.

My experience is that with that kind of coordination what we have achieved in the end is real economy. We have created lack of duplication and filled in gaps where needed. Our training—it's not only training professionals. In the last year we touched upon some 77,000 service providers in this service training in the process of upgrading their skills; which is, I think, another significant kind of contribution to services.

We realize these are difficult economic times. We would like to join with you in protecting the rights of these individuals, protecting their interests, yet still taking steps to combat inflation, an integral part of this.

We are recommending appropriations that are modest increases. We are recommending $36.9 million for CH 511 and 512 and $9 million in the disability act for UAF's. These recommended modest increases will allow us to continue to provide services to those 50,000 individuals who otherwise would not be served; and to continue to decrease the dependency of these individuals and others like them, thus reducing the costs to society.

Lastly, we want to work with the service delivery agencies to deliver more efficient services. In this spirit we would encourage you not only to consider this increase in appropriations, but that you be specific in your report language and that you concentrate on the role of UAF's in improving the efficiency of the delivery of services to handicapped individuals. We believe these people are entitled to this even though they are not covered by the basic entitlement kinds of programs.

MAINSTREAMING PROBLEMS

Senator SCHWEIKER. How much of the mainstreaming problem do you folks get into?

Ms. MAGRAB. Quite a bit. We have worked very closely with Public Law 94–142. In fact, we have been working with the Department of Education to take the most difficult children and try to put them in the least restrictive environment. I think we have been pretty successful in that regard.

Head Start is essentially a mainstreaming program.

Mr. TODD. Twenty-four percent of the school age children we see are referred by schools.

Senator SCHWEIKER. Who is next?

Mr. TODD. Dr. Emanuel and Dr. Stempfel and the rest of us would take questions.

PREPARED STATEMENT

Senator SCHWEIKER. Your prepared statement will be inserted in the record at this point.

[The statement follows:]

STATEMENT OF DR. PHYLLIS R. MAGRAB

Mr. Chairman, members of the Subcommittee, I am Phyllis R. Magrab. I am Director of the Georgetown University Child Development Center and a past president of the American Association of University Affiliated Programs for the Developmentally Disabled.

With me are Drs. Irvin Emanuel and Robert Stempfel, Directors of the Child Development and Mental Retardation Center of the University of Washington and the Mailman Center for Child Development of the University of Miami, respectively.

I am honored and pleased to speak today on behalf of the 47 University Affiliated Facilities (UAFs) across the nation. These interdisciplinary training and clinical centers are located in 33 states and actually serve more than that number of states, since many UAFs are regional centers. Together, they represent this nation's investment in the provision of quality care and programs to a most difficult population to serve -- the mentally retarded and otherwise developmentally disabled.

Some 17 years ago, the President of the United States reported to the Congress on the urgent need "to develop facilities which will increase the role of highly qualified universities in the improvement and provision of services and the training of specialized personnel" in order to combat the national problem of mental retardation. The proposed clinical and teaching facilities would bridge the gulf between academia's traditional ivory tower and the actual, and usually woefully inadequate, residential and care systems provided the mentally retarded. A system supposedly designed to aid an extremely vulnerable and difficult to serve population would be tied in directly to the nation's higher education system, so that in fact the system could begin to demonstrate sensitivity to the needs of the retarded. "Superior care for the retarded" would be the hallmark of these University Affiliated Facilities, and they would "augment teaching and training facilities for specialists ... including physicians, nurses, psychologists, social workers, and speech and other therapists."

That Presidential message provided the foundation for subsequent legislation (Public Law 88-164) which led to the present UAF program. The initial program authorization was for construction of facilities. Amendments

to P.L. 88-164 since that time have continued the UAF authorization, since 1970 as authority to support core administrative costs of programs operated within constructed UAFs and to support interdisciplinary programs in developmental disabilities at other colleges and universities.

The present UAF authorization is found in P.L. 95-602, the Rehabilitation Services and Developmental Disabilities Act Amendments of 1978. In fiscal 1980, 36 UAFs will receive a total of $7 million in administrative support from the Developmental Disabilities program[1] less some part of that figure which support a number of UAF "satellite" programs.

Twenty-one UAFs will receive support totaling $20.2 million in Maternal and Child Health[2] training funds during this fiscal year. This support recognizes the critical need for trained manpower to serve mentally retarded children and those with multiple handicaps and unusually complex health related problems.

But the UAF program is not just another health manpower program. Rather, the program provides interdisciplinary training to graduate level and undergraduate students who are working towards a degree in one of the professions or disciplines. Also, and of importance, practitioners who have long since left their primary training behind them are taught the special techniques and skills needed to serve the multiply handicapped and seriously disabled through inservice training programs.

Moreover, UAFs are clinical programs and provide considerable direct services as they carry out their training mission. Many of these services are delivered in community settings, away from the academic environment. The training experience in a UAF is strongly identified with actual practice, and results in significantly large numbers of clients actually being served. Those clients seen are usually the most complex, difficult to serve cases.

In 1979, over 77,000 professionals were trained by UAFs, and over 50,000 clients were served.

While these members are important and impressive, they do not adequately describe the full contribution of the program.

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1 HEW, Human Development Services, Developmental Disabilities University Affiliated Facilities grants.

2 HEW Health Services Administration, Bureau of Community Health Services, Maternal and Child Health research and training funds.

UAFs are a vital resource in the following areas of need:

PREVENTION

Prevention of developmental disabilities makes eminently good sense, both in human and monetary terms. Through an expanding network of genetics screening and counseling programs, and training programs which stress the basic principles of genetic counseling, the UAF network is increasingly responding to the goal of preventing mental retardation and other developmental disabilities.

UAFs focus on several aspects of effective prevention programs, including genetics screening, consultation, education, and basic and applied research.

UAFs carry out or provide support to phenylketonuria clinics which test for this preventable cause of mental retardation, and frequently monitor the progress of PKU clients. UAFs serve as newborn screening centers, provide amniocentesis, and provide training to students in public schools regarding medical genetics and handicapping conditions. They also provide genetics training to hospital staffs and personnel in newborn nurseries.

One program participates with the Navajo nation in prevention activities aimed at reducing the high incidence of handicapping conditions among Navajos.

All UAFs stress the need to train personnel in the early intervention and prevention of developmental disabilities. This focus is reflected in the actual services provided by UAFs, which include significant efforts to detect developmental problems in children as early as possible and at a stage when intervention will result in the prevention of further problems.

The American Association of University Affiliated Programs is working to strengthen UAF prevention efforts and to better coordinate those efforts among the 47 centers and federal agencies. Prevention has been given a top priority as a function of the program by the AAUAP Board of Directors.

RESEARCH

UAF research efforts have a strong prevention focus, but are also heavily invested in efforts to improve actual service delivery techniques. Research activities in UAFs are increasingly focusing on problems which emerge from the clinical treatment experience which they provide their clients and trainees.

UAFs work closely with the twelve mental retardation research centers supported by the National Institute of Child Health and Human Development. Ten of the 12 research centers are co-located with UAFs. This physical and

administrative contiguity has been highly instrumental and productive in providing good research background for UAF training, while the clinical experience of the program has stimulated and focused research activities on problem areas of interest to clinicians.

INSTITUTIONAL REFORM AND THE PROVISIONS OF ALTERNATIVES TO INSTITUTIONALIZATION

For those persons who are likely to remain in institutions, and for those whose seriously disabling conditions will not be prevented in future years and who may require institutionalization, there is a need to provide the best habilitation programs we can provide. For every person, there is in theory a less restrictive, more appropriate program setting. In practice, institutions will probably be around for a time. We need to make them humane and we should continue to upgrade the quality of instituional programs provided.

UAFs are a fundamental resource in this context. Personnel working in state institutions for the developmentally disabled are notoriously underpaid, undertrained and overlooked. Like the traditional institutions themselves, these personnel--who are key to effective, humane programs of habilitation--usually receive little incentive to remain in institutional employment, or even to consider such in the first place. UAFs have begun the process of changing this situation, even with the uneven availability of programs throughout the country. Institutions are finding it possible to recruit committed, dedicated and competent professionals from the ranks of the numerous disciplines which are needed to staff such facilities. In almost every instance, those staff persons received their training (and their interest in serving the developmentally disabled) in University Affiliated Facilities.

UAF trainees bring to their work a commitment to the dignity of each disabled person, a recognition of the developmental potential of every person, regardless of severity of disability, a belief in the principle of normalization, and a deep interest in the field of developmental disabilities. Moreover, and of great import in this field, they recognize that no one discipline has the skills and talent needed to address the complex problems faced by developmentally disabled persons. The interdisciplinary approach is fundamental to the program's mission and to any good program serving the developmentally disabled.

In addition to providing the personnel needed to achieve true institutional

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reform, UAFs are a major force behind the concept of deinstitutionalization. Personnel working in developmental disabilities who have trained in UAF programs are the leaders in efforts to establish alternatives to institutions, to move residents of large, expensive and dehumanizing institutions into more "normal" community programs, where residents can acquire daily living skills needed for independent living. The underlying philosophy is that every individual has potential for greater independence. Many developmentally disabled persons can become self-supporting, at least in part, and need not continue indefinitely to live as dependents of state-supported systems of custodial care.

UAFs are significantly involved in community activities in the developmental disabilities field. Direct services are provided in community settings, trainees receive clinical placements in those settings and many such community-based programs are UAF sponsored and established. "Exemplary" services are demonstrated in these settings, and those in training are encouraged to replicate the exemplary service techniques in underserved and unserved areas, once they return to or enter the service system as full-time practitioners.

EFFECTIVE IMPLEMENTATION OF VARIOUS FEDERAL PROGRAMS WITH MANDATES TO SERVE HANDICAPPED

Many federal programs are directed at large, categorical populations, and are expected to serve the severely, multiply handicapped population within those categories. The list of such programs includes Maternal and Child Health, Social Services (Title XX), Medicaid, Head Start, and others. A number of other federal programs are specifically aimed at helping the disabled, e.g., EPSDT, Crippled Childrens Services, Education of Handicapped Children, Developmental Disabilities, etc. Others, such as the Genetic Diseases Program, are directed at prevention.

The provision of services to multiply handicapped persons whose disabilities are far ranging, chronic and frequently not susceptible to "cure" in the medical sense is an intensely demanding activity. Few professionals will opt for a career with so many demands and so few rewards. Large formula grant programs such as Maternal and Child Health, with a broad mandate to extend and improve services for promoting the health of mothers and children, have an especially crucial role to play. Their success depends on the availability of trained professionals who are interested in and able to serve the severely disabled.

Simply increasing formula grant funds year after year does little to ensure that services are reaching the most seriously disabled.

Prevention directed programs, such as the Genetic Diseases Program, rely upon the UAF network directly as a resource for implementation. Over half the centers used in support of this program are UAF-based.

UAFs have an important role in the implementation of P.L. 94-142, the Education of All Handicapped Children Act. The centers work with local and state education agencies and school systems in designing education programs for the most severely handicapped youngsters. Children are evaluated by UAFs and individual education plans are prepared, and services are provided those children by the UAF in accord with the plan. In brief, the UAF program has been fundamental to efforts thus far to implement this landmark legislation.

STATES' SERVICE DELIVERY SYSTEMS

In many states, the federal funds administered by UAFs are a critical foundation for the statewide network of services for the developmentally disabled population. Should these funds decrease or be removed, it is quite likely that state service funds would diminish.

SUMMARY AND CONCLUSIONS

UAFs provide interdisciplinary training for physicians and other health professions in implementing maternal and child health services, and disseminate new techniques for evaluation, diagnosis and treatment of individuals with mental retardation and other developmental disabilities. In essence, the UAFs seek--through the training of leaders and professionals, and by example--to insure that physicians and all health-related professionals have adequate knowledge of mental retardation to prevent this disability wherever possible and to minimize its consequences where unpreventable. Through UAF training activities at existing universities and medical schools, the need for costly separate specialized services for the mentally retarded is minimized. The UAFs also provide state and regional networks for prevention and service.

UAFs provided special support to all major federal programs serving the handicapped, including but not limited to state Title V agencies. For example: one UAF trained the directors of Title V programs in two states; UAFs provide extensive support nationally and locally to the Head Start program; ICFMR

inspectors under Title XIX are UAF trained; over 50 percent of the genetic resource centers used in support of the Genetics Disease Act are UAF-based.

It has been estimated that only 18 percent of the mentally retarded children receiving MCH and other federally supported services receive services from personnel who are adequately trained. It has also been caluclated that for every case of severe retardation that is prevented, the total gain to society is almost $990,000. The GAO report on prevention of mental retardation documented the need for state and regional networks for preventive services in relation to metabolic disorders, insufficient prenatal care, chromosome abnormalities, rubella, measles, lead poisoning, RH hemolytic diseases, and adverse early childhood experiences.

RECOMMENDATIONS

We recommend funding levels of $36.9 million for MCH research and training and $9 million for Developmental Disabilities - UAF grants for fiscal year 1981.

These small increases in funding for UAFs are necessary to permit the program to continue serving the large number of seriously handicapped children now served. Any decrease in funding will undoubtedly require a reduction in the provision of services to this most difficult to serve, and now frequently unserved, population.

These increases are needed to address the following issues as well:

- to strengthen the ties with related programs, including the mental retardation research centers, to encourage the translation of research findings into practice as quickly as possible.
- to provide greater coordination or services provided the seriously handicapped by the various systems in the states and the number of federal programs which require skilled professionals for effective implementation.

Finally, we recommend that a total of $37 million be provided for mental retardation research and research training, to include $8 million to be designated for "core" grants for the existing 12 MR Research Centers.

REPRODUCTION RESEARCH

Mr. BRINKLEY. I'm Howard J. Brinkley, Department of Sociology, University of Maryland. I'm a reproductive endocrinologist by training. I'm appearing before you today as the Washington representative for the Society of Reproduction, an organization of approximately 1,500 reproductive biologists. The membership of our society is comprised pre-

dominantly of research institute scientists who conduct fundamental and applied research, and train young people and clinical researchers in biology.

Our comments regard the funding support for the Center of Population Research which falls under title 10, housed under the NIHCSD, in fiscal year 1981. This approach was chosen in recognition that the administration has stated its intention to submit a recommended 1981 budget. In fact, there have been rumors that some reductions in fiscal year 1980 expenditures may be forthcoming. I understand these are no longer rumors.

These statements do not give comfort to any enterprise dependent on Federal support for its continuing operations and is even more disconcerting to scientists conducting research.

COMMENTS AT ANNUAL MEETING

At the annual meeting of our society in August 1977, a doctor, from Harvard University and director of a Ford Foundation sponsored project to assess the status of reproduction, who serves through 1977, addressed our membership. In his presentation he established that the bulk of financial support for reproductive scientists is now derived from governmental sources. That share increased from 44 to 69 percent as early as 1977. Concomitantly the share coming from private funds declined from 22 to 14 percent while the proportion contributed by the pharmaceutical industry was cut more than half from 34 to 16 percent.

These figures have now been updated. Both the Ford and Rockefeller Foundations have announced their intention this year to reduce support for reproduction research because of their own physical limitations and change in management. Consequently flucuations in governmental appropriations send violent reverberations throughout the reproductive biology research establishment.

With such a boom and bust cycle of funding as has existed, it can be seen in the annual flucuations and percentage of approved grants funded by the Center for Population Research which is approximately one-half of the total of the NIACHD.

The percentage of approved grants funded has varied from a high of about 57.6 percent in 1972 to a low of about 25 percent in 1977. That represents approximately 500 approved grant applications. Obviously it is impossible for researchers to establish and maintain a consistent attack on research problems in the face of such instability.

DECLINE OF FUNDING

In concluding remarks at our annual meeting, Dr. Greek described the continuing decline of funding for reproduction research and the need to achieve a gradual increase support for several years until an appropriate level of stable support was established.

Thus in 1977 the future of our science appeared very bleak. In January 1978 the administration submitted a budget for fiscal year 1979 which included an increase of $32 million for the National Institute of Child Health and Human Development. Of this $32 million, $16.8 mil-

lion was to be allocated to the Center for Population Research, a subunit of NICHD that operates under title 10. Since almost all the research and reproduction conducted by members of our society is supported by grants from the Center we heralded this abrupt change in the funding of reproduction research as a significant reversal of a downward trend.

Unfortunately approval of the authorizing legislation for title 10 was not attained until very late in the 95th Congress and the $16.8 million increase in funds for reproduction research could not be included in the fiscal year 1979 Labor and HEW.

We operated under continuing resolution at the 1978 level to late in 1979 when this committee and House committee approved an appropriation. With the supplemental funding only 23.1 percent of the approved new research grant applications and only 13.1 percent of the approved renewal grant applications were funded. The worst funding record in the decade.

I want to point out—you were mentioning training grant discussions you have had with the Federal agencies and getting young people into the field. That 23.1 percent, of that, one-half of the grants were from new applicants with new Ph. D.'s and several years of postdoctoral work applying for the first time. That means something like 11½ to 12 percent at best of the new people coming into the field were funded.

You can well imagine the reproduction research situation in the United States if the Congress had not approved the supplemental appropriation. We are indebted to the Appropriations Committee for their leadership in preventing a national disaster in an important research area. The fiscal year 1980 budget included a small increase of funding for the Center for Population, but based on past years' experiences we estimate that this fiscal year's grant funding rate would not be improved over the last year's rate.

I can go into detail if you would like. Funding for reproduction research has not reached the significant level, wherein 50 percent of the approved research grants could be funded, but instead has continued to decline.

As a consequence of these events, statements and rumors to the effect that the fiscal year 1980 budget will be reduced and fiscal year 1981 budget will be amended downward are considered by us to be a serious reason for alarm. There are many areas in reproduction that require continued support if we are to serve the national health needs.

REPRODUCTION-RELATED HEALTH PROBLEMS

Many forms of contraceptives have been adopted but many of undesirable side effects or are not acceptable to large segments of the population. We need to develop more acceptable and effective contraceptive methods with fewer side effects. The existing methods have led to control of the birth rate in some segments of the population and can lead to significant advances in the quality of life of future generations of Americans.

The causes of infertility are numerous. Some of the causes can be overcome by application of existing fundamental knowledge. However, even those in use need to be perfected. The rate of pregnancy in the teenage population has become alarming. Teenage pregnancies contribute to a severe reduction in the quality of life of the teenage mothers and fathers, as well as their children. The teenage birth rate number of one year, 600,000 teenagers, are estimated to cost something on the order of $8 million over the next 20 years of those family and children's development. This is from a report from the Stanford Research Institute published last April 1979.

These are only a few of the reproduction-related health problems confronting the Nation which exemplify the need for continued significant funding of reproduction research.

In conclusion we urge you to approve the fiscal year 1981 budget for the Center for Population Research as proposed by the President in the January 1980 message. Funding at that level may at least arrest the downward trend of support for reproduction research and afford an opportunity for significant reversal of the trend in fiscal year 1982.

I might point out, too, it might be the beginning of stability and gradual return to proper support. I appreciate the opportunity to appear before the commitee.

Thank you.

PEDIATRIC RESEARCH AND ENDOCRINE SOCIETIES

Senator SCHWEIKER. All right. The last witness.

Mr. MURPHY. I am James Murphy, Mr. Chairman. I represent the Endocrine Society, with an interest in both the Arthritis Institute and Child Health Institute, and represent a group of Pediatric Research Society.

It's the end of the day. I am the last witness. I will not read my lengthy statement, which I intend to submit for the record on behalf of the Endocrine and Pediatric Research Societies.

[CLERK'S NOTE.—No statements were submitted.]

Mr. MURPHY. I would like to make a few comments and do my best to avoid the risk of speaking longer, by summarizing or actually reading, as sometimes happens.

About the prospect we face of an unknown budget. Having addressed a budget as delivered by the President in January, and now being faced with a new budget that will be coming out sometime presumably this week and to the extent that it impacts on NIH, I think it's most unfortunate; because as many witnesses have told the committee before, research just can't be conducted in fits and starts.

You can't put people together and get them going, tell them that this year it's going to be fine, we are all going to get together and do this project. And the next year, everything's dried up.

That is a phenomenon that has affected the Child Health Institute perhaps more than most. Looking back to 1979, the Child Health Institute was able to fund in that year 40 percent of the approved grants. That is at a time when NIH generally was funding 47 percent of their approved grants.

Of course, once you hit that level, then your funds get committed for the next couple of years to pay the grants that you have funded in the first year. As a consequence, in 1980, when the funding was not kept up proportionately, the Child Health Institute was able to fund only 23 percent this current year. It's going to be about the same next year.

This at a time when the rest of NIH is funding 37 percent the current year, and 33 percent in the President's original budget for the coming year, of their approved grants.

So this Institute starts at a disadvantage. We certainly hope that if there is going to be a session of cutting that the disadvantage that exists already will be recognized, that the low base that exists be recognized.

As a matter of fact, the budget for the current fiscal year, the original budget, is able to fund as many grants as I projected only by transferring $7½ million away from training, and $7½ million away from the grants and contracts used to develop and evaluate new contraceptives.

It's understandable in a year when there is inflation and it's felt necessary to cut the budget, that this would be one of the areas addressed, but I think it's very shortsighted. It may be possible to cut a few million or even hundreds of millions of dollars out of the NIH budget for one year, but what is the long-term effect of that?

Dr. Brinkley has talked about the impact of the population center at the Child Health Institute. Pediatric research in that area is very poor, too. About a quarter million babies are born too soon or too small every year. There is a cost of about $8 billion in intensive hospital costs associated with that.

Even aside from the humane considerations, as was mentioned earlier, there is a great financial saving to be realized by improvements made, and in a host of other areas, as witnesses here have described.

It seems as if we are selling the future for the very short-term minor gain when we break up these research teams and deduct the support that they have a reason to expect might continue on some sort of a stable basis.

So we urge that when the new budget comes out, and while recognizing the great difficulties associated with trying to engage in a budget-cutting process, nevertheless, we think there are special claims that can be made for scientific research; we think there are special claims that can be made, especially for the Child Health Institute.

Thank you.

Senator SCHWEIKER. Thank you very much.

Let's just ask the UAF group a question here. With the creation of the new Department of Education, developmental disabilities is left at HHS and vocational rehabilitation is moved to the new department.

My question is: Will this have any personal effect or impact on your program?

Mr. TODD. Mr. Chairman, the UAF program has been funded by different HEW sources. An interdisciplinary program committed to working with various Federal agencies. So the—it's not really a fundamental change.

Senator SCHWEIKER. Well, I gather that there is no problem with coordination, then, you are saying?

Mr. TODD. We expect none. There should be none.

Ms. MAGRAB. No more than there already is.

Senator SCHWEIKER. Maybe I ought to ask that question. Want to answer that question?

Ms. MAGRAB. I have been with the UAF for 12 years. It's definitely gotten better.

Senator SCHWEIKER. Has it gotten much better?

Ms. MAGRAB. Its not a big sweep.

Senator SCHWEIKER. What were the initial problems to begin with?

Ms. MAGRAB. I think they were that we had funding from multiple sources. And there are a lot of benefits to that, because it allows you to think broadly; but each source has a different mandate.

Sometimes the sources that generate the least amount of funds to the program come forward with the most mandates. But the agencies started talking to each other and developing coordination.

Mr. TODD. Congress has been very helpful in bringing about coordination. The funding development under the act was renewed, there was language put in by the authorizing committees requiring coordination among——

Senator SCHWEIKER. That is what our committee tried to do. I wonder if it's working?

Mr. TODD. It is; it's helped a great deal.

Senator SCHWEIKER. It is working?

Mr. TODD. Yes.

Senator SCHWEIKER. She had me worried.

Mr. TODD. No; it's helping. And I think continued language in the appropriations as well as the authorizing would help. We need some help from Congress.

Senator SCHWEIKER. All right.

Thank you very much.

Prepared statements were submitted to the subcommittee. They will be inserted in the record at this point.

[The statements and information for the record related to programs and topics discussed during the Tuesday, March 11, 1980, hearing follow:]

STATEMENT OF RUTH YOUNG, ACTING VICE PRESIDENT, UNIVERSITY OF MARYLAND, ON BEHALF OF THE COUNCIL ON SOCIAL WORK EDUCATION

I am Ruth Young, Acting Vice President of the University of Maryland and Dean of the School of Social Work and Community Planning at the University of Maryland.

This statement is presented on behalf of the Council on Social Work Education, an organization which is composed of 83 graduate schools of social work and over 200 undergraduate programs for social work training located in leading colleges and universities across the country. Over 40,000 students are enrolled in these programs, along with 4,000 faculty members. In addition to educational institutions, there are 4,800 members of the Council on Social Work Education ("Council") comprised of voluntary and public national, state and local social welfare agencies and related organizations, faculty members, and individuals concerned with social work education.

We appreciate this opportunity to testify before the Labor-HEW Subcommittee on Appropriations, and would like to commend the Subcommittee for its consistent commitment to the provision of quality services to people and to the training of qualified personnel in the human services field.

1. Title XX Training

Title XX of the Social Security Act supports the education and training of professionals to administer and provide social services in state social service agencies and private non-profit organizations. The individuals trained may administer or provide child care services, mental retardation services, homemaker services, etc. The training is done on the job by states, or through grants to universities or student aid. About 370,000 personnel were trained in FY 1979 at an average cost of about $250 per person. Training is of state agency and private agency personnel, and the training is often clinical, field training as well as academic training.

The most critical issue this year and next in the social work education and social service manpower area is the Title XX training program. The conference on H.R. 3434, dealing with Title XX services and training and child welfare services, has met and agreed upon a conference report regarding Title XX training. That report would establish a ceiling for Title XX training in the Social Security Act at 4% of the state's social services budget or its FY 1979 expenditure level, whichever is

higher. That ceiling would apply in FY 1980. At present, the Social Security Act provides for a training program which is an open-ended entitlement but which states must match at 25%. However, the appropriations law for HEW for fiscal year 1980 limits Federal expenditures to $75 million for FY 1980. In fact, this limitation has become about $61 million because $14 million of FY 1979 late claims have been filed in FY 1980 and are being paid for in FY 1980 funds. HEW has therefore requested an FY 1980 supplemental of $14 million to allow the program level to reach the $75 million set forth in the appropriations bill.

The fiscal year 1979 level of Federal spending by the states for Title XX training was at least $90 million, however. Therefore, even with the requested supplemental of $14 million, the states would have to absorb a cut of $15 million below FY 1979. Without any supplemental appropriation, the cut would be $30 million below FY 1979.

We would urge the Subcommittee to include in the first supplemental for FY 1980 sufficient funds to finance the Title XX ceiling included in the conference report on H.R. 3434. That amount is estimated at about $98 million for FY 1980. Title XX as amended provides the states with an entitlement for social service funds at the levels established by the conference agreement. Without a supplemental appropriation to finance the entitlement and ceiling established in the conference agreement, 47 states will receive substantial reductions in FY 1980 below FY 1979. Even if there were a supplemental, but only that requested by the Administration to bring the program level to $75 million, these 47 states would still have cuts.

The reduction of the current program to about $61 million has had very serious effects. Many states have notified universities that contracts already entered into supporting teachers' salaries and student scholarships and stipends are being terminated.

The Council on Social Work Education surveyed its 361 schools and programs regarding the effects of the limit on Title XX training spending in FY 1980. About 60% of the schools and programs responded and indicated that a total of $10 million of cuts in existing grants and contracts had been made as of February; only 1/2 of the way into the fiscal year. $10 million represents 25% of the funds schools received in FY 1979. By year's end, these cuts will be much worse than

that because most states have been attempting to continue programs rather than cancel them in mid-year pending enactment of H.R. 3434. Our survey indicates that about 500 students have had scholarship aid cancelled and that 151 faculty have been dismissed.

Since the estimate of FY 1980 spending without the appropriations ceiling was about $103 million for FY 1980 (see Finance Committee Report), a 40% cut below what states had programmed for FY 1980 is likely by the end of FY 1980. Contracts and grants with universities including student aid represents one-half the Title XX program but it is the half which is bearing a disproportionate share of the reductions at the state level. Some states are eliminating the grants and contracts to universities entirely.

In FY 1981, the Administration is requesting a budget of $116 million for the Title XX training program based on the assumption that a ceiling on expenditures of 4% of the social services budget with a hold harmless provision based on FY 1979 expenditures is enacted in FY 1981.

The Conference agreement on Title XX training for FY 1981 provides for the same ceiling as in FY 1980: 4% of the state social services budget or the FY 1979 spending level by the state, whichever is higher. HEW's estimate of $116 million is probably close to but not enough to fund that provision. We urge the Subcommittee to support a budget estimate for FY 1981 sufficient to provide each state with its entitlement for training up to the new ceiling. That will probably cost about $120 million because the Administration did not assume a hold harmless at exactly the FY 1979 level.

We do not believe that the Subcommittee needs to establish this amount as a legal ceiling on the program because H.R. 3434 places such controls in the Title XX law itself.

2. Child Welfare Training

Section 426 of the Social Security Act authorizes HEW, through the Childrens Bureau, to make grants to graduate programs in universities to support the training of professionals for the child welfare field. The FY 1980 budget for this program is $7.575 million. The FY 1979 budget was $8.1 million. The FY 1981 budget proposed by the President is for only $7 million, a 12% cut below FY 1979. The program has supported

students through traineeships, has provided for faculty and program development through teaching grants to universities and began supporting 11 regional child welfare training centers in FY 1980. Over 1,000 students were trained in FY 1980 and 80 institutions received teaching grants. The FY 1981 budget would result in 125 fewer student trainees and 7 fewer institutions receiving aid.

The field of child welfare is badly in need of trained professionals to deal with the problems of abused, neglected, delinquent children and their families. Problems in the program areas of foster care and adoptions are well known and inadequately educated and trained staff have been found to be a major reason for these problems. HEW itself in its budget indicates that "There is growing recognition that child welfare services suffer from a lack of professionally trained workers and supervisors and that additional education is needed to accomplish the improvements towards which the Child Welfare Amendments currently under consideration by the Congress are directed" (see Page 87 of the "Budget Justification"). The amendments to the Social Security Act provisions for foster care, child welfare and adoptions agreed to by the conferees on H.R. 3434 significantly expand funding expectations in these fields. States will be required to establish programs to provide family services to prevent costly foster care placements and either maintain children in their natural homes or place them in appropriate adoptive settings. These major new initiatives to prevent inappropriate institutional care demand change in the public and private agencies which in turn requires education and training of their staff.

We support a budget restored to the FY 1979 level of $8.1 million. This would enable full restoration of traineeships and teaching grants to prior levels, and allow for some needed new traineeships.

3. Mental Health Training

This program supports clinical and research training through grants to universities. It has a $90 million level of funding for FY 1979, FY 1980 and in the President's FY 1981 budget.

The President's Commission on Mental Health made a number of major program recommendations with serious implications for professional training. First, the major problem which the Commission focused upon was the needs of people with chronic

mental illness. The Commission recommended that "We must take steps to: Establish a national priority to meet the needs of people with chronic mental illness". In addition, the Commission recommended that there be coordination of "mental health services . . . with general health and other human services and with those personal and social support systems that strengthen our neighborhoods and communities". Finally, the Commission recommended that the Nation takes steps to "Assure that appropriately trained mental health personnel will be available where they are needed".

The Congress is now in the process of acting upon legislation recommended by the Administration to carry out the Commission's recommendations. This legislation puts major emphasis on new community programs to treat the chronically mentally ill. These programs are essentially social service programs aimed at managing service to those with chronic mental illness to enable them to live in community settings. This kind of approach requires greater emphasis on social workers.

The training programs of NIMH have already been redirected to respond to the national priorities delineated by the President's Commission on Mental Health. Training funds are targetted to provide trained personnel in certain areas of special need. The training projects are aimed at obtaining a better distribution of mental health professionals to meet the needs of specific underserved populations and geographic areas. The clinical training program was $74.2 M in FY 79, and is $71.6 M in FY 80 and in the President's FY 81 budget. The number of new and competing clinical training awards has declined precipitously however from about 400 in FY 79, to 230 in FY 80 to about 220 predicted for FY 81. Social work training has received about $11 million of the $71 million to $74 million clinical training program for the past three years but five years go received $13 million.

We would recommend that the Committee restore the clinical training programs to a level sufficient to maintain about the same number of competing and new projects as in FY 1979. This would assure some growth in the corps discipline's training capacity. An additional $10 million would be necessary to provide the same number of new and competing projects as in FY 1979. This should allow social work an additional $2 million and bring back its funding level to its level of about five years ago.

4. Health Care Delivery and Social Work

In the 1976 Health Professions Education Act Amendments, provisions were added to the special project training area to authorize training support for social workers practicing in primary care health settings and long-term care facilities as well as other health settings. Many social workers practice in the medical social service departments of hospitals, in nursing homes, and in primary care clinics in addition to serving as planners and administrators in health systems agencies and state health agencies. The budget item which refers to the special projects area generally under Section 787 of the Public Health Service Act is the interdisciplinary training item. That item, based on recommendations and action by this Subcommittee received $8.5 million of appropriations last year. This Subcommittee had recommended $10 million. We would recommend at least a $10 million appropriation for this amount and we would recommend that up to $2 million be made available for social work training in the health care field. As we attempt to move more and more patients from long-term care facilities and hospitals into the community, the services of social workers in the health system becomes more and more important and this is reflected in the rapid growth of medical social service departments and programs in hospitals and nursing homes.

Also with regard to health manpower training, we would recommend $5 million, as has the Administration, for special projects in the area of health planning and health administration. A recent change in the law with regard to this program enacted in 1978 opens the program to competition from a large range of institutions. Planning and management skills in the health care field are necessitated by the emphasis upon cost containment and through the implementation of the Health Planning & Resource Development Act and the regulatory activity thereunder.

I am including a chart with all of our recommendations.

(CHART IN MILLIONS OF DOLLARS)

COUNCIL ON SOCIAL WORK EDUCATION -- SUMMARY OF TRAINING BUDGET REQUESTS

	FY '78	FY '79	FY '80	FY '81 Pres.'s Budget	FY '81 Recommendation by CSWE
1. Child Welfare Training	$ 8.1	$ 8.1	$ 7.5	$ 7	$ 8.1
2. Mental Health Training	85	93(Total) 74(Clinical) 11(Soc.Wk.)	90(Total) 70(Clin.) 11(Soc.Wk)	90 70 11	100(Total) 81(Clinical) 13(Soc. Wk.)
3. Alcoholism	7.2	7.2	7.2	5.8	10
4. Health Care Services - HRA Interdisciplinary Training	4	7	8.5	0	10
5. Health Planning Project Grants	5	5	5	5	5
6. Rehabilitation	30.5	30.5	28.5	25.9	35
7. Aging	17	17	17		20
8. Maternal and Child Health	26	26.8	26.8		26.8

STATEMENT OF DR. CLEMENT B. SLEDGE, PROFESSOR OF ORTHOPEDIC SURGERY, HARVARD MEDICAL SCHOOL

I am Clement Sledge, Professor of Orthopedic Surgery at Harvard Medical School, Chairman of the Committee on Arthritis of the American Academy of Orthopedic Surgeons and Chairman of the National Arthritis Advisory Board. I greatly appreciate the opportunity to address you regarding the activities of the National Arthritis Advisory Board and to submit to you our Annual Report of activities including our recommendations regarding the appropriate level of funding for arthritis research and orthopedic research. I must also report to you the gross inadequacies in our present efforts to inform practicing physicians and other health-care providers about recent developments in arthritis research and improved modalities of care.

Musculoskeletal diseases, including arthritis, rank second in overall economic cost among all diseases affecting the citizens of this Nation. By the year 2000, expenses attributable to arthritis will reach 96.8 billion dollars. In spite of the fact that 12.7% of the total health outlay can be attributed to arthritis, only 1.4% of the NIH budget in 1978 was allocated for the study of these crippling diseases. Why this striking disparity between economic impact and research outlay? To me there appear to be three major reasons: Arthritis cripples but rarely kills. Thus its impact is less dramatic. The 37 million persons in this country with arthritis range from individuals with mild stiffness and deformity of the fingers to patients so crippled that they must be institutionalized for full-time care. Arthritis is truly the silent torturer. Rather than killing its victims, it destroys the very quality of life - preventing either useful employment or leisure time. The second factor contributing to the under-recognition of arthritis and musculoskeletal disease is the spectrum of diseases included; some 100 different forms of arthritis are recognized - ranging from a lethal or crippling disease that affects children to the wear and tear of age. This spectrum of diseases has made it difficult for the public and congress to focus on this problem as they have with more readily recognized disease categories. Bear in mind, however, that the incidence of arthritis increases from 23% of individuals between 40-65 years of age to a staggering 41% of those over 65. At the same time, 250,000 children have a form of arthritis, juvenile rheumatoid arthritis, and 100,000 will carry a crippling handicap into adult life. The third factor which has contributed to the under-recognition of the problem of arthritis is a general failure to recognize the importance of chronic diseases. We have too frequently focused

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on those acute diseases that affect lives dramatically or produce death. We have ignored the insidious loss of health and function that slowly cripples its victims, first removing them from the work force and later removing them from the mainstream of the enjoyment of life.

This Congress did recognize the importance of arthritis in the passage of the Arthritis Act of 1974 (PL94-562) which created the National Commission on Arthritis and Related Musculoskeletal Diseases. The report of that Commission, "Arthritis: Out of the Maze," was published in 1976 and contained more than 150 recommendations that collectively form the Arthritis Plan. In addition to proposals to address the physical, economic and psycho-social impact of arthritis, the Arthritis Plan recommended creation of the National Arthritis Advisory Board to monitor the implementation of the Arthritis Plan. The Board was officially chartered in December of 1976 and was directed to report annually to the Congress and to the Secretary of Health, Education and Welfare. I submit to you today the Third Annual Report of the Board. This report includes specific recommendations addressed to the areas of research, public policy in chronic disease care, community programs and rehabilitation, education and training, epidemiology, and the Multi-purpose Arthritis Centers established by the Arthritis Act. I will summarize salient features of this report and ask that the full report be included for the record. The National Arthritis Advisory Board, composed of government health officials, physicians from the private sector, and lay persons has addressed the broad spectrum of issues confronting both the arthritis victim and a nation whose economy is so strongly affected by this cluster of diseases. To perform the work of the Board, the members organized into sub-groups by areas of concern: Multi-purpose Arthritis Centers, research, public policy and chronic disease care, education and training, community programs, data systems, and epidemiology. The activities in these areas are summarized in the Annual Report and can best be characterized as investigative and integrative. The Board has sought to bring together existing information, to point out gaps in this existing information and to suggest appropriate remedies. In addition, the Board has sought to integrate the activities of various government agencies with those of the private sector and the medical community. For its own education, and that of other government agencies and health workers, the Board has held two workshops and two more are planned for this year. On Sept. 21, 1978 the Board sponsored a special forum, entitled "Public Policy in Chronic Disease" with three major goals: To introduce members of the National Arthritis Advisory Board to the major policy issues in chronic disease care so that the

Board could select high-priority issues, decide how those issues should be addressed and to set goals for the succeeding years. The deliberations of that forum have been published and provide an important review of current Federal activities with regard to chronic diseases, and an assessment of the scope and impact of chronic diseases in the United States. Legislative initiatives in chronic disease care are proposed, and problems in obtaining services provided by current legislation are highlighted. Also arising out of that forum was a checklist of services which may be funded by current Federal Legislation. This checklist covers services that are either directly or indirectly financed under existing legislation and lists the legislation under which such services can be obtained. This extremely useful tabulation of information is included in the Annual Report of the Board for 1979 and will be of great assistance in developing new legislation as well as in bringing to the attention of social service workers and others existing entitlements.

The work group on the Multi-purpose Arthritis Centers clearly recognized the importance of evaluating the effectiveness of those Centers, at the same time recognizing the limitations of current techniques of assessment. A workshop was therefore held early in 1978 which brought together various experts on methods of evaluation of research, led by Dr. Gerald Rosenthal, Director of the National Center for Health Services Research. This workshop identified the difficulties in programmatic evaluation, the high cost of such evaluation, and the need to build in evaluative processes early in the establishment of a new program.

The work group on Community Programs and Rehabilitation has designed a forum to be held April 8 and 9 at the National Institutes of Health to address the needs for arthritis-related research and education in nursing and allied health. This forum is intended to assist the Board in gathering information on the current state of the art in research and education in nursing and allied health professions and to establish priorities for future action.

Another important conference is scheduled for June 11, 1980 entitled "Useful Lives: Treatment of Arthritis and Chronic Diseases in Employed Persons." This conference will be a round-table discussion involving representatives of organized labor, management and the insurance industry to discuss problems relating to early diagnosis and access to appropriately trained physicians and allied health professionals. The consequences of inadequate treatment for arthritis victims in the work force will be addressed as well as the programs required to fulfill treatment needs and allow continued employment by these individuals.

In spite of exciting new advances in research - ranging from improved understanding of the immune system in arthritis and the genetic predisposition of certain individuals to develop arthritis, to the success of artificial joint replacements, there remains a huge gap between what we know about arthritis and what must be known to identify the cause and construct appropriate preventative measures. Treatment must remain empirical and unfocused until the cause of arthritis is discovered and the mechanisms of the destructive process are understood. Thus, there is compelling need for more fundamental research. At the same time, however, I must emphasize that there is a huge gap between what we now know about arthritis and its treatment and what is currently available to the American public. We have failed to educate the public and the providers of health care in what might be called a failure of technology transfer. The National Institutes of Health as currently constituted is extremely well suited to direct this country's efforts in fundamental research. What is sorely needed, however, is a mechanism to bring new findings in the cause and treatment of disease to those health professionals involved in patient care. Perhaps the most important goal of the National Arthritis Advisory Board in the past and its justification for continued existence has been its integrative role in bringing together existing federal agencies and groups from the private sector to focus on the discrepancy between current knowledge and current delivery capabilities. A very important role of the Multi-purpose Arthritis Centers has been to bring together educators, investigators and those involved in the delivery of care in the community. A recent analysis of this activity is included in the Annual Report of the Board. This analysis indicates that 21 of the current 24 Multi-purpose Arthritis Centers have been evaluated for educational programs. Nineteen of the 21 had educational activities for medical students, 18 for interns and residents and all 21 were involved in education of allied health professionals including nurses. In addition, all 21 were involved in patient and public education. These educational efforts display comprehensiveness in scope and innovation in the utilization of non-physicians and patients in the educational process. This program has resulted in a catalog of educational resource materials being produced within the NIAMDD Program Office.

Center activities related to development of community programs are still evolving. Centers are involved in case finding in the community, educational activities directed toward local providers of health care in arthritis, and patient education. Thus, in large measure, the Center is bridging the gap

between current knowledge and current delivery capability. I suggest to you that continuation of the National Arthritis Advisory Board and the Multi-purpose Arthritis Center Program are important methods in bringing the advances in arthritis research to the patient with minimal delay.

Let me now address the adequacy of current funding in musculoskeletal research. The total health outlay for individuals with arthritis will reach 96.8 billion dollars within the next two decades. Yet in 1980, we spent only 35 million dollars in fundamental research in these diseases. Thus, 12.7% of the total health outlay can be attributed to arthritis while only 1.4% of our research budget is allocated to the prevention and treatment of these diseases. The 1977 Research Budget in Arthritis increased only 2% over 1976 and the 1978 budget increased only 6% over 1977. The 1979 budget again represented a modest increase, not enough to keep up with inflation or keep the research effort stable let alone accelerate the search for causes and effective treatment. Only 35% of arthritis and orthopedic research grants reviewed by peer review mechanisms within the NIAMDD are funded. This is in spite of the fact that there are several promising areas of research which can provide new understanding and new modes of treatment with the likelihood of reducing the impact of these diseases. One of the most significant advances over the past two decades has been the development of methods to replace painful, functionless destroyed joints with artificial ones. Hip replacement has already returned thousands to productive, painfree life and has been shown to be cost-effective in their own right, without addressing the tremendous improvement in the quality of life produced in these patients. A great deal of research remains to be done before joint replacement surgery can be more widely and safely applied to younger patients and to the variety of joints destroyed by arthritis. New and improved materials must be developed and better methods of fixing the devices into the skeleton must be devised so that the maximum number of patients can be returned to active and productive lives with minimal risk and maximal assurance that the benefit will be longstanding.

Recognizing the discrepancy between the promise held out by research and current delivery capabilities, the National Arthritis Advisory Board has made specific budgetary recommendations in its Annual Report. We propose a 16 million dollar increase in arthritis research grants within NIAMDD, a 5 million dollar increase in the budget for Multi-purpose Arthritis Centers and more modest but appropriate increases in research training, epidemiology and data collection,

and intra-mural research. Justification for these increases is included in our Annual Report, and a summary table is attached to this statement.

I urge you to recognize the importance of chronic diseases in general and arthritis in particular and to appreciate the negative impact of these diseases on lives and productivity. I urge you to change from a policy of investing pennies in a disease whose impact is measured in millions and look upon increased research at this time as insurance against future disability. I urge you to recognize the importance of the National Arthritis Advisory Board as your agent to oversee implementation of the Arthritis Plan and to diminish the gap between what is currently known and what is currently available to the public in terms of prevention and treatment of arthritis.

I am grateful for the opportunity to address these important issues.

BUDGET RECOMMENDATIONS FOR NIAMDD ARTHRITIS PROGRAMS
(Thousands of Dollars)

	1980	1981	
		NIAMDD	NAAB
Research Grants	20,502	33,304	36,184
Centers	8,586	10,000	13,000
RCDA	1,062	1,062	1,551
RSA	1,607	1,271	2,207
Epidemiology	0	3,000	2,500
Data	500	750	750
AIC	200	300	250
Contracts	1,444	2,315	2,065
NAAB	300	300	350
Intramural	4,458	5,350	5,226

STATEMENT OF DR. STUART A. KLEIT, PRESIDENT,
NATIONAL KIDNEY FOUNDATION

It is a pleasure to provide you with this statement concerning research support for kidney and urologic research in the National Institute of Arthritis, Metabolism and Digestive Diseases. I am Dr. Stuart A. Kleit, Professor of Medicine and Chief of the Renal Section, Indiana University School of Medicine, and President of the National Kidney Foundation. I speak on behalf of both the lay and professional volunteer membership of this, the leading voluntary health organization dedicated to the needs of patients with kidney and urologic diseases.

I am also privileged to represent the Intersociety Committee for Kidney Research made up of organizations whose membership is dedicated to finding research answers to the problems of patients with kidney and urologic diseases. This group is composed of the following national organizations: National Kidney Foundation, American Society of Nephrology, American Society of Artificial Internal Organs, American Society of Pediatric Nephrology, the Council on the Kidney of the American Heart Association, American Society of Transplant Surgeons and the American Urological Association. Together their memberships represent over 90% of the physicians, teachers and investigators in the United States with primary interests in kidney and urologic diseases. These organizations have banded together because of a common concern over the present and future status of treatment for patients with kidney and urologic diseases.

Despite the dollar increases proposed in the President's budget, the net result is a continuing real decrease in federal research support. It is time to stem this erosion of research support by the federal government! During the 1980 fiscal year, two-thirds of approved Kidney-Urology grants could not be funded by the National Institute of Arthritis, Metabolism and Digestive Diseases (NIAMDD). Research support has suffered not only from budgetary constraints brought on by inflation but also because of a misunderstanding as to the nature of research and a short-term view of the potential of scientific inquiry. Moreover, kidney and urological research has suffered more than investigation in other disease and organ groups because kidney and urological research did not benefit from the growth and consolidation of research activity in the period from 1945 to 1960.

Strange as it may sound, uncontrolled inflation argues in favor of increased research support rather than against it. It must be stressed that our current health care delivery system is living off research completed a decade ago. It is only by uncovering new methods of prevention and treatment that the current high standard of health care delivery can be maintained and improved in a period of rising costs. During the past three years, the National Kidney Foundation has doubled its research support. However, because of the limited resources available to us, we cannot hope to take up the slack created by federal budget policies.

The high number of scientifically sound unfunded kidney and urology research grants indicates that the opportunities for further advances are present. The need is ever present and therefore we are seeking a total of $45 million for kidney and urological research at NIAMDD in the 1981 fiscal year.

THE NATURE AND OPPORTUNITIES OF RESEARCH

Research is essentially an approach to a problem which, over a period of time, may yield an answer. We cannot predict what questions can be answered or guarantee an answer within a specific length of time. However, it must be stressed that the potential of research to improve the quality of life and decrease costs has been proven again and again.

For example, last year our testimony described a newly-developed dialysis procedure, CAPD, which resulted from then just-completed research supported by NIAMDD. This procedure in selected patients offered a potential alternative to hemodialysis which would result in decreased cost and increasing patient mobility. During the intervening twelve months, approximately 1,000 patients have used CAPD. In

those in whom it has been successful, cost savings and improved quality of life are already evident. This experience indicates again the long-term positive effects achievable from our research investment. Many additional opportunities for future investigation remain and some are described below. However, without substantial increases in funding for the Kidney-Urology program of NIAMDD, these and other possibilities will be lost.

One area of inquiry where major funding could be well spent concerns immunology. New breakthroughs in this area could have a double payoff for end-stage renal disease: in prevention as well as in treatment through transplantation.

While the mortality of transplant patients has fallen, we have been unable to increase the survival rate of transplanted kidneys beyond the levels achieved five to ten years ago. This is because we have not developed an agent capable of specifically controlling rejection. At the present time, the only immunological suppressants available are those which block all immunological activity. As a result, many transplant patients develop severe and unusual infections. What we need is an immune suppressant which can be specifically targeted to transplant rejection and which does not also block the patient's ability to fight and survive infection. In addition funds are needed to enable us to understand better the role of typing and blood transfusion in transplantation. Recently-gained information suggests that both these areas hold real promise for breaking down the immunologic barriers to transplants.

The second needed area of immunologic research is in glomerulonephritis. At lease one-half of the patients afflicted with end-stage renal disease, requiring hemodialysis and/or transplantation, have glomerulonephritis. This is an immunologic disease involving the filtering units of the kidney, the glomeruli, which leads to the progressive destruction of these filtering units. Since glomerulonephritis is caused by disturbances of immunologic mechanisms, new understanding of immune mechanisms in general and those in the kidney specifically could bring about their effective management or prevention.

Another area where research is at the cutting edge of prevention of chronic renal failure is hypertension. Eighty percent of patients on dialysis suffer from hypertension. In the case of twenty percent of the patients enrolled in the End-Stage Renal Disease Program, high blood pressure is the main cause of their kidney disease. Control of hypertension is one of the few available measures for preventing the development of end-stage renal disease. While we are able to control high blood pressure, we understand little about its cause or its effects on the kidney. Research here would open the way towards true prevention.

While glomerulonephritis and hypertension are major causes of ESRD, they represent but a few of the problems which may result in this devastating catastrophe. We are equally lacking in knowledge about most of the many other causes whether they are related to diseases such as diabetes which attack the kidney as secondary events to a primary process, or due to primary disease of the kidney as seen in congenital malformations such as polycystic kidney disease.

As great a concern to us are a large number of kidney and urologic diseases which while not having fatal conse-

quences have significant impact on health as well as significant social and economic consequences. Why, for example, do women get urinary tract infections, a leading cause of days lost from work in our female population, in such significant numbers? What can be done to ameliorate this? Why and how can we prevent the epidemic of prostatic hyperplasia which results in urinary tract obstruction in such a high proportion of males in their 60's and 70's? How can we prevent the eventual need for surgical relief in 60-70% of men in this age group? These and many other questions deserve our attention.

TRAINING

We are deeply concerned about the recent stagnation of federal programs for the development of new research scientists. The current proposals are totally inadequate and if followed will ultimately result in destruction of our medical research abilities. For example, if significant additional funding beyond the President's budget is not provided, there will be no new research trainees in urology and nephrology in the coming year. As I have already noted, and as I call to your attention again, current health care delivery for kidney and urology patients has essentially been determined by research completed some time ago. The failury to provide a continuing influx of young people with inquisitive minds and new ideas will doom us to the halfway solutions to renal disease we have today, with their large cost and imperfect quality of life. Furthermore, young investigators are needed to fill future needs for medical school faculties. As detailed in the attached articles based on a survey by our Scientific Advisory Board, published in both The Journal of Urology and Kidney International, an additional 483 faculty members will be needed in the next five years to fill projected vacancies in teaching and research in renal disease in departments of medicine, pediatrics and urology. A serious gap here will affect not only research but the training of specialists and primary care physicians as well. This in turn will impair possibilities for early detection and prevention of kidney disease. Thus, a failure to provide adequate training funds and capability is a short-sighted move which has severe implications not only in research but in health care delivery as well. We urge you strongly to reverse these developments and adequately fund training grants.

FUNDING AND FUNDING FORMULAS

The debate over proposals for the development of a new formula for research funding at the National Institutes of Health, whether to guarantee 5,000 grants per year or to pay based on a specific priority score, shows that there is new interest in preserving the viability and productive capacity of the U.S. research effort. However, such an approach would not affect all research equally and would be only a partial solution to the overall problem of lost research opportunities and their potential impact on health care. The main fault of these proposals is that they fail to provide a balanced approach to research problems. The approach itself is partly responsible for the proposed decrease in training funds. Another difficulty with the proposal is that it does not address funding of research centers and contracts nor does it address the appropriateness of such funding.

The administration's proposal is a piecemeal approach which may ultimately distort research in general. Since it has the broadest significance it should not be implemented

as an isolated phenomenon but as part of an overall plan for research funding. There is no question in our minds that investigator-initiated research grants are fundamental to good research. In fact, a much higher percentage of money in Kidney-Urology research is in investigator-initiated grants than in other parts of the NIAMDD or NIH. Of great concern is that the magic number of 5,000 rather than being a floor, looks more like an upper limit, resulting ultimately in loss of flexibility and in inhibition of research activity.

What is needed is a continuing commitment to research as a form of investment in the future. Accordingly, the best start that could be made in our judgment is the devotion to research by the federal government of a specific sum of money, calculated as a percentage of total health-care expenditures. Once this base was established, then a more rational overall plan for its expenditure could be developed.

It should be realized that the National Institutes of Health did not have a program for research in kidney disease until 1965. In the big growth era of NIH from 1945-60, kidney research was largely neglected. The President's proposal treats all research as if its need had stabilized. In truth, in Kidney-Urology research, we must catch up with research in other areas with comparable morbidity and mortality problems. Yet this plan and the proposed budget treat Kidney-Urology areas as if the momentum for kidney research had been fully established.

Three years ago, we analyzed the deficit created by the late start of kidney and urologic research at NIH. Our conclusions at that time were that if Kidney-Urology research could be funded in FY1981 at 45 million dollars, we would have come a long way towards closing this gap. While the increases in the past two years have had a positive effect, 7.5 million dollars are required in this year's over last year's appropriation to meet this modest goal. Our membership and the patients we serve ask you to meet this goal and allow us to move forward together on an equal basis with the other disciplines in the Institute.

CONCLUSION

We have closely analyzed the current NIAMDD budget and budget projections for the next fiscal year. This year, two-thirds of projects scientfically valid were left to die. Research training has reached a low and disastrous level. Research opportunities which could lead to the prevention of end-stage renal disease and methods for the management of chronic renal failure which are both less expensive and more acceptable to our patients have been lost, perhaps forever. The President's budget request continues this downward slide towards disaster.

Based on our analysis, we recommend that a minimum increase of $7.5 million over the last year's appropriations is necessary to continue the onward research thrust in NIAMDD's Kidney-Urology Program and to permit new inititives. The budget we recommend of $45 million represents a small fraction, less than 3 percent, of the $1.5 billion the federal government will spend on end-stage renal disease alone this year. It represents a much smaller portion of the total cost of care of all kidney and urologic illness, but it is the only investment we can make to reduce the overall cost of the delivery of care in the future. To fail to make this investment would be to perpetuate the half-way technologies of another generation of research and perhaps undermine our commitment to universal care for the victims of end-stage renal disease.

Kidney International, Vol. 17 (1980), pp. 135–138

SPECIAL REPORT

Need for faculty members in renal research in clinical departments: Report of the Scientific Advisory Board of the National Kidney Foundation

REX L. JAMISON, NANCY B. CUMMINGS, and JAY H. STEIN

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The need for faculty members in renal research in clinical departments. To provide an approximate estimate of the need for academic faculty in renal research, 1200 questionnaires were mailed to most departments in all medical schools in the United States. There were 627 completed questionnaires returned from 99 divisions of nephrology, 79 divisions or departments of urology, and 67 divisions of pediatric nephrology or departments of pediatrics in 120 medical schools. Analysis of the responses revealed that in these three departments there are 1057 faculty members engaged in teaching and research related to the kidney and urinary tract, and 131 current vacancies. The responses suggest that from 1979 to 1984 another 483 faculty members will be required to fill projected vacancies in the foregoing three clinical departments, making the total needed 614.

Besoins en universitaires de la recherche rénale dans les départements cliniques. Afin de fournir une évaluation approximative des besoins en universitaires de la recherche rénale, 1200 questionnaires ont été adressés à la plupart des départements de toutes les écoles de médecine des Etats-Unis. Six cent vingt sept questionnaires remplis ont été renvoyés par 99 divisions de néphrologie, 79 divisions ou départements d'urologie et 67 divisions de néphrologie pédiatrique ou départements de pédiatrie appartenant à 120 écoles de médecine. L'analyse des réponses indique que dans ces trois types de départements il y a 1057 universitaires impliqués dans l'enseignement et la recherche en rapport avec le rein et l'appareil urinaire et 131 postes actuellement vacants. Les réponses suggèrent un besoin supplémentaire de 483 universitaires afin de remplir les postes prévus dans ces trois types de départements de 1979 à 1984, ce qui porte le besoin total à 614.

In an effort to secure objective information about future needs for academic faculty in research in kidney and urinary tract biology and, therefore, current needs for fellowships in nephrology and urology, a questionnaire was prepared by a subcommittee[1] of the Scientific Advisory Board of the National Kidney Foundation. The questionnaire was mailed to all departments of physiology, anatomy, biochemistry, pharmacology, pathology, immunology and bacteriology, genetics, radiology, medicine, surgery, and pediatrics, and all divisions of nephrology and urology in 120 medical schools in the United States. Twelve hundred four questionnaires were mailed July 26, 1978, with a second mailing August 23, 1978.

[1]The subcommittee consisted of Nancy Cummings, Associate Director, Kidney, Urologic and Blood Diseases, National Institute for Arthritis, Metabolism and Digestive Diseases; Jay Stein, Professor and Chairman, Department of Medicine, University of Texas Health Science Center, San Antonio; and Rex L. Jamison, Head, Division of Nephrology, Stanford University Hospital, who was appointed Chairman. Dr. Robert Berliner, Dean, Yale University School of Medicine, and Dr. Rosemary Stevens, Professor of History and Sociology of Science, University of Pennsylvania, agreed to act as consultants to the committee.

Results

A total of 627 questionnaires returned from 120 medical schools were analyzed. They came from 99 divisions of nephrology, 79 divisions or departments of urology, and 67 divisions of pediatric nephrology or departments of pediatrics. In our view this is an excellent response. As the returns were analyzed, some ambiguities in the questions became apparent:

Question 1. In order to assess the current status of research positions, fill in the numbers applicable to your department in the appropriate space. [See next page.]

"Total number" was often taken to mean total faculty members in a department, rather than that which was intended, namely total number of faculty members devoted to kidney and urinary tract teaching and research. "Teaching, Research, or Both" was interpreted by some to be mutually exclusive. With regard to faculty in medicine (nephrology), surgery (urology), or pediatrics (nephrology), we found that by comparing numbers in each box in question 1, the actual number of faculty members

Received for publication April 20, 1979
and in revised form July 30, 1979

0085-2538/80/0017-0135 $01.00
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Question 1. In order to assess the CURRENT STATUS OF RESEARCH POSITIONS, fill in the NUMBERS applicable to your department in the appropriate space.

Total number	Faculty positions in kidney and urinary tract			Number of occupied positions	Number of vacancies	Ph.D. (No.)	M.D. (No.)
	Teaching	Research	Both				
———	———	———	———	———	———	———	———

devoted to kidney and urinary tract, the number of positions occupied and vacant, and the number of Ph.D.'s and M.D.'s in each department were nearly always apparent. Ambiguities made it difficult to interpret answers from departments other than medicine, surgery, and pediatrics. We therefore restricted our analyses to these three departments. Review of all questionnaires returned, however, indicated that most faculty positions devoted to teaching and research related to the kidney and urinary tract are in these three departments.

The results of question 1 are summarized in Table 1. In the 120 medical schools represented in this questionnaire, there are 624.5 faculty members in nephrology, 370 in urology, and 130.5 in pediatric nephrology, making a total of 1125 faculty members. One thousand fifty-seven positions are occupied, and 130.5 positions are vacant. The sum of the latter two, 1187.5, does not equal total number of faculty positions (1125), because some responders interpreted "Total number" and "Occupied positions" in kidney and urinary tract to mean the same thing, whereas others interpreted "Total number" to indicate both "Occupied positions" and "Vacancies" (as was intended). Nevertheless, approximately 10% of current faculty positions in the three departments are unfilled.

Question 2. What do you estimate are the needed numbers of faculty you should recruit in the period 1979-84?

Retirement _____ Expansion _____ Other _____

The responses to this question are summarized in Table 1. The purpose of this question was to determine the number of faculty positions in kidney and urinary tract that are likely to become available in the next 5 years. Only replies from departments of medicine (nephrology), surgery (urology), and pediatrics (nephrology) were analyzed. There were proportionately more vacancies due to retirement anticipated in urology than there were in nephrology or pediatric nephrology, possibly reflecting the longer existence of urology as a recognized subspecialty. By far the most openings, however, were due to expansion, indicative of anticipated growth needs in these specialties. The total of projected vacancies in the next 5 years, 483 (which does not include current vacancies), represents nearly half of the current number of faculty members (1057) engaged in teaching and research in the kidney and urinary tract in the three clinical departments.

Question 3. Has the number of faculty changed during the past 5-10 years? Yes _____ No _____ If yes, note numbers of each where available.

	1968–72	1972–75	1976 to present
M.D.	☐	☐	☐
Ph.D.	☐	☐	☐

Because the estimate of needed faculty owing to expansion might overestimate new positions actually created, question 3 represented another attempt to gauge future needs by observing a trend over the past decade. Most but not all of those responding completed this section of the questionnaire. An indication of the growth of the field is shown in Fig. 1. According to those questionnaires in which question 3 was answered, the number of faculty in surgery (urology) was 173 for the period 1968 to 1972, 202.5 in 1972 to 1975, a 17% increase over the preceding period, and 270 in 1976 to 1978, a 33% increase over the period from 1972 to 1975. Similarly for medicine (nephrology), the figures were 242 (1968 to 1972), 371.5 (1972 to 1975), a 54% increase

Table 1. Faculty in kidney and urinary tract

Department/ division	No. of divisions/ departments	Total faculty	Occupied positions	Current vacancies	Projected need 1979 to 1984*			Total projected vacancies
					Retirement	Expansion	Other	
Nephrology	99	624.5	583	79	27	190	36	253
Urology	79	370	356	32	32	100	19	151
Pediatrics	67	130.5	118	19.5	7	66	6	79
Total		*1125*	*1057*	*130.5*	*66*	*356*	*61*	*483*

* Need categorized according to cause, that is, vacancies created by retirement, expansion, and other causes.

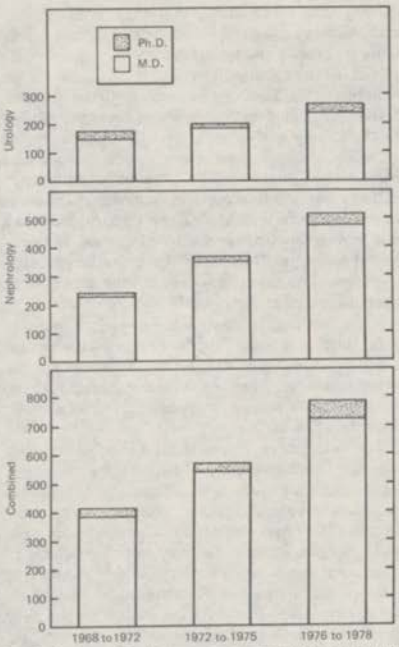


Fig. 1. *Number of faculty in surgery (urology)* (top panel) *and medicine (nephrology)* (middle panel) *in each of the three periods defined below.* The two groups are combined in the *bottom panel.* The *clear portion* designates faculty with M.D. degrees, the *shaded portion*, those with Ph.D. degrees.

over the preceding period, and 520.5 (1976 to 1978), a 40% increase over the period from 1972 to 1975. (A sufficient number of answers to this question for pediatric nephrology was not available for analysis). For medicine and surgery combined, the numbers were 415 (1968 to 1972), 574 (1972 to 1975), a 38% increase over the preceding period, and 790.5 (1976 to 1978), a 38% increase over the period from 1972 to 1975. If the same growth rate continues, it would result in 1091 positions by 1981 and 1505 positions by 1984. The last figure (1505) agrees reasonably well with the sum of total occupied positions (939), current vacancies (111), and total projected vacancies for 1979 to 1984 (404) (sum = 1454) for medicine (nephrology) and surgery (urology). This agreement adds credence to the 483 total projected vacancies for nephrology, urology, and pediatric nephrology (Table 1).

Question 4. Please list the principal areas of research engaged in by your department.

The answers to this question span the breadth of nephrology from basic physiology to clinical therapy. The most frequently listed areas of research included transplantation, salt and water metabolism, renal hemodynamics, renal metabolism, renal failure (acute and chronic), hypertension, immunopathology of glomerular diseases, dialysis drug metabolism, calcium and phosphorus metabolism, tumor immunology, urinary infections, urodynamics, and urolithiasis.

Question 5. Please list areas of research devoted to Kidney and Urinary Tract which, in your opinion, are underdeveloped (no more than five).

Many areas of research were thought to be underdeveloped. The most frequent areas listed included: immunochemotherapy, renal tumors, pathophysiology of urodynamics (specifically, vesico-ureteral reflux), urinary tract infection, diagnostic radiology (better means of diagnosing renal disease, etc.), methods of assessing benefits of dialysis, pathogenesis of chronic renal failure, renal metabolism, salt and water balance, potassium imbalance, renal hypertrophy, developmental nephrology, renal immunology, transplant immunology, renovascular hypertension (renin-angiotensin system, etc.) drug metabolism by the kidney, pathogenesis of glomerular nephritis, molecular basis of proteinuria, and pathophysiology of interstitial nephritis.

Discussion

Analysis of the questionnaires reveals that in the United States over 1000 faculty members in the departments of medicine (nephrology), surgery (urology), and pediatrics (nephrology) are engaged in research and teaching related to the kidney and urinary tract. The data also suggest that approximately 600 more faculty will be needed between 1979 and 1984 (130.5 current and 483 projected vacancies).

No attempt was made to assess the validity of the estimated needs for faculty expressed in the questionnaire. Such an assessment involves an estimate of what can be accomplished during the next two or three decades and which problems in the broad field of kidney and urinary tract research should be addressed. (See the report recently completed by a committee under the direction of Gottschalk and Lassiter [1]).

Our goal was simpler. We tried to determine the number of full-time academic jobs for teaching and research in the field of kidney and urinary tract likely to become available in the period 1979 to

1984. It is possible that the number of new positions actually created during this period will fall short of this estimate. Conversely, it may exceed it. This report should be considered as only a first step toward a more rigorous evaluation of the need for academic faculty in kidney and urinary tract teaching and research.

Owing to certain ambiguities in the questionnaire, it was difficult to evaluate the number of faculty presently engaged and the additional faculty needed in kidney and urinary tract teaching and research in departments other than those of medicine, surgery, and pediatrics. This is unfortunate, because undoubtedly a substantial number of faculty in departments of physiology, pathology, immunology, and radiology are engaged in research and teaching in the fields of kidney and urinary tract. Moreover, not every department of medicine, surgery, or pediatrics responded. Nevertheless, a remarkable number of questionnaires was completed and returned. Furthermore, it seems reasonable to assume that most faculty positions now and in the next 5 years in kidney and urinary tract are included in the departments of medicine, surgery, and pediatrics.

Identifying the sources of new faculty is beyond the scope of our project, but nevertheless it is worthy of brief consideration. The National Kidney Foundation (NKF) annually awards approximately 30 full-stipend fellowships; local chapters of the NKF bestow approximately 10 additional full fellowships (that is, stipends of at least $10,000). The National Institute of Arthritis, Metabolism and Digestive Diseases (NIAMDD) awarded 113 postdoctoral fellowships in kidney and urinary tract in 1978, and it expects to support a similar number in 1979, but NIAMDD postdoctoral fellows (both M.D.'s and Ph.D.'s) are distributed throughout all departments in medical schools. If it is assumed that two thirds of NIAMDD fellows are supported for training in the three clinical departments of nephrology, urology, and pediatric nephrology, this amounts to 75 trainees per year. (There is, however, a restrictive clause in the NIH fellowship agreement, namely the well-known "payback" provision. Thus, potential trainees who are uncertain as to their aptitude for research may be hesitant to apply for an NIH fellowship [2]). There are also several fellowships from other sources, for example, the local American Heart associations, but as a whole they are unlikely to supply a great many additional faculty members in the areas under consideration. Thus approximately 125 fellowships are annually awarded to support training in kidney and urinary tract research in nephrology, urology, and pediatric nephrology. Of the recipients, many inevitably choose a nonacademic career upon completion of their fellowships [2].

Similar considerations pertain also to the need for faculty dedicated to teaching and research related to the kidney and urinary tract in departments of anatomy, genetics, biochemistry, immunology and bacteriology, pharmacology, physiology, pathology, and radiology. It thus appears that the present number of fellowships in kidney and urinary tract may not provide enough faculty to fill current and projected openings. The causes of this predicted shortage are beyond the scope of our assignment but have been discussed recently by Wyngaarden [2].

Assuming that this estimated need for faculty is valid, how it is to be filled is unclear. The present study provides some support for the view that the principal funding agencies should try to increase the number of fellowships for training in kidney and urinary tract research.

The impressive response to this questionnaire leads us to recommend that periodically an inquiry be prepared and sent to those engaged in renal research to update and extend information presented in this report and to address other issues as well. For example, it might be an appropriate vehicle to determine how many trainees in kidney and urinary tract research go on to academic careers. Such information would be useful for evaluating the need for training in biomedical research.

Acknowledgments

We wish to thank the following people: R. Berliner, R. Glassock, I. Goldenberg, M. Lee, J. Seely, R. Stevens, G. E. Stewart, Jr., and the staff of the National Kidney Foundation for help and advice during the study. D. Hall, B. Myers, and R. Rabkin gave helpful criticism of the manuscript. Especially we would like to thank all those in medical schools across the United States who took the time to complete and return the questionnaire.

Reprint requests to Rex L. Jamison, Division of Nephrology, Stanford Medical Center, Stanford, California 94305, USA and also the National Kidney Foundation, Inc., 2 Park Avenue, New York, NY 10016

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THE JOURNAL OF UROLOGY
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Vol. 122, November
Printed in U.S.A.

Special Article

THE NEED FOR ACADEMIC FACULTY IN UROLOGIC RESEARCH: REPORT OF THE SCIENTIFIC ADVISORY BOARD—NATIONAL KIDNEY FOUNDATION

JAY Y. GILLENWATER

From the Department of Urology, University of Virginia School of Medicine, Charlottesville, Virginia

The field of urology is perceived to be suffering unfairly from a lack of academic scientists engaged in research on urologic diseases. The scarcity of urologists successfully competing for grant support from the National Institutes of Health would seem to support the contention that our specialty does not have its share of scientists engaged in basic research. Last year urologists received 12 grants from the National Institute for Arthritis, Metabolism and Digestive Diseases, which accounted for $1 million of the $31.8 million awarded by the Institute for research on renal diseases. Last year 2 urologists received Career Development Awards.

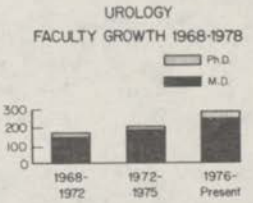
The Scientific Advisory Board of the National Kidney Foundation appointed a committee in 1977 to look into the need for academic faculty in renal diseases in departments of medicine, pediatrics and urology. The committee was chaired by Dr. Rex L. Jamison, Head of the Division of Nephrology, Stanford University Hospitals, and included Dr. Nancy B. Cummings, Associate Director, Kidney, Urologic and Blood Diseases, National Institute for Arthritis, Metabolism and Digestive Diseases, and Dr. Jay Stein, Professor and Chairman, Department of Medicine, University of Texas Health Science Center, San Antonio. Dr. Robert Berliner, Dean, Yale University School of Medicine, and Dr. Rosemary Stephens, Chairman, Department of Health Systems Management, School of Public Health and Tropical Medicine, Tulane University, acted as consultants. Their report was presented to the National Kidney Foundation in 1979 and has been accepted for publication.[1] Since it is unlikely that any of this information will be available to most of the urologic community the findings in this report relating to the field of urology are reported herein.

SUMMARY OF REPORT

A questionnaire was mailed to departments of medicine, pediatrics and urology on July 26, 1978. A total of 627 questionnaires was returned from 120 medical schools, including 99 divisions of nephrology, 61 divisions of pediatric nephrology and 79 departments of urology. The results indicated that there is a total of 1,057 members of the faculty engaged in kidney and urinary tract teaching and research, and 130 current vacancies. In the next 5 years it is estimated that an additional 483 faculty members will be needed to fill projected vacancies in the foregoing 3 clinical categories, making the total required 613.

UROLOGIC NEEDS

The faculty growth in urology is depicted in the illustration. The data gathered from the 79 departments or divisions of urology from which a completed questionnaire was received reveal that the total faculty in these 79 departments was 388, with 356 positions occupied and 32 vacant. The total projected number of vacancies in urology in these departments for 1979 to 1984 is 151.



If these vacancies are to be filled by urologists with an investigational and a surgical background we will need to train approximately 30 each year. Currently, 3 or 4 American Urological Association Scholars, who are awarded support for 2 years of research after their urology training, are funded each year. Four research fellowships for urology residents are funded each year by the American Urological Association and the National Kidney Foundation. Thus, it is evident that more sources of funding are needed if we plan to expose the new urologic faculty to basic research. Conversely, anyone with excellent training in surgery and investigational techniques can find an opportunity in academic urology.

Academic faculty in urology requires training in investigational methodology. Most important, we must determine the mechanisms of urologic diseases. Contrary to many surgical disciplines there are few basic scientists conducting research on urologic diseases. Second, urologists entering the field of academic urology must play the game of publishing to advance up the academic ladder. In order to publish one must either 1) discover a new disease, operation or gimmick, 2) conduct prospective or retrospective clinical studies or 3) conduct clinical and laboratory investigations into various urologic problems. Realistically, the young urologist entering academic medicine needs to publish, and to publish something more substantive than case reports.

Our specialty has come far academically. Initially, much effort went into dilating strictures, removing calculi and prostates, and treating venereal diseases. The present and previous generations of urologists unquestionably have established the reputation of urologists as excellent surgeons. The challenge of our generation is to continue to expand our surgical skills and, in addition, to become recognized as scientists. To accomplish this goal we must train urologic surgeons in investigational techniques.

Requests for reprints: Department of Urology, Box 422, University of Virginia School of Medicine, Charlottesville, Virginia 22908 and National Kidney Foundation, 2 Park Ave., New York, New York 10016.

[1] Jamison, R. L., Cummings, N. B. and Stein, J.: The need for academic faculty in nephrology and urology: report of the scientific advisory board—National Kidney Foundation. Kidney Int., 17: January, 1980.

STATEMENT OF THE LUPUS FOUNDATION OF AMERICA, INC.

National Institute of Arthritis, Metabolism & Digestive Diseases

National Institute of Allergies & Infectious Diseases

BACKGROUND: NIAMDD and NIAID are the two principal institutes at N.I.H. that conduct the majority of relevant research in Systemic Lupus Erythematosus. Major research projects in the fields of Arthritis and Immune Responses are vital to unraveling the mysteries surrounding not only this life threatening disease, but also, will do much to enhance the overall knowledge of Arthritis and the myriad of immune related disorders -- two areas that have been grossly underfunded not only in humanitarian terms, but also, in the pragmatic terms of dollars and cents. Arthritis victims alone lost $4.7 billion in yearly wages with $2 billion paid in disability.

Federal Research Support in FY 1978 for Selected Diseases

Disease	No. of Victims	Dollars	Dollars per Victim
Arthritis - (Category in which S.L.E. is most frequently classified)	31,600,000	$ 14,940,000	$ .47
Heart/Stroke	20,000,000	$260,200,000	$13.01
Cancer	10,000,000	$692,500,000	$69.25

PROPOSED BUDGET FY 1981 will drastically curtail two major areas that are essential to S.L.E. patients: 1) training and research career development, 2) research centers. The cutback in training programs will not only be felt in 1981, but the backlash will cripple the quality of medical care in years to come. The cutback in funding for research centers closes important doors that N.I.H. and the government have in assuring the public their tax dollars supporting Bio-Medical Research translates into benefits with which they can readily identify. Furthermore, and of tremendous significance, is that without clinical research programs, the laboratory investigation will not have the feedback it needs as to its effectiveness and benefit to society.

RECOMMENDATIONS:

1. The Professional Judgement Budget submitted by NIAMDD and NIAID be accepted.

2. Congress should strongly encourage with additional adequate funding the training and career development programs at NIAMDD and NIAID.

3. Congress should allocate sufficient increase in funding for the continuation and expansion of research centers supported by NIAMDD and NIAID.

4. Increase funding for lupus research as requested by Congressman Anderson in his testimony before the N.I.H. House Appropriation Committee.

STATEMENT OF ALFRED A. BAUMEISTER, PH. D., VANDERBILT UNIVERSITY AND GERSHON BERKSON, PH. D., UNIVERSITY OF ILLINOIS

My name is Alfred Baumeister. I am Professor of Psychology and Director of the Institute on Mental Retardation and Intellectual Development at Vanderbilt University. Appearing here, I represent the Division on Mental Retardation of the American Psychological Association and the American Academy on Mental Retardation. In behalf of my colleagues I am grateful for this opportunity to offer testimony before this distinguished Committee in regard to appropriations to the National Institute of Child Health and Human Development. We sincerely hope that our views will be of assistance to the Committee in its deliberations. Our concern is that mental retardation research has been seriously jeopardized by recent financial and policy developments affecting NICHD.

The cost to society of mental retardation and the other developmental disabilities in human and material terms is staggering. Although we hear that statement often, it is my considered judgment that no other human affliction creates so much suffering at such great cost. It is estimated that one of six families is directly affected by mental retardation. In the United States, at this very moment, about 6,000,000 people are mentally retarded, many of whom are seriously disabled. The financial commitment required to care for a severely retarded individual for a lifetime is well over $1,000,000 today. Together all levels of government pour billions of dollars into a large variety of services. We must remember that mental retardation and the other developmental disabilities, if uncorrected, persist over a lifetime and that many thousands of babies will be born in this new decade who will never have a chance, for even part of their lives, to share in the ordinary opportunities and challenges that we here enjoy. More than that, they will be unable to contribute to the common and shared goals and aspirations of our society.

Inevitably, the Congress must make hard decisions as to how scarce dollars must be allocated to achieve the greatest good for our people as a whole. The human condition presents an enormous and bewildering variety of afflictions, problems, and suffering all of which demand our attention and concern. But, I submit to you that none is as tragic to our children as mental retardation and the other developmental disabilities. And none has such a great potential for a favorable cost benefit payoff from a relatively minimal investment in research.

The Congress by its actions in the past has been responsive to the needs of the mentally retarded and other developmentally disabled people. Legislation passed in the early '60s paved the way for the establishment of a research enterprise that is unparalleled anywhere in the world. The twelve National research centers, created by Public Law 88-164, are a unique intellectual resource that has contributed and continues to contribute measurably to the welfare of society. Many investigators outside the Centers, funded through regular and program project grants, also have added significantly to our scientific understanding of developmental disabilities. Training grants, both at the predoctoral and post-doctoral level, have created for the first time in our history a pool of extraordinary scientific talent committed to the solution of a particular health problem. Within less than twenty years we have put into place a system that is effective and that has already proved that it is worth the cost. This has been really a remarkable success story in that the original intent of Congress was explicitly fulfilled in practice.

However, times have changed and in recent years a slow but steady erosion of support for research in developmental disabilities is evident in the policies and funding patterns of NICHD. Although NICHD is not the only agency that supports research on problems directly related to developmental disabilities, it is the one agency with the historical and clear Congressional mandate to carry out a comprehensive basic research program in mental retardation. NICHD not only has the responsibility for the twelve National Research Centers, but through its various programs has been committed to a broad spectrum of research support on problems of developmental disabilities, most notably mental retardation.

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Since 1975 researchers have viewed with increasing alarm the deterioration of commitment by NICHD to support of research in mental retardation. In particular, core support funding to the twelve research centers has been severely affected. Part of the problem, of course, is that research is subject to inflationary pressures. But the significant considerationis that the programs of the Centers have suffered more than other programs. New programs, inaugurated without additional appropriations, must inevitably be funded to the detriment of existing programs. Increased support for other activities can only be accomplished by making less money available for program projects, regular project, and research training grants. Research support for behavioral studies in particular has been the victim of shifting Institute priorities.

These issues were put into clear focus by Dr. Edward Zigler of Yale University in an editorial that appeared in the July 1978 issue of the American Journal of Mental Deficiency. After reviewing the history of NICHD, its legislative background, and its current policies, he concluded that mental retardation research is in a "crisis," to use his word, and that if significant and fundamental changes are not soon forthcoming the entire structure created so deliberately by Congress together with the scientific and university communities is in serious danger of collapse. In the two years since Dr. Zigler prepared his editorial the situation has continued to deteriorate and the crisis has worsened.

ANALYSIS OF FUNDING PATTERNS

In order to investigate these concerns Dr. Gershon Berkson of the University of Illinois and I recently conducted an analysis of NICHD funding patterns as these relate to mental retardation. Using data made available to us from the Institute we endeavored to ascertain funding trends for mental retardation research over a ten-year period. One of the first problems we encountered had to do with the very definition of mental retardation research. Currently Institute policy seems to favor an extremely broad definition of research that does not immediately impact on the lives of mentally retarded people. Of course, the administrative advantage of a broad definition is that the same projects can be counted in a variety of ways depending upon one's purpose. In any case, given this broad definition and counting the projects referred to us as "mental retardation" by the Institute, the NICHD itself indicates that there has been a shift in priorities away from mental retardation research since 1974. Using as baseline the total budget of the Center for Research on Mothers and Children and calculating mental retardation research as a proportion of that budget, we find that for the last six years mental retardation research programs have steadily eroded. Graphing the results we see a regular and continuing decline in funding for three major categories: a) Total mental retardation related research by the Center for Research on Mothers and Children, b) Grants from the Mental Retardation and Developmental Disabilities Branch, and c) Core support for the twelve Mental Retardation Research Centers. The overall decline since 1973 in support for mental retardation research is about 13% and shows every prospect of continuing its downward trend. Although it is true that absolute dollars have increased over that period for mental retardation research, it is also true that in 1980 dollars our research capability is about half of what it was in 1974. Of course we are all aware of the terrible impact of inflation on all programs, but I wish to stress the point as strongly as I can that, in relative terms, mental retardation research has suffered the greatest erosion. It seems to be a matter of Institute policy to take from mental retardation to cover other programs.

When we employ a more stringent definition of mental retardation research that includes only those projects clearly and expressly focused on mental retardation as a categorical entity the picture is even more dismal. In that sense the decline in support for mental retardation research since 1974 has been precipitous. In 1971 mental retardation research comprised about 33% of the research budget of the Center for Research on Mothers and Children. By 1979, mental retardation had dropped to approximately 12% of the total.

Another fact that has become abundantly clear from the analyses conducted by Dr. Berkson and me is that NICHD is shifting more and more toward biomedical and away from behavioral research. In 1971 the relative proportions

of NICHD biomedical and behavioral grants were 72.5 percent and 27.5 percent, respectively. In succeeding years the discrepancy has steadily widened until the differential is now 79.5 percent versus 20.5 percent in favor of biomedical research.

A manifestation of the decline is not only budgetary, but is reflected in a reduction in personnel in the Branch and a lowering of status of this administrative unit within NICHD. Although officials in the Mental Retardation and Developmental Disabilities Branch have attempted to counter the downward trend in mental retardation research support, they do not operate at the level of policy-making and have not been in a position to influence key decisions of the Institute.

This trend causes us great concern from two points of view. First, NICHD has had from its very beginning the clear and explicit mandate from Congress to support basic research on problems of human development, including the development of behavior. Without systematic research concerning the nature and course of behavioral development, most of the significant health problems of children can never be adequately addressed and corrected. As important as biomedical research is, it only represents one side of the developmental coin, so to speak. There must be a corresponding and balanced effort to support behavioral research as well. Current policies of NICHD clearly favor biomedical research at the expense of behavioral research.

A second reason for our great concern over the disparity between biomedical and behavioral research support is that mental retardation is first and foremost a problem of behavior. The most widely employed definition of mental retardation, that given in the Manual on Terminology and Classification in Mental Retardation, published by the American Association on Mental Deficiency is as follows: "Mental retardation refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period" (page 5, 1977). This definition is accepted by virtually all workers in the field and represents the collective wisdom of a century of experience. It will be impossible to attack the problem of mental retardation without directly addressing those behavioral issues that are fundamental to the definition.

It is clear to me from our analyses that the high value placed on mental retardation research that was so central in the creation of the Institute in the mid-'60s no longer exists. I do not think this trend is consistent with the initial and continuing intent of Congress. To quote from the record of the Senate Committee on Appropriations, August 16, 1978: "The Committee is aware that mental retardation has a large impact on our Nation's population of both children and adults, and strongly supports research that will contribute to the prevention and amelioration of this problem" (page 55). Again, on June 13, 1979: "The mental retardation program within the Institute stresses prevention of mental retardation and when prevention is not possible, ways of developing the person's skills and well-being. The Committee strongly supports the efforts of the Institute and directs that a substantial portion of the increase above the 1979 amount be used in this high priority area" (page 60).

Although it is obviously possible to construe fiscal data such as these in a number of ways, I must conclude that, in fact, mental retardation research is in a period of retrenchment and that, if current trends are not reversed, the national commitment made in the 1960s to the alleviation of this social problem will have become an empty promise. The goals for the Institute articulated in the legislation that created the Institute cannot be met with the resources now available.

Very simply stated these goals are to develop methods to prevent and to ameliorate mental retardation, to enhance the quality of life for all those who are afflicted. The goals may be straightforward, but unfortunately the problem of mental retardation is one of such overwhelming biological, psychological, and sociological complexity that it will not yield to simplistic and quick solutions. This is not to say that scientists have been unable to penetrate some of the mysteries of mental retardation. The truth is that we made some very significant advances in our understanding of both the biomedical and behavioral aspects of mental retardation and much of this knowledge has

been put into practice with outstanding results. For example, we now understand the biochemistry underlying some specific genetic disorders and through proper intervention we are now able to create environmental conditions where these people, who only two decades ago would have been profoundly retarded, are able to live normal lives. We can identify in utero through amniocentesis babies who have Down's Syndrome thus providing parents meaningful and humane choices. A recent study reported in the State of New York has shown how dramatically the incidence of Down's Syndrome can be reduced by this intervention. Studies of learning have enabled us to develop educationally-based procedures for highly effective intervention early in the life of the at risk child--educational procedures that spell the difference between impaired and normal development. One of my own areas of research concern is that of severe self-mutilation among retarded children, a condition that occurs with appalling frequency and which can produce permanent injury and even death. A few years ago the primary method of dealing with these unfortunate children was to restrain them permanently, either mechanically or with drugs. Now, the behavioral technology is available that enables clinicians to intervene with a high degree of effectiveness in many cases. There are but a few examples of research-derived technology that has greatly improved the lives of many of our people. Without the financial support provided by Congress, little of the research that has enabled scientists to discover new methods of intervention would have been possible.

My colleagues and I realize there are many requests placed before this Committee for increased funding of programs that are socially important and worthy of support. We also recognize that in this period of economic uncertainty and with the current climate of fiscal restraint that large increases in research funding are not likely to occur. Nevertheless, we do respectfully encourage Congress to increase appropriations to the NICHD to a level that, at the minimum, ensures the continuity of research and research training programs and at a level that begins to redress the decline in funding for mental retardation research about which I spoke earlier.

But aside from this general consideration we urge the Committee to focus explicitly on certain research issues that, in our view, cannot await better times and which, if not addressed now, will take a terrible toll, both in human and material terms. By way of background, Dr. Berkson and I contacted over 100 active researchers and clinicians in the field of mental retardation in order that we might identify the major research issues that: a) will have the largest potential impact on the greatest number of retarded people, b) will produce relatively rapid payoff in terms of improved care and habilitation, and c) which would have a highly favorable benefit to cost ratio. The results of this survey yielded some highly consistent patterns which I should like to address briefly. In all, four areas of research were identified which meet the criteria listed above. This is as close to a professional consensus as one could expect to find in any field of scientific endeavor as diverse and complex as mental retardation. It is our hope that the Committee will see the virtue in these research priorities and, in its charge to NICHD, make specific reference to the need to conduct research in these areas.

THE IMPACT ON INDIVIDUAL DEVELOPMENT AND BEHAVIOR OF ALTERNATIVE SETTINGS

Since the beginning of formal services to mentally retarded individuals in the mid 1850's, we have seen enormous swings in professional and public attitudes concerning the means by which this population can best be served. These shifts can be attributed, in part, to the relative emphasis placed on the welfare of the individual as contrasted against social and community needs.

Now the dominant theme is to integrate, as fully as possible, mentally retarded people into the local community. This national commitment has found primary expression in the goals of reducing numbers of individuals in public residential facilities and the provision of public education to all children, regardless of the extent or nature of their disabilities. The movement toward community integration rests upon the principle of normalization, with the goals of placing retarded people in least restrictive environments in order to a) increase the complexity of their behavior, b) increase their ability to control the environment, and c) enhance their human qualities. While in the past the institution was the only real alternative to family care, we now see

great interest in the development alternative arrangements including: a) foster homes, b) group homes, c) sheltered apartments, d) sheltered work shops, e) day care centers, f) nursing homes, g) boarding houses, and h) activity centers.

As a nation we are now investing hundreds of millions of dollars in the development of various community alternatives. The enormous investment by the federal government in these programs comes through the ICF/MR Title XIX program, Community based Title XX programs, and Public Education, Special Education Funds, PL 94-142, ESEA funds. Federal courts across the land have also forced state agencies into the position of creating more community alternatives to institutionalization. Over the past decade, beginning with the landmark decision of Wyatt vs. Stickney in Alabama, the momentum to protect the constitutional rights of retarded people has become a virtual judicial stampede.

Despite the widespread enthusiasm for deinstitutionalization and mainstreaming, the fact remains that we are operating in a virtual knowledge vacuum as to how to these goals can best be achieved and what their effects are. These movements have proceeded without benefit of any significant empirical base. The fact that NICHD currently supports only two relatively small research projects on these issues is testimony to the lack of commitment regarding the formulation of public policy on the basis of documented and tested procedures.

A number of problems and obstacles have been encountered in the deinstitutionalization process. Community integration often does not work out well. In 1977 the Comptroller General of the United States reported to the Congress in great detail the myriad of problems and questions concerning placement of mentally disabled persons in the community. New living situations may be less desirable than the institution in many respects. Often people cannot make the transition and have to return to the institution. Reinstitutionalization occurs at alarming rates. There is evidence, moreover, that many individuals taken from public institutions and moved into the community find their way into the correctional system. New environments are often similar to the institutions from which the retarded persons were transferred. This situation can, in part, be traced to the lack of empirically-determined criteria for successful community placements.

Systematic data on the adjustment of retarded individuals in community settings, as well as the specific adaptive problems encountered by these individuals, is a necessary step in slowing or stopping the "revolving door". At the same time, data about the nature of these residential placement units are needed, since lack of environmental support has been implicated as an important factor in unsuccessful community placement.

We can be fairly sure that different behavior patterns can be functionally related to social and physical environmental characteristics. Community-based residential facilities differ considerably from one another in the nature of their physical and social climate. These environments can vary on a number of dimensions (e.g., social climate, client-staff ratios) which can affect the quality of support provided to individuals. Systematic research comparing the various residential environments and relating them to successful placement over time is needed. What is it about the value of these alternative residential environments that might mediate placement? How does the quality of those new environments affect a deinstitutionalized person? Are these community residential facilities really better than institutionalization for all retarded persons?

A number of other factors must be taken into account when placing the mentally retarded in community residential environments. The possibility must be considered that mentally retarded individuals might not be able to transfer some of the skills they have acquired in the institution to a new environment. Community residential environments need to be better understood to increase the probability that appropriate behaviors will generalize from the institution to these alternative settings.

Some maladaptive behaviors are learned through interaction with specific aspects of one's environment. For example, the institutionalized retarded person may have learned that aggressiveness "pays off" more in terms of rein-

forcement from the human environment. Similarly, it is possible that he/she will have adopted the motivational deficits characteristic of "learned helpfulness". One must also consider the quality of the life situations individuals will have in the communities to which they return. Finally, decentralization of services in the community complicates the evaluation of the impact of community placement upon the development of mentally retarded individuals. For example, the use of short-term care facilities for the temporary relief of families as a supplement to care of the individual in the community presents another environment which must be assessed in evaluating successful placement.

Successful integration into the community also depends on the number and types of community services, both habilitative and rehabilitative, that are available to the mentally retarded individual. At the present time, the quality of services is variable. Additionally, the limited range of available services are among the problems encountered by a deinstitutionalized person. We have no systematic data base upon which to organize these services. The result is a haphazard approach that not only is often ineffective and inefficient, but is enormously costly.

Obstacles encountered in developing community mental retardation services include problems with social service agencies, education, lack of availability of medical services for the developmentally disabled, and community resistance. Even when habilitative and rehabilitative services are available, mentally retarded individuals may not receive the treatment necessary (e.g., to increase adaptive behaviors) because of the distance from the residential setting, cost of transportation, and restrictive operating hours. Although the relationship between successful community adjustment and the number and type of community facilities is not established, evaluation of this set of variables relating to successful deinstitutionalization is clearly needed. In short, at the present time we do not even know how the hundreds of million of dollars are spent on services for the mentally retarded actually affect the lives of these people. The need for systematic research to answer these and other question is desperately needed.

More specifically, the types of studies needed in this area include:

a) Identification of behavioral and personal traits of the individuals and the characteristics of the enviornment that produce success or failure in community adjustment. The question of multiple handicaps must be addressed in this context. It is important to determine how environmental settings are similar and how they differ, and which for the individual is the most conducive to the development of self-sufficiency.

b) Research that examines the lives of retarded people over time, in the context in which those lives are lived, and from the point of view of the retarded themselves. We need to know, from a longitudinal perspective, how alternative settings affect the development of self-concepts, patterns of interpersonal interaction, maldaptive behavior, adjustment, cognitive development, and coping skills among different subgroup of retarded persons. We need life-span studies of the mentally retarded. The urgency of such knowledge increases as deinstitutionalization proceeds. As a telling example, we do not even know something as obviously relevant as the life-expectancy of significant subgroups within the retarded population.

c) The effect of mainstreaming on teacher, parental, peer attitudes, expectations and perceptions. We need to develop a better understanding of stigma and labelling processes and how to modify these. Since mainstreaming is not being applied uniformily, the effects probably differ in various school systems. It is important that evaluative studies of these various programs be undertaken immediately so that we have reliable data for future program development.

d) The degree to which opportunities are actually provided to subgroups of the retarded and the relationship of such "normalizing" experiences to subsequent behavior and development, family attitudes, and community acceptance.

e) The degree to which positive attitudes within the community, including those of parents and teachers, can be fostered. Research is needed regarding

the education of others concerning the myths and realities of working and living with the mentally retarded.

f) The administrative climate and bureaucratic process are a significant part of the environment and have profound effects on individual performance and adjustment. Among the issues that should be investigated include: factors that facilitate or impede inter-agency cooperation and coordination; service delivery variations and their effects on the individual; facility standards and their relationships to administrative accountability versus resident care and well-being; studies of service organization and their adaptability to client needs. Decisions to implement (or terminate) programs is based on political parameters or economic fluctuations. Funding of evaluation projects which could identify and use behavioral measures to rate the performance of agencies would assist in developing a more rational and sensitive budget methodology.

AMELIORATION AND MENTAL RETARDATION

Although there are some notable exceptions, amelioration of mental retardation, principally, requires attention to the teaching and development of complex behaviors--those that define cognition, understanding, language. Even in those cases where a specific etiological factor can be unequivocally identified as the causative agent, the only meaningful interventions are usually educational in nature. Thus, amelioration of mental retardation means intensive training to help people solve problems, to think more clearly, to communicate effectively, and to approach new situations in adaptive ways.

Enormous sums are spent each year in this country on programs of educational intervention. There are hundreds of programs for infants, children, and for adults, some funded by private groups and most by public agencies at all levels of government. Education is our best hope and we have, quite appropriately, invested heavily in this strategy. Yet, the problem with all such programs is that they are based largely on guesswork about what is important to learn and what is the best way to learn. That is, we do not know a great deal about either the content of adaptive knowledge or about the processes by which people learn.

What is it that retarded people should know in order to behave "normally"? What is apparent to all laymen and psychologists alike is that it is unlikely that we learn to respond in each new situation independently of all other situations. What we do believe is that people learn general rules or principles concerning domains of behavior--learning about spatial relationships, about time, about enumeration (counting, social concepts concerning reciprocity, giving and expectation of return, contracts) and so on. Research is needed that involves identification and verification of these domains of intellectual development or knowledge. We need to know how these principles are learned and what is responsible for their generalization.

But even given that we might know what to teach retarded people, we do not know clearly how to teach them. We are just beginning to understand the processes whereby people learn--the perception, cognitive operations and linguistic contributions to learning and how these processes have been impaired in retarded persons. Without knowing how or what retarded people see and hear we can't design appropriate materials. Without knowing how they think, we can't arrange their experiences to match their capabilities.

Because we do not know to what extent language plays a role in learning, we do not know to what extent to emphasize language learning. Language is obviously very important to appearing intelligent. We are going to continue to have to invest in the teaching of language--its comprehension as well as its production.

In short, research on effective intervention is of the highest priority. This includes research which contributes to our knowledge of how retarded people learn and what they can learn. Translated into psychological topics, this means research on cognition, perception, learning, and language development. Fundamental research and development of methodologies for understanding the processes that constitute cognitive development and dysfunction are urgently needed, at all levels of development from early infancy to adulthood, from

profound through mild mental retardation. If we are to make a serious attempt at facilitating intellectual behavior in retarded individuals, then the emphasis must be placed on evaluating, understanding, and improving their cognitive functioning because it is this deficiency that, more than any other, is the basis for their status as retarded invididuals. In addition to the foregoing, the following are areas in which we recommend increased research commitment.

Behavior modification and the severely/profoundly retarded. We need to test existing behavior modification procedures (which have proved valuable with small numbers of selected subjects) with much larger samples of subjects from this population. Also systematic longitudinal studies directed at developing multiple behavioral skills (e.g., self-help, language, social, academic skills) need to be conducted.

Behavior modification in the classroom. Both the technologies for teaching teachers of the retarded and teaching the retarded academic skills need to be extended and evaluated. Cognitive behavior modification procedures now used with normal children need to be examined with regard to their effectiveness with EMR and TMR children.

Programming generalization. More work needs to be directed at developing a technology of generalization, that is, techniques which not only affect direct, short-term changes in behavior, but which also result in changes which are maintained over time and generalized over situations. In this connection, we need research for the development of procedures to introduce and fade instructional prompts, particularly with respect to stimulus control and cue utilization. Research should be conducted on the problem of self-monitoring of learning and the adaptive application of learning strategies.

Reading. Research needs to be conducted on the cognitive processes that undergird performance in the area of reading.

Intermediate research. The knowledge we do have on cognitive functioning needs to be integrated with the serving of the retarded on a daily basis in the school, home, and work settings. Intermediate research needs to be conducted that would focus on extending basic research findings to application.

Perception, memory and thinking. At the level of basic research, we need to understand how perceptual (particularily vision and audition), memory, and thought processes function in different types and subgroups of retarded people and how these processes interact to determine simple and complex behaviors.

ENVIRONMENTAL HAZARDS

Within the past decade we have seen an increasing concern with the effects of various environmental hazards, particularly pollutants, upon physical health. We can now assume that a multitude of environmental factors are associated with increased risks of cancer, cardio-vascular and respiratory diseases, birth defects, chronic degenerative disease, to name the most commonly identified. The identification, measurement, and control of environmental factors affecting health must be considered a major challenge facing the scientific community for the next decade and beyond.

It would be difficult to exaggerate the role of behavioral science in this context. On the one hand, environmental hazards do not work their effects in an all or none fashion, but no doubt can best be represented along a bio-behavioral gradient where at one end the outcome is death and at the other effects are expressed in subtle behavioral changes that escape detection by conventional medical procedures. Available data, in fact, suggest that for every instance of clear biological teratogenesis there are many more instances where detrimental effects are seen in various behavioral indices; hyperactivity, lethargy, retarded cognitive development, learning disabilities, impaired motor coordination, appearance of maladaptive responding, and reduced affect, to name but a few. As an example, we now can be sure that low and continuous exposure to lead produces behavioral alterations without any clear evidence of brain pathology. It has been estimated that as many as 600,000 American children under 6 years of age have significantly elevated blood lead levels. Many of these children have profound developmental impairments. Recent

evidence suggests that sub-toxic levels affect many more children whose symptomatology consists of behavioral alternations. The fetal alcohol syndrome is another example in which the most likely outcomes of exposure to an intoxicating agent are to be found subtle, but enduring and significant behavioral changes. Recent observations suggest an incidence of fetal alcohol syndrome between 1 and 2 per 1000 live births, with partial expression in perhaps 3 to 5 births. When more subtle effects are considered, there is probably a more widespread prevalence of the problem than has been appreciated.

A quite likely possibility is that some of the most significant hazards associated with environmental hazards have not received significant and intensive scientific scrutiny because the alterations are of a behavioral, not of a biological nature. Virtually all money expended by the NICHD on this problem is concerned with gross teratogenic effects of chemical intoxicants. Consequently, we have only rudimentary knowledge of the specific effects of crowding, noise, prenatal emotional stress, smoking, and so on upon the psychological development of the child. It remains a matter of conjecture as to whether the millions of retarded individuals for whom there is no known medical etiology owe their condition to the pernicious operation of environmental factors. That is one side of the behavioral coin; the other lies in the consideration that most enviornmental hazards result from the behavior of the people. To the extent that we can successfully alleviate or eliminate enviornmental hazards that produce developmental disabilities we must alter behavioral patterns. Thus for example, knowing that ethanol has detrimental effects upon the developing fetus is only part of the picture. Once the behavioral effects are known, then we must explore methods that can produce significant changes in alcohol consumption.

We advocate greater support for research concerned with the effects of environmental hazards on behavior. This research should be conducted with animal models in experimental situations and with children in natural settings. A special program within the Center for Mothers and Children should be established with the mission to encourage and coordinate research initiatives in this area. A parallel research program should be initiated with the objective of finding methods of reducing hazards to children that are the direct result of own and others behavior.

Statement of the American Academy of Pediatrics

The American Academy of Pediatrics is grateful for the opportunity to submit for inclusion in the hearing record our comments on the fiscal year 1981 appropriations directly affecting the health and well-being of pregnant women, infants, children and adolescents. This subcommittee has an enviable record of support for adequate funding for maternal and child health programs which attests to your commitment to improving the quality of life for this segment of our population. The pediatric community is most appreciative of your past efforts and we hope that these comments will be of assistance as you consider the proper appropriation levels for these programs for FY 1981.

The American Academy of Pediatrics is a member of the Coalition for Health Funding (CHF). As such, we wish to indicate to the subcommittee the Coalition's recommendations regarding next year's funding levels for federal health programs which it has presented to you. Our testimony comments on the need of those programs in the Department of Health and Human Services with which the Academy is most directly and knowledgeably involved, as well as several programs in the Department of Education. The recommended funding levels offered in this testimony respond to the Administration's budget proposal sent to Congress on January 22. We are confident that the forthcoming recisions from the Administration will not impede this subcommittee in its effort to obtain the necessary funding levels which will ensure maximum delivery and quality of health care services.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

I. Title V Maternal and Child Health and Crippled Children's Programs

Title V of the Social Security Act, Maternal and Child Health and Crippled Children's Programs, provides Grants to States to enable the States to extend and improve services for promoting the health of mothers and children. These programs have played a key role in reducing maternal and infant mortality and establishing new and better ways of delivering health care for mothers and their children. While the funds do purchase direct care, their main purpose is to assess health needs and resources and plan and demonstrate improved high quality delivery programs. Title V funds also provide training for hundreds of health professionals in the care of crippled or handicapped children and specialized practitioners for maternity and newborn care and research in the area of health services delivery.

The Academy wishes to offer a very strong objection not only to the level of appropriations requested for Title V programs under the Administration's budget proposal for FY 1981, but to the means proposed to implement Title V as well. We believe the proposed budget to be a very serious conflict with the mandate of Title V and the intent of Congress.

The President has requested for Title V programs only $391,543,000 of a possible $399,864,200 authorization for FY 1981. It is proposed that $360,500,000 be provided as formulas Grants to States (a 4 per cent increase over FY 1980) and $31,364,200 be provided to fund Training and Research activities (a $478,000 decrease from the FY 1980 appropriation of $31,843,000). Neither of these appropriation levels had been adequately explained by the Administration, and the major reductions that these low funding levels will mandate cannot be defended. Our major concern and recommendations are as follows.

The Academy recommends that the Title V programs be funded at the full authorization level of $399,864,200. Research and Training activities should receive $31,364,000 for University Affiliated Facilities and Pediatric Centers. The formula Grants to States should receive $368,500,000 with directions from Congress that no new projects are to be specified and that these funds will be allocated on a formula basis as required by the Title V mandate. The Academy's proposal of a 6 per cent increase is conservative, and unlike the Administration's proposal, it does offer a hedge against spiraling inflation and ultimately secures the maintenance of the existing program. Current Title V programs at the state level have been struggling to exist, with a real decrease in program funds over the past two years. Earmarking for new projects, as is the current practice, is ill advised.

II. Sudden Infant Death Syndrome

The Sudden Infant Death Syndrome (SIDS) program provides information and counseling to affected families. SIDS, which occurs between 7,500 and 10,000 times annually, is the leading cause of death in infants less than one year old. The emotional trauma and grief experienced by parents and other family members following this type of death is compounded by the unexpected and silent nature of the death of an infant presumed to be healthy, as well as the present inability of medical science to explain the cause. The potential for additional guilt occurs when sudden infant deaths are confused with neglect, child abuse, or "mismanagement" by well-meaning emergency workers, health care providers, family members or others.

For fiscal years 1978, 1979, and 1980, the SIDS program was funded at a constant level of $2,802,000. For FY 1981, the SIDS program is authorized to be funded at $7,000,000. The Academy recommends that the SIDS program receive an appropriation of $4,000,000 to establish SIDS programs in all fifty states. Currently only thirty-three SIDS projects are funded.

III. Genetic Information and Counseling

The Genetic Diseases Act, first passed by Congress in 1976 and re-enacted in 1978, established a program of genetic testing and counseling and the development and dissemination of information and educational materials relating to genetic diseases. In fiscal year 1978 Congress for the first time appropriated funds for this program in the amount of $4 million. To this appropriation $3,578,000 was added for sickle cell testing and education centers funded under this section of the appropriations law, for a total appropriation of $7,578,000. In FY 1979 these programs received $7,567,000 and in FY 1980, $14,567,000. This figure includes $3,000,000 for 25 hemophilia diagnostic and treatment centers serving 2,500 persons; $3,567,000 for 22 sickle cell screening and education clinics serving 183,000 persons; and $8,000,000 to fully fund the existing 21 areawide genetic systems serving over 630,000 persons. The Academy recommends that $21,000,000 be appropriated for these programs for fiscal year 1981, a figure which would fund 45 areawide genetic systems, an increase of 24 over those now funded.

At the present time, funds are lacking in many States to provide a full range of genetic testing and counseling services. Tests for genetic diseases can reduce the burden of birth defects by allowing prompt therapy before irreversable damage occurs. Prenatal diagnosis offers parents the options of terminating a pregnancy which would result in the birth of affected offspring or of preparing for such a birth. Recent data indicate that more pregnancies were undertaken and healthy babies delivered, as a result of prenatal diagnosis; its availability encouraged women at risk for birth defects to undertake the pregnancy. Carrier testing informs individuals of their risk of having affected offspring. Counseling is essential if individuals and families are to understand the meaning of genetic tests, their results, and the options available.

For the past two years, forty-one grants were requested under the Genetic Diseases Act; only twenty-one received funding, and then at less than the amount requested. Increased funding would allow more grants to be approved, at higher amounts. In addition, there are still many unknowns regarding the optimal way of providing genetic services. Consequently, increased funding would allow adequate planning and evaluation projects to be undertaken both on the part of individual States and federal agencies.

IV. Migrant Health Program

The Migrant Health Program improves the availability and provision of adequate health care services for migrant workers, seasonal farmworkers, and their family members. The federal government has been the only source of health services for these impoverished Americans, since they do not qualify for state programs. Located in areas with the highest concentration of migrant and seasonal farmworkers and their families, migrant health centers and projects provide diagnostic, treatment, and consultant referral services in general medicine, laboratory, x-ray, pharmacy, preventive dental and vision services, and, where appropriate, certain environmental health services. Only a few centers are able to offer supplemental services which include hospitalization, rehabilitation, and mental health care.

Statistics prove that the incidence of communicable diseases, accidents, infant mortality and need for hospitalization among migrant families far surpass those of the general population. Insufficient funds earmarked for migrant hospitalization benefits, have combined with disincentives for Medicaid participation to allow participation of only 18 percent of eligible migrant and seasonal worker families. Current funding levels are insufficient to provide the primary and supplemental health services required under P.L. 94-63 to be offered to all eligible migrant workers and their families, regardless of their ability to pay.

The Academy recommends that $47,640,000 be appropriated for fiscal year 1981. This figure represents an increase of $7,940,000, or 20%, over the 1980 level. This increase would: 1) more realistically respond to the

health needs of an increased number of migrant families that are expected to enter the stream, 2) provide funds to explore and develop linkages with a migrant educational tracking system for including health records, and 3) provide limited funds for emergency inpatient medical care when no other resources are available or until resources can be identified.

V. Center for Disease Control Project Grants

A. Venereal Disease Control and Prevention

The purpose of the venereal disease control and prevention program is to reduce morbidity and mortality from venereal disease. The program provides support to States and localities for gonorrhea screening, controlling the spread of penicillinase, syphilis screening, patient contact referral services, preventive education services, and encouraging the involvement of the private medical community in the control of venereal disease.

Since the federal program began in 1938, all complications from syphilis have declined, infant deaths from syphilis have declined 99 percent and the number of all deaths caused by syphilis have declined 98 per cent. Gonorrhea remains the most often reported disease. However, the incidence of reported cases of syphilis and gonorrhea has recently been in decline. Thus, this program must be kept operating at its current level of effectiveness to assure that this decline continues. Therefore, the Academy recommends a $45,200,000 appropriation for this program for fiscal year 1981, a 13% increase over its fiscal year 1980 appropriation, to counter the impact of inflation.

B. Immunization Programs

An extremely successful program is the federal government's effort to immunize children against the diseases of measles, polio, diptherea, rubella, tetanus, mumps and pertusis. The goal of the CDC childhood immunization program has been to protect at least ninety per cent of the nation's children against these preventable diseases; for all except mumps (which is not required in all States), this goal has been achieved. However, to assure that 90% or more of all children continue to be immunized, this program's budget must at least keep pace with inflation and be maintained in real dollars. Therefore, the Academy recommends that the immunization program receive a 13%, or $3,189,000, increase over its fiscal year 1980 appropriation in fiscal year 1981 for a total of $27,721,000. We would expect, however, that should the birth rate increase in the future, as is expected, the Center for Disease Control will request increases in the appropriation for its immunization program sufficient to not only keep pace with inflation but to assure that at least the 90% goal is always achieved.

C. Rodent Control

The Rodent Control program of the Center for Disease Control provides grants to fund rodent control projects. It also provides technical assistance to State and local public agencies in the provision and coordination of services to reduce rat infestation. For fiscal year 1979, $13,000,000 was appropriated for this program; for fiscal year 1980, $14,000,000 was appropriated. The Academy recommends that for fiscal year 1981, $15,000,000 be appropriated.

This program has proven itself effective in reducing rat infestation with a minimum of federal funds and intervention. Agencies which have established both sound programs and local financial support to combat this problem are given first priority in receipt of these CDC funds. Over two-thirds of all program costs are paid by States and localities, with that share steadily increasing. A $15,000,000 appropriation--only $1,000,000, or 7%, more than the fiscal year 1980 appropriation--would increase by five the number of communities

receiving federal asssistance and would secure a rat-free living environment for 95,000 more people.

D. Lead-Based Paint Poisoning Prevention

One of the Center for Disease Control's most successful programs is its effort to reduce the incidence of lead-based paint poisoning. As noted in Senate Report 96-247 accompanying H.R. 4389, the fiscal year 1980 appropriations bill for the Department of Health, Education, and Welfare, "lead-based paint poisoning is a particularly cruel affliction because of the impact it has not only on the child, in terms of shortened lifespan and increased risk of mental retardation, but also upon the family as well." Through its assistance to communities and private non-profit entities in the development of screening, health education and follow-up programs and through its assistance to and coordination of other child health programs involved in lead-based paint poison prevention activities, this program since its inception has significantly reduced the number of occurences of serious cases of childhood lead poisoning. With its relatively modest annual appropriation--$11,250,000 in fiscal year 1980--this program has proven itself to be not only one of the nation's most successful preventive health programs, but also one of its most cost-effective.

However, while lead-based paint has been removed from thousands of houses and while thousands of children have been screened, treated and cured of lead-based paint poisoning, the problem still remains. While poorer inner-city areas are cleared of lead-based paint, the potential for resurgence of cases of childhood lead poisoning due to this paint still exists. As marginal areas are renovated and families move into these houses, the cycle of lead-based paint poisoning continues. In addition, more affluent areas are witnessing occurences of this poisoning, occurences which more affluent communities previously viewed as an inner-city problem. Therefore, for the continued protection of children in all communities against the massive residual hazard of lead exposure, this program should receive an appropriation for fiscal year 1981 that would allow it to continue at its present level of effectiveness. Thus the Academy recommends that an appropriation of $12,712,500 be provided for FY 1981--$11,250,000 as provided for FY 1980 plus an additional $1,462,500, or 13%, to compensate for inflation.

VI. Office of International Health

The Office of International Health provides the framework for the development of policies and priorities in international health for the Public Health Service and coordinates international activities across the six PHS agencies, including the management of some twenty bilateral agreements; serves as the principal staff resource for the Subcommittee on International Health of the Development Coordinating Committee, which has been charged with moving forward on the President's international health initiatives; bears primary responsibility for programmatic relations between the U.S. and World Health Organization; and assists the Agency for International Development in conducting bilateral and regional projects with less developed countries in health, family planning, and nutritional activities. The activities of this office deal directly and indirectly with international child health.

For the operations of the Office of International Health, $652,000 was appropriated in fiscal year 1979 and $700,000 was appropriated for fiscal year 1980. The Academy recommends that for fiscal year 1981, $1,392,000 be appropriated to allow for increases in costs due to inflation and to allocate $600,00 for the initiation of new programs. Of this $600,000, the Office would be allocated $50,000 for various expert consultations. Three other new programs would be initiated, as follows:

U.S. - Mexico Border Initiative - $200,000

For the past 36 years there have been mutual initiatives for health improvement of citizens of both countries who live along the border. This has been handled by the U.S.-Mexico Border Health Association, supported by the Pan-American Health Organization (PAHO). The border area is one of the poorest areas of our country with evident health problems of children. In the past most funds have come from local, state, and county governments, beside PAHO. These new global funds would take the form of core support for working groups to focus on particular problem areas. Among the proposed program areas, those dealing directly with children include: control of diseases preventable by vaccination, tuberculosis control, programs on fluoridation and chlorination, and maternal and child health.

The international health money would be used as a stimulus for local authorities to begin work in the above areas.

Policy Studies Related to Achieving the World Health Organization (WHO) Goal of "Health for All by the Year 2000" - $200,000

The theme of health for all, meaning health care for all has its priority in the care of mothers and children. Besides the direct monetary support for WHO by the U.S. government, the U.S. has a role in determining where the action program should be concentrated in order to reach the goal. This money will fund studies which will be used as the basis of policy setting.

Training in International Health - $150,000

This money would be utilized to encourage training in international health at schools of public health.

VII. Adolescent Pregnancy Services

The Adolescent Health, Services and Pregnancy Prevention and Care Act was passed by Congress in October 1978. It creates a new program to establish better coordination, integration and linkages among existing programs to expand and improve services to prevent pregnancies, to provide proper care and to enable the development of a productive life. The Act authorizes appropriations of $50 million for FY 1979, $65 million for FY 1980, and $75,000,000 for FY 1981.

Appropriations for this program in FY 1980 totaled $17,500,000, and it is still hiring staff and attempting to get off the ground. The Administration has requested $17,500,000 for FY 1981. While supportive of the goals and objectives of this program, the Academy believes the Office of Adolescent Pregnancy Programs must demonstrate its effectiveness and the effectiveness of the program itself to some degree before significant expenditures are made. For this reason, the Academy recommends that $19,500,000 be appropriated for FY 1981.

VIII. National Institute of Child Health and Human Development

The National Institute of Child Health and Human Development (NICHD) is responsible for research that will contribute to the health of mothers and children and to the quality of family life. Basic to that responsibility is the development of knowledge that can be applied to problems of fertility and infertility and to the prevention and treatment of diseases associated with pregnancy, infancy, and childhood. Among the disorders addressed by research at the NICHD are many of the most significant and costly health problems of our society and for which solutions are significant to health and quality of life. The priorities of the Institute, as they have been in the past, reflect its continued commitment to support a multidisciplinary mix of studies in reproductive and developmental biology and behavioral and

social sciences, and to three objectives that serve to guide the Institute's efforts in these areas:

a. to assure the birth of healthy babies through investigations on nutrition, normal and abnormal fetal development, and problems of pregnancy and birth; and

b. to assure the birth of wanted babies through studies on human fertility and infertility, contraceptive development and safety, and the reduction of unwanted pregnancies, particularly among adolescents; and

c. to provide all children opportunity for productive and healthful adulthood through research to prevent problems in childhood such as smoking, obesity, environmentally-induced mental retardation, and learning disorders that contribute to adult disease and disability.

The Academy recommends that $251,000,000 be appropriated for NICHD for fiscal year 1981. This figure represents an increase of $42,019,000 or 20.1%, over the fiscal year 1980 appropriation of $208,981,000. Such an appropriation would allow the continuation of current programs in general and provide expansion and initiation of programs in high priority areas, as detailed below. In addition, an appropriation of $251,000,000 would result in the funding of approximately 45% of approved competing grant applications. Applications could be paid up to priority scores of about 245. This contrasts with FY 1979, for which 38% of approved applications were funded, and with FY 1980, for which only 20% of approved applications will be funded at an average of $85,000-$90,000 per grant. It would also bring NICHD up to the average level at NIH, where an average of 45% of competing research grants were funded between 1970 and 1980. NICHD during that decade funded only 36% of its grants.

Clinical Nutrition and Early Development

Multidisciplinary research is planned on maternal smoking and the physiological consequences for both the mother and fetus. Studies on the effects of oxygen deprivation on brain development will be expanded to include factors such as the use of vasoconstrictive drugs by the mother and other elements encountered in the environment. Investigations on prematurity and low birth weight will focus on maternal-fetus-placental interactions to identify factors that may be controlled through cooperative pregnancy management practices.

Research will continue on the underlying gene-controlled cellular and molecular processes that contribute to congenital defects and will include environmental and cultural factors. Emphasis will be placed on basic genetic studies, such as those that use recombinant DNA technology to isolate and amplify certain human genes. The underlying causes of neonatal dwarfism or short-limbed syndromes will be explored through clinical assessment, morphologic studies of skeletal abnormalities, and biomedical evaluations of normal and abnormal cartilage. Investigations of a lethal immunodeficiency disease, severe combined immune deficiency, will be pursued. A new important initiative is planned to develop animal models that mimic various common congenital defects in humans.

Studies on Sudden Infant Death Syndrome will focus on the refinement of design and testing of the monitor that would permit research on prolonged sleep apnea in infants who may be at high risk for SIDS. New behavioral research is planned to explore possible changes in relationships between mothers and infants, within families, and among siblings where an infant at risk for SIDS has been identified.

A major effort will be initiated on nutritional aspects of infantile diarrhea and malabsorption syndromes through studies on the maturation

of cellular organization and transport functions of the infantile gastrointestinal lining. An important research priority therefore is to ascertain daily nutrient for both enteral and parenteral feeding. Behavioral and social science research is planned to support studies on aspects of weight gain during pregnancy, infantile obesity, and cerebal control of food intake.

Human Learning and Behavior

Major emphasis in this program will be given to research on childhood antecedents to adult illness through studies on maternal-infant relationships and family life styles. Investigations will be encouraged that examine the attachment and bonding processes that take place between mother and child immediately following delivery and the effects of this phenomenon or its absence on late psychosocial development. A major contract program on evaluation of brain function associated with information processing in reading disabled children will attempt to construct and evaluate a neuropsychological test battery that can be utilized at the preschool level to identify children predisposed to reading problems.

Mental Retardation

First order priority will be given to the continuing program of genetic research on trisomy 21 (Down syndrome) with emphasis on paternal contribution to this disorder. Epidemiologic studies are planned to focus upon the contribution of social and other agents to the etiology and correction of mental retardation. In addition to studies of social agents, investigations will be initiated to identify other environmental factors that have a causative relationship to mental retardation such as intrafamily relationships.

Reproductive Sciences

New initiatives are planned to expand and continue research on human infertility. Studies will be supported in all areas of biomedicine concerned with infertility of the human couple with emphasis on 1) evaluation of current therapy for infertility, 2) identification of male, female, and couple factors associated with infertility, and 3) development of knowledge that may improve diagnostic and therapeutic techniques for infertility. Research activities will be increased on fertilization of the egg by the sperm and its subsequent development and transport to the uterus. Studies will be supported to examine the interrelationships of nutrition and reproduction including menarche, menopause, menses, the development of sperm, and fertility. The relationship of nutrition and breast feeding practices on the length of postpartum amenorrhea and subsequent fertility will also be investigated.

Social and Behavioral Sciences

A substantial effort is planned to expand research on changes in the structure of the American family as these affect patterns of fertility and the well-being of children. New emphasis will be given to social and interpersonal factors that lead to early sexual behavior and affect contraceptive usage. Special problems of adolescent contraception and the psychosocial acceptability and effects of various methods of contraception will be examined.

Contraceptive Development

Applied research will be supported to expand clinical trials of drug delivery systems, long-acting injectable contraceptives, and new oral formulations. Investigations will be supported on new barrier methods of contraception and on prostaglandins as luteolytic agents. Initial clinical evaluation of a method to predict ovulation for use in natural family planning will be undertaken.

Contraceptive Evaluation

A new research initiative is planned to identify forms of oral contraceptives that might best be used by adolescents, such as the progestin-only pill (mini-pill) or very low dose estrogen combination preparations. A study is planned that will specifically focus on cardiovascular risks for vasectomized males. Cardiovascular complications for the female will receive attention through studies to determine more specifically the age dependence of known cardiovascular and other adverse effects of contraceptive steroids.

DEPARTMENT OF EDUCATION

I. School Health Education

In 1978, Congress included in P.L. 95-961, the Education Amendments of 1978, a provision which established a new program to provide demonstration grants to State and local educational agencies for programs that are designed to establish and support programs of health education in elementary and secondary schools. This grant program has the potential for greatly improving the understanding and knowledge of our nation's school children about good health, preventive health care, and the need to make choices in personal lifestyle that are designed to prevent illness and injury. Such an increase in knowledge and understanding will, in the long run, greatly decrease the need for, and cost to the nation of, medical care; reduce the incidence of premature deaths; minimize suffering from disease; and help us fulfill our dream that each child will have the opportunity to develop his or her potential to the fullest.

The Administration requested in its fiscal year 1980 budget an appropriation of $2,000,000 to fund eighteen State education agency and thirty-six local education agency projects. These demonstration and model projects were designed to focus on developing strategies and programs with duplication potential in staff development and training, curriculum and methodology, evaluation, implementation and validation and dissemination of health education programs. Unfortunately, no funding was included in the final appropriations bill. This year, the Academy requests that $2,000,000 be appropriated for this grant program, the entire authorized funding level for fiscal year 1981. Excellent regulations to govern the award of these grants have already been issued by the Office of Education. We urge the Congress to carry through with its oft-stated intention to support preventive health education programs by adequately funding a program which can greatly enhance the opportunity of today's school children to enjoy a healthy adulthood.

II. Child Abuse Prevention and Treatment

Recent figures indicate that, even by conservative estimates, approximately one million children suffer from abuse and neglect each year in the United States. In addition to the emotional and developmental traumata at least 100,000 of these children are left with serious physical and/or neurological sequelae and about 2000 die from their injuries. The enormity of the child abuse problem can be seen by comparing these figures with a poliomyelitis epidemic year, 1952: 57,879 cases of polio, of which 21,264 demonstrated some paralytic residuals.

Last spring a special task force outlined six priorities for the Academy in the area of child abuse and neglect:

1. Expansion and improvement in services relating to the identification and initial management of suspected child abuse and neglect in all social and cultural groups (including sexual abuse, failure-to-thrive, emotional abuse, neglect and institutional abuse).

2. Promotion of healthy family dynamics and parent-child relationships (from perinatal period through adolescence and in all social and cultural groups).

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3. Improving the community response system for families (protection services, parent education, child advocacy, child care including crisis care and neighborhood centers).

4. Exploration of funding sources for child abuse/neglect services (case evaluation services, family support services, hospitalization and follow-up).

5. Development of treatment services appropriate for child abuse/neglect (medical, social, psychological and legal).

6. Encouragement of data accumulation especially in longitudinal studies (follow-up of reported cases, experiences of resource centers, community councils and child protection teams and evaluation of traditional and innovative programs in prevention and treatment).

These priorities can be implemented by improved education and training of all disciplines, legislative changes, public education and expanded professional and community resource centers, action groups, programs and councils.

All of these programmatic and implementation recommendations are high priorities of the National Center on Child Abuse and Neglect/Children's Bureau (NCCAN/CB) and they have made excellent progress toward their goals. NCCAN/CB should be supported and rewarded for excellent, cost-efficient performance by increased funding to allow optimal operation of their current and proposed programs.

Therefore, the Academy recommends that NCCAN/CB receive an appropriation for fiscal year 1981 of $28,265,400. This figure includes 13%, or $2,987,000, over its fiscal year 1980 appropriation of $22,980,000 to cover the impact of inflation plus 10%, or $2,298,000 for programmatic growth.

III. Adoption Opportunities

The Adoption Opportunities program was enacted in 1978 as part of the Child Abuse Prevention and Treatment and Adoption Reform Act and provides for several initiatives to be undertaken to address the "special needs" of minority, handicapped and older children seeking adoption.

When this legislation was passed there were over 400,000 children in foster care--many of whom did not belong there or who were there too long. The majority of these children were school-aged, handicapped, or both. Although there were a number of qualified persons seeking to adopt these children, they were unable to do so because of various legal and financial barriers to a permanent placement. Thus the Adoption Opportunities program was enacted to facilitate the elimination of some of these barriers and to provide permanent and loving home environments for children who would benefit by adoption, particularly children with special needs.

Among the initiatives provided for by the Adoption Opportunities program are the following:

1. Model State Adoption Legislation and Procedures to help standardize adoption codes and eliminate jurisdictional and other legal barriers to adoption;

2. A National Adoption and Foster Care Data Gathering and Analysis System to gather child welfare data and state sociodemographic facts which will be incorporated into an annual report that will permit cross tabulations of adoption variables;

3. A National Adoption Exchange System, a network of state and regional adoption exchanges which will coordinate efforts to find permanent homes for children and identify those children who need to be relocated for adoption;

4. Extensive training and technical assistance programs to states and localities.

For fiscal years 1979 and 1980 the Adoption Opportunities program was funded at $5,000,000. For fiscal year 1981 the Academy recommends that the Adoption Opportunities program receive an appropriation of $5,650,000, a 13% increase. This increase would continue and activate programs begun recently with particular emphasis on the Adoption Information Exchange System and the Adoption and Foster Care Data Gathering and Analysis Systems, with the goal of extending these networks into all the states. Funds will also be used to develop other resource potentials for adoptive parents and agencies.

Letter From Dr. James L. Boyer, President, American Association for the Study of Liver Diseases

March 12, 1980

Mr. Terry L. Lierman
Staff Director
Senate Labor-HEW Appropriations Subcommittee
1108 Dirksen Senate Office Building
Washington, D.C. 20510

Dear Mr. Lierman:

In lieu of testimony before the Senate Labor-HEW Subcommittee on Appropriations, the American Association for the Study of Liver Disease would like to offer the following statement for inclusion in the hearing record.

The AASLD believes that Congress should increase appropriations for the digestive disease programs related to the study of liver function and diseases in fiscal year 1981 by:

1. appropriating additional funds up to $500,000 for health manpower training to address the current manpower shortage in research physicians and scientists devoted to the study of liver function and disease

2. increasing appropriations for basic research programs up to $5,000,000 to devote to studies of

   a. pathogenesis of viral hepatitis (type B and C), the prevention of hepatic failure which it produces, and the pathogenesis and treatment of chronic hepatitis and cirrhosis which evolve from this infection

   b. to increase our understanding of liver metabolism, how the liver makes bile, and what alterations in bile occur that result in the formation of gallstones

   c. to study the effects of surgical diversion of blood flow around the liver in patients suffering from cirrhosis and intestinal hemorrhage

   d. to further understanding of the rejection phenomena following hepatic transplantation

   e. to increase the ability to detect and prevent drugs and environmental toxin-related liver injury

f. to further studies on the pathogenesis and prevention of alcoholic liver disease

g. to further the diagnosis and treatment of diverse diseases of the liver which occur in childhood

Existing manpower and research support systems to carry out this work are dangerously low or non-existent in many institutions devoted to medical research. Progress in each of these areas can only be forthcoming by increasing appropriations for basic research in these important yet neglected areas of the nation's health.

Sincerely yours,

James L. Boyer, M.D.

Statement of Coalition of Digestive Disease Societies

The North American Society for Pediatric Gastroenterology has vigorously endorsed The National Commission on Digestive Diseases and its recommendations.

The Society further urges an increase of 10 million dollars over the current budget proposals for support of activities in Digestive Diseases. This would represent only 15 million dollars over last year's budget.

Digestive Diseases in children are common, often serious and frequently interfere with growth and development, yet expenditures for research into these disorders are woefully inadequate.

Of the priorities cited by The Commission report, we select the following as having greatest importance for children with Digestive Diseases:

1. Establish a National Digestive Disease Advisory Board. It is through this Board that pediatric Digestive Disease priorities for research and education will be established.

2. Support Training Programs in Pediatric Digestive Disease. Funds for training of medical and paramedical personnel in pediatric Digestive Disease are extremely limited. Progress here is mandatory.

3. Expand basic and applied clinical research. Knowledge of the causes, mechanisms, treatment and outcome of pediatric Digestive Diseases is lacking. A marked increase in funding in this area is likely to have important impact on <u>preventing</u> Digestive Diseases in adult life.

4. Identify influences of nutrition on Digestive Diseases, and of Digestive Diseases on nutrition. For Pediatric Gastroenterology this is a key area of emphasis. Dietary factors in causing pediatric Digestive Diseases have been largely ignored, as have the nutritional imbalances produced by pediatric Digestive Diseases. Research funds focussed here could have significance both for children and for adults whose diseases continue from a start in childhood.

The other priorities of The Commission have tremendous implications for pediatric Digestive Diseases and must be taken seriously:

Establish an information clearing house for the public, patients and medical personnel

Strengthen professional education in Digestive Diseases

Standardize terminology and diagnostic criteria for Digestive Diseases

Determine epidemiologic patterns of Digestive Diseases

Identify environmental and industrial pollutants as causes of Digestive Diseases

Funds directed toward pediatric research and prevention of Digestive Diseases have the greatest promise of influencing health status, changing patterns of disease and lowering health care costs.

SUBCOMMITTEE RECESS

Senator SCHWEIKER. The subcommittee will stand in recess until 10 a.m. tomorrow morning, when the public witness testimony will continue.

[Whereupon, at 4:07 p.m., the subcommittee was recessed, to reconvene at 10 a.m. on Wednesday, March 12.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1981

WEDNESDAY, MARCH 12, 1980

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

The subcommittee met at 10:06 a.m., in room S-128, the Capitol, Hon. Lowell P. Weicker, Jr., presiding.

PUBLIC WITNESSES

STATEMENTS OF:
RUTH GRAVES, READING IS FUNDAMENTAL
EILEEN COOKE, AMERICAN LIBRARY ASSOCIATION

READING BASIC SKILLS AND LIBRARIES

Senator WEICKER. The hearing will now come to order. We have as our first witness this morning on the subject of basic skills and libraries in the area of education, Ms. Ruth Graves from Reading Is Fundamental and Eileen Cooke from the American Library Association.

It is a pleasure to have you, ladies.

Ms. GRAVES. Thank you for the opportunity to testify on the inexpensive book distribution program.

Mrs. McNamara, who was to testify, sends her apologies. She is ill. She would appreciate it if her written testimony were printed in the record.

The inexpensive book distribution program has brought together private citizens and Federal funds in a unique grassroots effort to improve the reading of our young people. Under contract with the Department of Education, Reading Is Fundamental operates this program.

As the legislation mandates, Reading Is Fundamental subcontracts with local private and public groups to operate reading motivation programs and make books available to youngsters for personal ownership.

We provide matching Federal funds to purchase those books and other services to enhance program operations. For instance, we have negotiated special discounts and services with nearly 300 book suppliers—all the major suppliers of children's books—so the projects can purchase books at substantial discounts.

There are presently some 3,400 local projects—1,000 more than we were able to report last year at this time—operating in all 50 States, the

District of Columbia, Puerto Rico, the Virgin Islands, and Guam. They are funded to serve approximately 3 million children with 11 million books.

In the last year we have made a special effort to reach normally hard to reach children, such as through a statewide program in Connecticut to reach children out of the mainstream, children who are for one reason or another in State institutions.

Throughout the country, nearly 100,000 citizens are volunteering their time to the projects. About 40 percent of these are parents.

In the 3 years of this program's operation, we have received numerous reports on its effects on reading patterns of children. Parents, teachers, educators, and volunteers tell us as a result of the program that youngsters are reading more, parents are encouraging more reading at home, in many cases reading prompted by the program has resulted in higher reading scores, library circulation has risen, communities are giving more support to the schools.

MATCHING AND BUDGET REQUEST

The projects, and Reading Is Fundamental itself, are attracting considerable support from the private sector in funds, goods, services to augment this program. We estimate that this private support equals $2 for every $1 of Federal funds invested.

The Congress appropriated $6.5 million for the inexpensive book distribution program for fiscal 1980. The administration has requested $6 million for fiscal 1981. In justifying a reduction from $6.5 million for fiscal 1980 to $6 million for fiscal 1981, the Department of Education refers to carryover funds. There are carryover funds, but this fact is somewhat misleading unless the circumstances are known.

The carryover is not new this year. RIF has always had carryover in its contract. The reason is the way the Office of Education structured the contract.

In our first year with this contract, we received $4 million. However, OE did not let us get started subcontracting to local groups until March. With the fiscal year ending September 30, and our beginning to subcontract in March, that left only 6 months for obligating funds to local groups throughout the 50 States.

OE recognized the need for a full 12-month subcontracting cycle and has been permitting us to carry over funds each year to complete the full 12-month, March to March, subcontracting cycle. Since we are running on a March to March subcontracting cycle, it only stands to reason that on September 30 there are unobligated funds because that is only 6 months into the cycle.

That has been true every September 30 since this program has been in operation and for every appropriation applied to this program. If that is used as a justification for reducing the fiscal 1981 appropriation, then the rules are being changed in the middle of the game.

It further means that we will have to refund a $6.5 million program, operating throughout the country, with only $6 million.

I should also point out that effective this fiscal year, by act of Congress, the funding formula changed from 50–50 to 75 percent Federal, 25 percent local matching shares—a 50-percent increase in the Federal share for most groups. By the same congressional act, migrant farm worker programs are to be funded 100-percent Federal.

These factors, taken along with an inflation rate of 13 percent last year, which promises to be higher this year, place additional strain on attempting to maintain this program's level of services to children. We recognize the special burdens of this committee this year, and we appreciate the national concern for a balanced budget. Certainly, we could not profess to know what is necessary in the interest of the national economy.

We do, however, feel it incumbent on us to get the record straight about the obligation of funds by this program, and to point out that a reduction of $500,000 would mean that some 250,000 fewer children would be served.

We genuinely appreciate the consideration the Congress has given this program in the past and the opportunity to bring you up to date on its progress.

The program is serving its purpose. It is getting young people to read and to want to read better, and it is doing so at very little cost to the taxpayer. It is much in demand across the country. We have received more than 3000 proposals already this fiscal year and continue to receive them at the rate of 65 per week. Because it is meeting its purposes, we hope you will give it your favorable consideration.

Thank you.

Senator WEICKER. I only have one question here. If your estimate is that 250,000 fewer children would receive the books through the $500,000 cut, what is your estimate based on? The fact is, you probably will run against a 20-percent inflation rate this year. So it is even less than indicated.

Ms. GRAVES. We were basing that on the current price of books. If there is a 20-percent inflation rate, it would be substantially higher, obviously—300,000 to 400,000.

[The statement follows:]

STATEMENT OF RUTH GRAVES

With bipartisan support, in 1975 Congress created the Inexpensive Book Distribution Program. Funds were first appropriated in FY 1976. Since October, 1976, Reading Is Fundamental, Inc. has operated the program under contract with the Department of Education.

This program is part of a broad federal effort to improve basic skills, particularly reading. Its specific mandate is to mobilize local communities to encourage their youngsters to read. The program provides federal funds to match local funds to buy books for young people, with technical assistance to help local groups organize and operate comprehensive reading motivation projects.

THE PROBLEM

American reading problems are, by now, familiar. Recent studies and reports show that they continue. For instance:

- A 1979 study for the Ford Foundation revealed that, depending on the definition used, 18 to 64 million American adults are illiterate; some 15% (23 million) have serious reading problems. The same number are not sufficiently literate to function adequately in American society.

- The link between reading problems and employment problems is clear. A survey of New York City employers showed that many considered the lack of basic education skills --- rather than the lack of specific job skills --- to be the decisive obstacle in hiring unemployed inner city youth. Even the national defense suffers. According to Department of Defense statistics, 20% of all recruits are functionally illiterate. They endanger themselves and expensive equipment because they cannot read instructions written at sixth-grade level.

UNIQUE RESPONSE

Among all public and private literacy efforts, the Inexpensive Book Distribution Program is unique. It creates an effective, workable partnership for reading between government and local communities. It provides federal funds without burdening local groups with undue paperwork or stifling local initiative with regulations. Its public funds are an incentive to private effort. They encourage citizens to donate time to the literacy effort, and corporations and local business to donate funds.

The Inexpensive Book Distribution Program is unique in that it gives young people two things basic to acquiring reading skills: books and the desire to read them.

Studies have repeatedly demonstrated that attitude, a person's motivation to read, is a crucial factor in the reading equation. For example, a 1977 report published by the International Reading Association concluded:

> "Attitude. . .is the hidden variable of the literacy problem. . . . It is this factor which will determine the ultimate success or failure of literacy programs, for there is no program nor legislation that can force a person to learn if he does not want to learn. Attitude is the very core of the problem and the factor which is virtually impossible for educators to control."

Educators cannot control attitude. Schools cannot compel a desire to read. Yet, when schools, parents and community leaders cooperate, they can encourage positive attitudes toward books and learning. It is precisely this cooperation that the Inexpensive Book Distribution Program makes possible.

READING IS FUNDAMENTAL, INC.

This program employs methods that Reading Is Fundamental has used for 14 years. A private, nonprofit organization, RIF works from a simple premise: if young people are allowed to choose and own books they like, they will want to read more. Ultimately, they will read better.

Today, projects in this federal program use the same methods RIF projects have traditionally used. Several times each year, they hold "book distributions," festive occasions when youngsters select books and keep them. Throughout the year, parents, teachers, members of service clubs and other citizens volunteer to stage reading-related activities. These activities --- such as library visits, talks by authors and essay contests --- reinforce the youngsters' desire to read.

The Inexpensive Book Distribution Program has brought this approach to thousands of communities. It has enabled RIF to test the premise on a nationwide scale.

RESULTS

Studies have shown conclusively that young people who have books in their homes are better readers than those without books. In 1978, for instance, analyses by the Pennsylvania and Texas departments of education showed that the youngsters with books of their own scored higher on reading tests. Both reports specifically cited RIF and this program as factors in improved reading.

Reports from local communities also support the program's effectiveness. During the three and one half years the program has operated, reports have repeatedly concluded that, as a result of the RIF projects:

- Young people read more. They ask for books, instead of avoiding them. With their heightened interest in reading comes better motivation for schoolwork. In many cases, the reading prompted by RIF results in higher scores on standardized tests.

- Parents encourage more reading at home. They begin to buy books for their children, and make reading a family habit. In several instances, the enthusiasm RIF sparks in a child has inspired parents to complete their own schooling.

- Library circulation rises, among adults as well as youngsters.

- The community gives better support to the schools. Schools sponsor more than 50% of all RIF projects, but volunteers and funds come from PTA's, service groups and local business.

- Once RIF pulls citizens into schools, they start cooperating with principals, teachers and the school board. Education becomes a community concern.

Of all citizens volunteering their time to local projects, nearly 40% are parents. Complete cross-sections of communities donate funds, time and resources. Supporters include businesses, service clubs, professional groups, parent-teacher associations, librarians, local media and many others.

To show the impact of involving parents and communities in reading, we reprint the letter of a youth center director in North Dakota:

> "From the beginning RIF has had a near magic attraction on the kids. Our neighborhood is unique in that it contains all within a few blocks, 192 units of nonprofit housing, 180 trailer court homes, and 18 units of Public Housing. It's a neighborhood of children, the majority from homes with a single parent.
>
> "Book Distribution Day has become a neighborhood extravaganza with children and parents alike coming out to participate. It's quite a sight to see 100 neighborhood children gathered

together and excited about getting their books. The RIF program has become the focus of our efforts for child development in our neighborhood. . . ."

Youth Center Director
Fargo, North Dakota

Librarians regularly report that RIF increases library usage:

"The value of the program to the young people involved was, and continues to be, immeasurable.

"We are still seeing evidence of RIF's value: kids coming into the library will ask for a 'book like I got this summer,' or they will start rattling off the plot of something they got from RIF. Families who'd never been in the library before have become Saturday afternoon regulars."

Young People's Librarian
Walla Walla, Washington

PROGRAM STATUS

The expansion of this program has been astonishing. In 1976, before the appropriation of federal funds, there were some 400 RIF projects. Last year, we reported to this Committee that there were 2,400 projects. Today there are 3,400 local projects. They are located in all fifty states, in nearly every Congressional district, in Puerto Rico, the Virgin Islands, Guam, and the District of Columbia.

These projects have been funded to distribute nearly 11 million books to close to 3 million youngsters, age three through high school.

Each project may serve children at several different sites. Together, the projects are serving children in more than 12,000 locations. These include schools, libraries, hospitals, juvenile detention centers, day care centers, and other places where young people congregate.

Nearly 100,000 citizens are volunteering to work in RIF projects. Their efforts are supported by close to 7,000 businesses, service clubs and other groups.

Together, these citizens comprise a true grassroots movement for literacy.

Local public officials have also supported the program by providing matching funds to communities as the local share of book costs. In Puerto Rico, for instance, the legislature earmarked $200,000 for the program. The Louisiana legislature set aside $500,000.

PROGRAM RETURNS TWO TO ONE ON THE GOVERNMENT INVESTMENT

The most significant return of the Inexpensive Book Distribution Program is that it clearly meets its purpose.

In economic terms, as well, this program is a valuable investment. For each $1 the government contributes to the program, it is estimated that Reading Is Fundamental and local projects contribute $2.

In addition to raising private matching funds for books, local projects raise their own operating costs and secure all services and materials. They contribute millions of man-hours in volunteer time.

As a leader in the literacy movement for 14 years, Reading Is Fundamental attracts private funds to augment the federal program.

Among the services that RIF donates to this program, at no cost to the government, is a public service advertising campaign. Since 1972, RIF has used

public service advertising to urge citizens to work for reading. RIF ads for television, print and radio have received more than $16 million in free time and space. In 1979 alone, the figure was an estimated $2.5 million. Free RIF advertising has generated much of the overwhelming interest in this program.

Reading Is Fundamental also secures private funds to produce aids, publications and other materials for local projects. RIF saves the government money by negotiating high book discounts with publishers and distributors. On occasion, RIF has secured corporate funds to help needy communities defray book costs. Private funds also permit RIF to stage special projects to promote reading.

In 1979, for instance, RIF celebrated the International Year of the Child with privately funded activities that peaked on "National Reading Is Fun Day," October 11. This national/local celebration focused the country's attention on reading. Around the nation, RIF projects held gala book distributions. They involved their communities in special reading events. At the same time, the President's family hosted Reading Is Fundamental at the White House for a spotlight celebration. Forty-one governors proclaimed the day. An estimated one million young people chose books to keep. Walter Cronkite devoted his radio commentary to RIF and literacy, and other media coverage was wide.

OPERATION AND FUNDING CYCLE

In accordance with authorizing legislation and its Department of Education contract, Reading Is Fundamental subcontracts to local groups the operation of reading motivation projects. RIF obligates federal matching funds to the groups. The federal funds and local funds matched may only be used to purchase books. Normally, a subcontract is valid for one year.

As we have pointed out to this Committee before, RIF signed the first contract to operate this program in October, 1976. The government, however, did not permit RIF to sign subcontracts until February, 1977. This established a March to March subcontracting cycle, a cycle which crosses fiscal year lines. Each year, the fiscal year funds have been carried forward to complete the funding cycle.

In each 12 month subcontracting period, RIF has obligated to local projects all appropriated funds. To complete the March, 1979 - March, 1980 cycle, some $1 million of the appropriated $6 million was carried forward into fiscal 1980.

By an Act of Congress, the funding formula for this program changed on October 1, 1979. A 50/50 match became 75% federal and 25% local. For migrant and seasonal farmworker projects, the federal share went to 100%.

The federal share, therefore, increased by 50%. The appropriation did not, however, increase by 50%.

PUBLIC RESPONSE

As noted before, the response to this program has been amazing. In just the first five months of this fiscal year, RIF received 3,000 proposals for funding. We continue to receive an average of 65 proposals per week.

Clearly, this program has touched a nerve in the American public.

One reason for its success is simplicity. Reading is Fundamental has kept red tape to a minimum. Local control is preserved wherever possible.

Local volunteers select books to offer youngsters. They may order these books from any of nearly 300 book suppliers with whom RIF has negotiated special discounts. Among these are all major suppliers of children's books. To avoid entanglements that often plague federal programs, however, local volunteers are never asked to handle federal dollars. They send their book payments to RIF. RIF adds the federal share and forwards the checks to the suppliers.

With the equivalent of only 48 full-time employees, RIF provides in-depth services to 3,400 projects. In addition to serving the projects daily, RIF handles the myriad details attendant to a government contract, freeing volunteers to concentrate on the children.

CONCLUSION

We at RIF appreciate the national concern for a balanced budget, although we certainly do not profess to know what is necessary for the national economy.

We do know, however, based on our intimate and expert knowledge of RIF, that it will take $6.5 million in Fiscal 1981 to serve the same number of children the projects expect to serve in Fiscal 1980.

We also know that the Department of Education request of $6 million would mean that some 250,000 fewer children would receive books.

The Inexpensive Book Distribution Program is more than fulfilling the purpose for which Congress created it. It is developing positive learning attitudes in millions of young people. It is getting them to read while young, a habit they will keep for life. It is actively engaging parents and communities in education. It is in tremendous demand, and it is cost effective.

In sum, this program is moving the nation a step closer to full literacy for every American.

AMERICAN LIBRARY ASSOCIATION

Senator WEICKER. Ms. Cooke?

Ms. COOKE. Thank you. I appreciate the opportunity to be here to point out the American Library Association is a nonprofit educational organization of some 35,000 librarians, trustees, educators, and other friends of libraries. We are dedicated to the improvement of library services for all citizens.

My statement consists of a one-page summary of our fiscal year 1981 recommendations and justification papers on library and related programs covered by the Labor-HEW appropriations bill. Since you have requested that testimony be limited to 10 pages and oral statements to about 5 minutes, I will simply outline a few highlights. I would be glad to answer any questions you may have or provide any additional material you may require.

INTERLIBRARY COOPERATION

First of all, we support the administration's request for increased funding of $12 million for LSCA III, interlibrary cooperation. In these days of shrinking budgets and purchasing power, the only hope users of libraries have for adequate service is through increased resource sharing and cooperation among libraries.

LSCA funds assist this and often combine with State funds to make an impressive difference. For instance, in Connecticut the next round of LSCA III funding will help support CONNECTICAR, a delivery system through which needed materials can be delivered from libraries anywhere in the State to a user's home library within 48 hours.

In Missouri, LSCA III helps support development of seven area networks, including libraries of all types. Now a bill before the State legislature would give formal recognition to this network structure.

In New Mexico, LSCA III assists the interlibrary loan network. With State support, the current TWX machines will be replaced with OCLC terminals, providing more efficient communications and direct access to the holdings of many libraries of all types in the State and elsewhere.

For most other library programs, the administration has recommended level funding—ignoring not only the serious fiscal plight of libraries and the increasing demands for services, but also inflationary increases. To cite just a few of many examples, the price of printed materials has been increasing about 13 percent per year; the average hardcover book now costs $22.80, the average annual periodical subscription $30.37.

I have attached a chart which shows how the prices have been going up over the years. If we are concerned about sharing resources, this is one of the most cost-effective programs we have. The cost of audiovisual materials will be affected by the alarming increases in silver and petrochemical prices. Between December and February the price of film stock rose 59 percent for color and as high as 92 percent for black and white.

LIBRARY TRAINING AND DEMONSTRATION PROGRAMS

We are particularly concerned about the college library and library training and demonstration programs. While the budget estimates are for level funding, the amounts requested are substantially below the fiscal year 1979 level of $9.9 million for HEA II–A and $3 million for HEA II–B. While the II–A basic grants to college libraries are modest, if thought of on a State basis, they provided $547,000 for Pennsylvania in fiscal year 1979 and $165,000 for Washington. These amounts provide a significant contribution to the academic library resources of the State, and through interlibrary cooperation, serve all the State's residents.

The HEA II–B training program is targeted toward minority recruitment—still a critical need in the library and information science fields. Funding for the II–B research and demonstration program provides a necessary foundation for more effective resource sharing among libraries. The first major bibliographic information network, OCLC—formerly Ohio College Library Center—received II–B grants at two critical stages in its development, insuring its success.

That built up into a nationwide network in terms of making resources available. There is a continuing need for the application of new technology to library processes.

Finally, Congress has demonstrated its understanding that effective decisionmaking requires substantial information resources through its support of the Congressional Research Service. The CRS budget request for fiscal year 1981 is $31,600,000 or $59,000 per Member of Congress. The total amount for public library services under LSCA I for fiscal year 1980 amounts to only 28 cents per capita. In a democratic society decisionmaking is an important activity at all levels of the population.

Thank you for this opportunity to present the views of the American Library Association.

NETWORK SYSTEM

Senator WEICKER. I know in the justification they say, given the rapidly escalating cost of books and periodicals due to inflation, up 67 percent between 1975 and 1978 for printed materials, the concept of library network sharing of resources is an idea whose time has surely come.

Now, the only thing I don't understand of that statement—maybe I don't understand the concept of network in the sharing of resources. How is it possible to travel miles and miles in the sense of being able to get a book? I understand as between institutions the sharing of knowledge between departments of institutions. That I understand. But the basic resources of the library, people walking in there to read. How do you network out?

Ms. COOKE. That is a very good question. Many people wonder about that. What we are talking about are those more esoteric items that are really outside the reach of many institutions. They need to have a basic collection so people can continue to come in and get the things that are in daily demand, access to ordinary periodicals, for example. But there are things like the Journal of Kinesiology, and Advanced Technology, things of that sort, that only some institutions can afford.

Increasingly they are having to question whether they are justified on the basis that they will be sharing it. The research library program is a case in point. The Harvards of the Nation are very limited in their resources but with something like a research program, we help them to continue to maintain their collections and then through interlibrary loan, other libraries can borrow it—so it can go from Connecticut or Massachusetts to New Mexico or Washington State and be used.

As new technology comes about, it will be possible and is possible for those who have the wherewithal to transmit the information electronically. That is the direction we are moving into. Libraries are very labor intensive.

SETTING BUDGET PRIORITIES

Senator WEICKER. I would say to both of you ladies and also to those that will follow, the talk of further budget cuts, et cetera—this is a good time and a good set of witnesses to make the point as far as I am concerned—the inflation which we enjoy is one that has been primarily fueled by our inability to establish an energy policy. It seems to me the choice the Congress is making right now is that we will not cut back—in the sense of the gallon of gasoline which goes poof—but we will cut back in terms of knowledge acquired by our children from reading in our libraries. This knowledge is not burned up in our automobiles but is an investment that comes back many times in the future.

I don't mind saying publicly that to go the road we are going now, and I might add in the sense of these budget cuts, we are talking about a situation that excludes defense. Budget cutting will come clearly in the areas that we will be discussing throughout the morning.

But let's understand the choice that this Nation is about ready to make. It puts a higher premium on a gallon of gas than it does on the knowledge that it gives to its citizens, young and old. If nobody thinks that that is another sign of how addictive we have become as a nation, believe me, we are unwilling to face reality.

All I can say, speaking for myself, and I know Senator Schweiker expressed thoughts relative to the importance of this budget yesterday, there are those who fully intend to fight as hard as we can for the matters that are of a lasting value. Indeed, not money thrown away, but money invested, rather than go the route that is being suggested.

Indeed, another road is open if we ever want to divorce ourselves from the sacred American cow known as the automobile.

Ms. COOKE. I couldn't agree with you more. Perhaps we will have to reinvent something like the National Defense Education Act to make people realize the very point you have made. This is a long-term investment, when we are talking about education.

Many of the resources will not be retrievable if we don't get them now for the future.

[The statement follows:]

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Statement of Eileen Cooke

PUBLIC LIBRARY SERVICES (LIBRARY SERVICES & CONSTRUCTION ACT TITLE I)

Purpose: Grants to states for (1) providing library services to disadvantaged persons in both rural and urban areas, (2) services to the institutionalized, (3) to the handicapped, (4) to persons of limited English-speaking ability, (5) to the aging, (6) strengthening state library administrative agencies to meet the needs of all the people, and (7) strengthening metropolitan public libraries that serve as national or regional resource centers. When appropriations exceed $60 million, a portion of the funds are earmarked for urban libraries.

Appropriation FY 1980:	$ 62,500,000
Budget Estimate FY 1981:	62,500,000
ALA Appropriation Request FY 1981	100,000,000

Justification: 1. LSCA I expresses a national concern for groups of citizens who may be out of the mainstream of public library services and thus underserved. It is an umbrella title with a long list of congressionally-mandated emphases as listed above. An appropriation of $100 million would provide an additional $5 million for each of these important purposes.

2. A recent amendment to LSCA I provides that up to 50 percent (depending on a state's urban population) of any amount over $60 million will be reserved for libraries in cities over 100,000. At current funding levels this means that something less than $1,250,000 is divided among as many as 170 cities. To effectively support these major urban resource libraries which serve persons well beyond the city boundaries requires a more adequate funding level.

3. A representative example of what LSCA programs can mean to one library system is illustrated by the following excerpt from the 1978-79 annual report of the Brooklyn Public Library: LSCA funds have made possible the majority of innovative and forward-looking activities of the Library. Although many of these programs are currently offered only in a single location and can serve relatively small numbers of people, the impact of their activities tends to exceed the size of the effort. Most significant is the lasting effects on the lives of individuals who learned to read, found new purpose to their existence, developed latent talent or simply discovered a source of help that answered a pressing personal need. These programs are supported by LSCA funds:

Learn Your Way provides guidance, counseling and information to individuals seeking to further their education particularly in non-traditional ways. Librarians trained in these areas arrange for tutoring, refer to appropriate agencies and work with the non-campus degree programs available.

Job Information Center maintains information files on employment available and also provides counseling on formulation of new employment goals and procedures for seeking employment.

Literacy Volunteers provides individual tutoring to adults who have not learned to read.

El Centro Hispano De Información is the Library's first foreign language center. Providing both Learn Your Way and Job Information Center services, its collection and programming are given in the Spanish language.

SAGE (Service to the Aging) provides the elderly with books (including large-print), films and programs at senior centers and in branch libraries.

PUBLIC LIBRARY CONSTRUCTION (LIBRARY SERVICES & CONSTRUCTION ACT TITLE II)

Purpose: Grants to states for public library construction, defined as the construction of new public library buildings and the acquisition, expansion, remodeling, and alteration of existing buildings for use as public libraries. Remodeling to remove architectural barriers and to conserve energy are priorities added in the LSCA Amendments of 1977.

Appropriation FY 1980:	-0-
Budget Estimate FY 1981:	-0-
ALA Appropriation Request FY 1981:	$50,000,000

Justification: 1. Federal policies encouraging and assisting handicapped persons to fully participate in society formally recognized the importance of providing access to information by adding remodeling for handicapped access as a new priority under LSCA II (PL 95-123). Barriers in the form of massive steps, narrow aisles,

antique plumbing fixtures, and lack of electrical hookups for equipment used by the blind and the deaf are examples of the obstacles in the 8,147 public libraries currently inaccessible to the handicapped. Section 504 of the Rehabilitation Act of 1973 requires necessary structural modifications by June 3, 1980. $50 million for LSCA II would bring 1500 library buildings into compliance.

2. The state of Oklahoma reported recently that 35 libraries could be made accessible to the handicapped through changes of a nonconstruction type, but that in 24 library buildings structural changes are necessary because equivalent library services cannot be provided otherwise. In Illinois, the Joliet Main Library, built in 1903, would require $170,000 to eliminate architectural barriers to the handicapped.

3. Persistent concerns over energy availability in combination with the need to reduce local taxes underline the benefits to be derived from funds used to insulate and remodel older library buildings. Dollars not spent for fuel can be better used to buy library materials of direct benefit to the users. Energy conservation is the second of the priorities added by the LSCA Amendments of 1977. In the state of Delaware, for instance, at least 15 public library buildings are badly in need of retrofitting for energy conservation. Of the $75,000 required for this purpose, 15 percent would be retrieved through reduced energy consumption.

4. During the fifteen year period since FY 1965 when public library construction funding began under LSCA II, over 2,000 projects have been approved. Each federal dollar stimulated over $2 in state and local support for public library construction projects. This represents an overall support level of 71 percent from non-federal sources, and testified to the effectiveness of the LSCA program in stimulating matching support.

5. Other sources of federal funds for public library construction are miniscule. Currently they include the Appalachian Regional Development Act, General Revenue Sharing, Community Development Block Grants, and loans from the Farmers Home Administration. However, since FY 1965, LSCA II has provided $175 million for public library construction projects. All other federal sources combined have provided only $21 million. In New Jersey alone, fourteen public library construction projects would be ready to start in FY 1981 if LSCA funding were available. All fourteen projects would require only $4.5 million in federal funds.

INTERLIBRARY COOPERATION (LIBRARY SERVICES & CONSTRUCTION ACT TITLE III)

Purpose: Grants to states for the planning for, and taking other steps leading to the development of, cooperative library networks; and establishing, expanding, and operating local, regional, and interstate cooperative networks of libraries, which provide for the systematic and effective coordination of the resources of school, public, academic, and special libraries and information centers for improved supplementary services for the special clientele served by each type of library.

Appropriation FY 1980:	$ 5,000,000
Budget Estimate FY 1981:	12,000,000
ALA Appropriation Request FY 1981	12,000,000

Justification: 1. ALA supports the administration's request to increase LSCA III to $12 million, and we agree with the Education Department's rationale: "According to State adopted standards, only 11 percent of the population has access to adequate library services. Yet the very high inflation rate for printed materials precludes acquisition by all libraries of a comprehensive collection. We feel it is therefore imperative to pursue the strategy of promoting a national network of library resources whereby the collections in one library are made readily accessible to other libraries. Our thinking is consistent with that of the recent White House Conference on Library and Information Services which met last Fall and independently voiced the need for such a policy."

2. The strain on the nation's library budgets is severe. The inflation rate for printed materials has been averaging 13 percent in recent years. The average hardcover book cost $22.80 in 1979; the average periodical subscription $30.37. When the institutional or library rate for periodicals is taken into account, the average subscription cost $48.37. Faced with these increases plus higher energy costs, libraries have had to reduce their purchases of new materials with the hope of borrowing items in lower demand.

3. Delegates to the November 1979 White House Conference on Library and Information Services called specifically for federal and state support of library networks and for additional funding for LSCA III. They noted that "resource sharing is now mandated by the information explosion, the advance of modern technology, the rapidly escalating costs of needed resources, and the wide disparity between resources available to individuals by reason of geographic location or socio-economic position."

4. A USOE funded evaluation study issued in 1978 indicated three important contributions of LSCA III: (1) greater centralization of planning and administration of library services at the state and regional levels, (2) playing a major role in influencing state legislatures to modify or pass legislation favoring cooperation and networking, and (3) providing the impetus for participation in intrastate and multistate cooperative/networks, and for increased use of telecommunications.

5. Interlibrary cooperative activities under LSCA III have changed in emphasis and focus. From single purpose projects involving more than one type of library (such as development of union catalogs and lists or development of centralized processing centers), states have moved to projects that require different types of libraries within a geographic area to assess needs cooperatively, jointly develop plans and programs to meet needs, and jointly evaluate their efforts. Such projects require a commitment from each library to see itself in relation to the total community and to the larger world of library and information services.

SCHOOL LIBRARY RESOURCES & INSTRUCTIONAL MATERIALS
(ELEMENTARY & SECONDARY EDUCATION ACT TITLE IV-B)

Purpose: Grants to states for acquisition of school library resources, textbooks, other printed and published instructional materials, instructional equipment and materials suitable for use in providing education in academic subjects for use by children and teachers in public and private elementary and secondary schools, which shall be used for instructional purposes only. Local educational agencies make the decisions as to how their allotments will be divided among the program purposes.

Appropriation FY 1980:	$171,000,000	(ESEA IV-B is
Budget Estimate FY 1981:	171,000,000	advance
ALA Appropriation Request FY 1981	205,000,000	funded.)

Justification: 1. The White House Conference on Library and Information Services in November 1979 urged that school library programs be funded at authorized levels, showing citizen recognition of the critical difference school libraries make in helping students gain basic reading and writing skills. Another WHCLIS resolution asked Congress to set guidelines for the establishment of a school library in each school. Despite recent progress, about one million students attend schools with no library or media center.

2. Nearly 36 percent of IV-B funds go toward the acquisition of audiovisual materials. Recently, schools have been critically impacted by the rampant escalation in raw materials prices, particularly silver and petrochemicals. Since December 1979 the price of raw film stock has increased 59 percent for color and as high as 92 percent for black and white. The cost of plastics for AV materials and equipment has increased 37 percent. The price to schools of AV materials is expected to increase 13 percent as a result of the escalation of raw materials prices alone. Increased IV-B funds would help ensure that schools will not fall victim to this sudden turn of economic events.

3. The 1978 Survey of School Libraries/Media Centers conducted by the National Center for Education Statistics revealed that 72 percent of school financial assistance needs for acquisition of books were going unmet; 58.5 percent of the schools did not have the necessary financial assistance to purchase periodicals; 75.7 percent did not have the necessary financial assistance to acquire audiovisual materials, and 72.5 percent needed additional funds to purchase audiovisual equipment.

4. Youths who are slow readers face dim prospects in finding good jobs because they have few marketable skills. Recent reports on the all volunteer army indicate that 27 percent of the U.S. Army's new enlistees have difficulty reading their training manuals despite the fact that the Army has a higher percentage of high school graduates than ever before. Increased IV-B funding would help provide all students with resources to stimulate their interest, thereby giving each a better opportunity to begin a productive adult life.

5. In the September 1979 Ford Foundation report on literacy, the importance of literacy training materials with immediate relevance to people's lives was stressed as a prime factor in the success of literacy programs. School libraries have long attempted to meet the diverse needs of heterogenous student bodies. The title IV-B dollars invested in materials for children who are still challenged by the world of reading and figures, return dividends to all segments of American society as the children grow to become successful as literate adults.

6. Over 96 percent of the nation's nonpublic schools participate in the IV-B program, according to the U.S. Office of Education. This is the most participation by nonpublic schools in any federal education program.

COLLEGE LIBRARY RESOURCES (HIGHER EDUCATION ACT TITLE II-A)

Purpose: To assist higher education by providing (1) basic grants of up to $5,000 to institutions of higher education for library resources, (2) supplemental grants of up to $20 per student to particularly needy institutions, and (3) special purpose matching grants to combinations of institutions needing special assistance to establish and strengthen joint-use library facilities.

Appropriation FY 1980:	$ 4,988,000
Budget Estimate FY 1981:	4,988,000
ALA Appropriation Request FY 1981:	15,000,000

Justification: $12.5 million is required to provide the $5,000 basic grant authorized in the law for the 2,500 eligible institutions. $15 million in funding would allow a modest $2.5 million for aiding developing institution libraries and supporting cooperative efforts under the supplemental and special purpose grants. According to the Higher Education Price Index, the cost of goods and services purchased by colleges and universities has more than doubled since 1967. However, the cost of books and periodicals has more than tripled. College librarians themselves discussed the importance of HEA II-A in the September 1979 Journal of Academic Librarianship. Excerpts:

ILLINOIS, Lake Forest College: The collection strength made possible through II-A has been important in gaining support for significant sharing with other types of libraries. When bibliographic information was scarce, libraries were abnormally dependent on large libraries well known for being exhaustive in their collecting. With the development of better locational information on small collections, request volume has shifted toward these other libraries.

INDIANA, Earlham College: As Earlham's budget began to be squeezed by tightening funds on the one hand and double-digit inflation on the other, II-A funds were used more and more to help pay for items which, in the past, would have been regarded as standard purchases by the library. II-A's valid and important contribution is to help bridge the gap between limited budgets and increased costs.

MARYLAND, Frostburg State College: Cooperative arrangements are helpful, but most small libraries need basic materials common to all and not obtainable through cooperative arrangements or impossible to access because of the library's location. If our academic libraries are unable to support the education of our young people today, it will surely be reflected in the quality of performance of those people tomorrow.

MASSACHUSETTS, Suffolk University: First, with awards received over the past four years, the library has been able to begin an effective program of buying periodicals in microform, enabling it at one time to expand its title/volume holdings and to conserve space. Second, Suffolk University through reciprocal borrowing shares its periodicals with ten other members of the Fenway Library Consortium. Most of these libraries are eligible for II-A awards of a similar amount. The effect of this award is considerably magnified, therefore, by this cooperative action.

NEW YORK, Skidmore College: II-A funds invested with an eye to developing regional resources are in no way ineffective, and become comparable conceptually, if not in magnitude, to the strengthening of research library resources grants. The continuous annual allocation of funds results in long-range funding, which denies the argument of thinness advanced by the administration, made plausible only by looking at a single year's grant in a vacuum. The ongoing grant program has already become the equivalent of a $40,000 to $50,000 stipend paid out in annual installments.

LIBRARY TRAINING AND DEMONSTRATIONS (HIGHER EDUCATION ACT TITLE II-B)

Purpose: (1) to assist higher education by grants to higher education institutions or library agencies to support training of professionals and paraprofessionals in library and information science through fellowships, traineeships, and training institutes; and (2) to strengthen the delivery of library and information services by making grants to institutions of higher education and other organizations for demonstrations.

Appropriation FY 1980:	$1,000,000
Budget Estimate FY 1981:	1,000,000
ALA Appropriation Request FY 1981	6,000,000

Justification: 1) Training. Minorities remain seriously under-represented in the library and information science field. Of the 128,000 professional librarians and

HEA II-A ACADEMIC LIBRARY PURCHASING POWER CUT

Federal Aid

FY 1969 Appropriation for
HEA Title II-A ($25,000,000)



purchased the
equivalent of



2.7 million books @ $9.37 average cost

OR



2.7 million periodical subscriptions
@ $9.31 average cost

FOR



7.9 million students
1969 enrollment 7,916,991

FY 1979 Appropriation for
HEA Title II-A ($9,975,000)



−60%

purchased the
equivalent of



437,500 books @ $22.80 average cost
+ 143%

OR



328,449 periodical subscriptions
@ $30.37 average cost +226%

FOR



11.7 million students
1979 enrollment 11,669,429
+47%

The purchasing power of the Higher Education Act Title II-A College Library Resources program has been cut drastically by a combination of reduced appropriations plus increased costs for library materials and increased enrollment. From 1969 to 1979, the HEA II-A appropriation was reduced 60 percent, while the average cost of a book increased by 143 percent and the average cost of a periodical subscription increased by 226 percent. Student enrollment in higher education has increased 47 percent during the same period. Funding was cut even further in FY 1980, to $4,988,000.

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information scientists in this country, only about 250 are Hispanics, about 7,000 are Afro-Americans, about 1,600 are Asian-Americans and only about 20 are Native Americans. These figures, small as they are, represent the increase of the last ten years largely due to II-B. Library educators continue to report that demand for minority librarians is very strong, and that such graduates are promptly placed.

Library schools are finding that the supply of new faculty members who can teach in areas such as computer technology and newer communications media or service to special user groups like the aging is not sufficient to meet the needs. Lacking large-scale research projects typical in the science fields and lower-level teaching-assistant-taught sections that characterize some of the humanities fields, library schools find it particularly difficult to support doctoral students. HEA II-B programs have been extremely important in meeting these needs.

Chicago Public Library has only 4 Spanish-speaking librarians out of around 400. Three of these were II-B fellowship recipients. The essential services provided to Spanish-speaking library patrons by just one of these librarians include helping people fill out government forms such as citizenship certificates and forms required of aliens, helping them make arrangements to learn English through classes at the library, informing people about employment agencies, voter registration, federal taxes, and state of Illinois agencies and their services. Thus the II-B training funds have a multiplier effect through increased levels of literacy and self-sufficiency of the special user groups served.

2) Demonstrations. An appropriation of $6 million for HEA II-B would provide $2 million for the only major program supporting research and demonstrations in library and information services. In FY 1979, applications totaled $9 million although only $1 million was available. Only 11 of 129 projects could be funded.

Demonstration projects have made an impact in two very important areas -- innovative methods of extending service to minorities and other underserved groups, and adaptation of newer technologies to library operations. The needs in both these areas are great, yet funding sources are very few and very small. For every $1 million spent to maintain the public library system, only about $650 goes for public library research and development.

Most communications and data processing technologies were not developed specifically for library purposes and must be adapted to that use. Yet in few areas could a modest investment pay off so handsomely in terms of more efficient library operations and services. As libraries struggle to do more with less through resource sharing and improved methods of processing, storing, distributing and retrieving information, the need for demonstration projects is acute.

STRENGTHENING RESEARCH LIBRARY RESOURCES (HIGHER EDUCATION ACT TITLE II-C)

Purpose: Promotes research and education of high quality by providing grants to major research libraries (including academic, state, public, or independent research libraries) whose collections make a significant contribution to higher education and research, are broadly based and recognized as having national or international significance for scholarly research, are of a unique nature and contain material not widely available, and are in substantial demand by researchers and scholars outside the library's primary clientele. Institutions receiving grants under II-C are not eligible for HEA II-A grants.

Appropriation FY 1980:	$ 6,000,000
Budget Estimate FY 1981:	7,000,000
ALA Appropriation Request FY 1981:	10,000,000

Justification: 1. The report of the President's Commission on Foreign Language and International Studies released in November 1979, recommended $4 million in research library assistance for international studies collections. The report warns that "...the future of advanced international training and research is threatened by library problems: the steeply, constantly rising cost of books and periodicals, mailing, essential processing services, and space to house acquisitions. Worsened by adverse foreign exchange rates, these problems are complicated further by the urgent need for research libraries to introduce expensive new technologies to make possible the regional and national inter-library cooperation that is now imperative and for which federal assistance is essential."

2. The largest research libraries increased their spending for periodicals by 16 percent in 1978/79, but the increased funds bought one percent fewer subscriptions than the year before. Additional funding for II-C would help these libraries maintain their unique collections and make them available to users of other libraries. About 50 percent of II-C funds have been used in making these collections more accessible. Cooperative networks through which library resources are shared help to expand use and to eliminate duplication.

3. The report, Research Universities and the National Interest (New York: Ford Foundation, December 1977), identifies some of the problems of research libraries and the reasons federal support is needed. An example: "Exceptional collections are created less frequently now, and most of those that exist are maintained with increasing difficulty. The high cost of continuing acquisitions, the physical deterioration of materials, and the expense of maintaining the necessary skilled staff are all problems of growing magnitude. The hazard they pose to future intellectual vitality is serious."

OTHER PROGRAMS

NATIONAL COMMISSION ON LIBRARIES AND INFORMATION SCIENCE (NCLIS)

The American Library Association supports the full budget request, $699,000, of NCLIS for FY 1981. The recommendations for improvement of library and information services made by the delegates (two-thirds were citizens not connected with libraries) to last November's White House Conference on Library and Information Services comprise an agenda which could fully occupy the Commission for some years to come. The Commission is the source for both Congress and the President of independent and objective evaluations of various aspects of library and information resources and services. The amount requested is certainly the minimal level at which NCLIS' services can be carried out. As it is, $699,000 does not fully cover inflationary increases and thus would require some reduction of NCLIS activities.

NATIONAL LIBRARY OF MEDICINE

The Association recommends an appropriation of an additional $3.5 million for the National Library of Medicine above the budget request of $34,899,000. ALA also urges that $3 million be added to the budget request of $9,831,000 for the Medical Library Assistance Act.

In few areas of library and information work does the need for quick and comprehensive response to information requests occur so often, or have such direct consequences for human life and welfare. Funding for a critical program such as MLAA should not be reduced, as the budget recommends. Increased support of MLAA would help increase dissemination and retrieval of health information, much of which is generated through federal support of biomedical research. The potential for better service through computers in medicine and increased automation in health science libraries should also be further explored.

The current prices of medical books and journals illustrate one example of the unusually high and increasing costs facing medical libraries. The average hardcover medical book cost $27.73 in 1979, considerably higher than the average hardcover price in all subjects of $22.80. Similarly, the subscription price of the average medical journal cost $63.31, more than double the $30.37 price of the average periodical subscription.

SALARIES AND EXPENSES - DEPARTMENT OF EDUCATION LIBRARY UNIT

The American Library Association has long been concerned about the level of support given USOE's Office of Libraries and Learning Resources. Staff reductions, staff details and staff downgrading make it difficult to administer federal library programs with distinction. We urge that the congressional committees dealing with library programs monitor closely the organizational framework and financial support for library programs within the new Department of Education. The delegates to the White House Conference on Library and Information Services recognized the importance of the library unit by calling for an Office for Library and Information Services at the Assistant Secretary level. ALA supports this recommendation and believes that adequate financial support for the library unit is long overdue.

NATIONAL CENTER FOR EDUCATION STATISTICS

The American Library Association supports the library survey program of the National Center for Education Statistics, and urges Congress to provide adequate funding to NCES to enable it to continue its important surveys of public, academic, school, state, and special libraries as well as its surveys of library networks and the planned surveys of library personnel and of research libraries. We urge further that Congress take whatever steps are necessary to ensure that the library survey program continues as an effective and viable component of education statistics.

The data on libraries provided by NCES are used not only by government agencies and congressional committees, but by state and local library administrators and education and community planners, library associations, students and researchers. For these groups, NCES is the only official source of comprehensive and continuing statistics on library finances, collections, staff and services.

EDUCATION COMMUNICATIONS PANEL

Senator WEICKER. Thank you very much.

The next panel we have consists of Mr. Howard Hitchins of the Association for Educational Communications, Mr. Donald McNeil from the University of Mid-America, and Mr. Frank Norwood of the Joint Council on Educational Telecommunications.

As I understand the ground rules here, you fellows have 15 minutes. You can shuffle any way you want to.

PUBLIC LAW 95-561

STATEMENTS OF:

HOWARD HITCHINS, ASSOCIATION FOR EDUCATIONAL COMMUNICATIONS

DONALD MCNEIL, UNIVERSITY OF MID-AMERICA

FRANK NORWOOD, JOINT COUNCIL ON EDUCATIONAL TELECOMMUNICATIONS

Dr. HITCHINS. I am Dr. Howard Hitchins, executive director of the Association for Educational Communications and Technology and I am here to speak on behalf of Public Law 95-561, the Education Amendments of 1978, ESEA IV-B, which is a title that allows the acquisition of school library resources, textbooks and other printed and published construction materials and instructional equipment for use in academic study.

It touches virtually every instructional program in our elementary and secondary schools. The association I speak for is a group of 8,000 specialists concerned with the improvement of teaching and learning through the application of technology.

We are facilitators who combine learning theory and communications research to help teachers use their time and talents better.

By relegating routine instructional tests to audiovisual devices and techniques, teachers can spend more time working with students individually and can match media to learning style and stimulate students to open themselves to the excitement of learning.

BUDGET RECOMMENDATIONS

Our rationale for recommending a minimal increase in the fiscal year 1981 budget appropriation for ESEA IV-B to $205 million is based on four major needs:

One, the need to offset the vicious ravages of inflation during the past few years;

Two, the need to overcome the penalties of politically induced budget reductions;

Three, the need to plug up deficiencies in present school funding for instructional materials and equipment; and

Four, the need to improve the quality of education by using the most effective resources available.

Between December 1979 and February 1980, the price of film stock alone rose 59 percent for color and as high as 92 percent for black and white. There are indications that raw materials price jumps alone could

increase the price of audiovisual materials by almost 13 percent, even before the general inflationary effects are taken into account.

Similarly, the cost of plastics used in the production of records, audiovisual equipment, and film cases has increased 37 percent and 60 percent of this increase is attributed to rising oil prices.

Allocations for instructional materials, equipment, and resources are not only being squeezed by inflation, both general and superordinary; they are also being buffeted by a politically inspired fever of budget cutting, as exemplified most notably by California's Proposition 13.

And like inflation, these measures strike hardest at nonpersonnel sections of budgets; in California, for example, substantial cuts were made in new materials, equipment, supplies, and maintenance, while salaries and benefits went untouched.

Within the past 15 years, while school budgets in general have risen dramatically, allocations for instructional materials have declined by more than 50 percent. The national average per pupil cost for instructional materials now is only $14, and some States spend as little as $5 per pupil.

Teachers report that instructional materials structure 95 percent of classroom time, yet the Nation annually allocates a paltry 1.1 percent of its annual budget for these resources. In fact, it is estimated that teachers spend at least $30 million each year out of their own pockets to buy what the schools are unable to provide.

ESEA IV-B

Diminishing support for ESEA IV-B will hit hard at schools everywhere in the country. Nearly all of these funds—95 percent—are distributed among local education agencies on the basis of enrollments.

More than 96 percent of the Nation's nonpublic schools participate in the ESEA IV-B program—more than in any other Federal education program.

Despite the progress these funds have brought about, 1 million students today attend schools that have no library media center at all. Such facilities are lacking in 16.5 percent of the Nation's schools—and in rural areas, more than one-quarter of our schools still are without these needed resources.

We have evidence that instructional materials significantly influence the effectiveness of teaching and learning. Validated research shows that educational media can enable learners to achieve instructional objectives in substantially less time—as much as 25 percent less—than conventional methods.

Other studies have demonstrated that test scores improve when audiovisual media are used in conjunction with textbooks. Research conducted by educational turnkey systems bears out these findings: Students learn best when the same information is presented in a variety of ways.

I attached to my testimony letters and comments from educators in school systems from eight States around the country.

Thank you for the opportunity to speak on behalf of increasing ESEA Title IV-B to $205 million, about a 20-percent increase.

[The statement follows:]

STATEMENT OF HOWARD HITCHINS

It is my privilege to appear before you today on behalf of the nation's greatest asset for the future—our children and young people. Specifically, I am here to testify in support of increased funding, in Fiscal Year 1981, for Public Law 95-561 of the Education Amendments of 1978, ESEA IV-B. This legislation—authorizing funds for the acquisition of school library resources, textbooks, and other printed and published instructional materials and instructional equipment for use in the academic subjects—touches virtually every elementary and secondary, public or nonpublic school child in the United States.

The budget estimate you are considering, $171 million, is the same figure as the FY 1980 appropriation. As you are well aware, however, taking into consideration the violence that inflation is perpetrating turns a steady-state budget into an actual decrease in purchasing power. Such a diminution in resources is inconsistent with the federal government's expressed intent to support the improvement of our education system.

Speaking for the constituency of the Association for Educational Communications and Technology, I urge you to increase the FY 1981 appropriation of $205 million. This request is based not on any idealistic projections, nor on any plans for rapid expansion, but on urgent realities—the minimal financial assistance required merely to sustain this vital program. I cannot stress this point too strongly: the need for increased funding of instructional materials and equipment is far greater than the $205 million we are recommending, but this lesser figure reflects a sympathetic awareness of the current federal budget constraints you also are facing.

The membership of the Association for Educational Communications and Technology (AECT) is pressing this appropriations increase because we know at firsthand the benefits ESEA IV-B delivers—and the consequences of any further budgetary cutback in instructional materials and equipment at the present time. AECT is a professional association of some 8,000 specialists concerned with the improvement of teaching and learning through the application of technology. We are facilitators who combine learning theory and communications research to help teachers use their time and talents better. By relegating routine instructional tasks to audiovisual devices and techniques, teachers can spend more time working with students individually. And by integrating appropriate technology into their work, they can match media to learning styles, and stimulate students to open themselves to the excitement of learning.

AECT believes that this is no time for retreat in education. Ironically, in an age when so many of our young people are surrounded at home by the products of a rich technology—radio and television, personal computers, even video games—at school they frequently revert to an environment little changed from a quarter-

century ago. How can we reasonably expect our schools to prepare them for an increasingly technological society if we do not in the classroom provide the foundational tools? Without the assistance of ESEA IV-B, the slow diffusion of technological innovations in schools would have been slower still. Unless adequate support of this program continues, the schools will fall even farther behind. In fact, most schools today are being forced to spend less than one percent on teaching tools due to the pressures of higher personnel costs and the soaring costs of keeping school doors open.

Our rationale for recommending a minimal increase in the FY 1981 budget appropriation for ESEA IV-B to $205 million is based on four major needs:

1. The need to offset the vicious ravages of inflation during the past few years.
2. The need to overcome the penalties of politically induced budget reductions.
3. The need to plug up deficiencies in present school funding for instructional materials and equipment.
4. The need to improve the quality of education by using the most effective resources available.

The first two needs cited stem directly from fiscal factors not strictly within the control of education systems. The other two emanate from our commitment to guarantee equal opportunity for a high-quality education to all our people. Although these needs are interdependent, I shall address them individually.

WE NEED TO OFFSET INFLATION.

I need hardly call your attention to the impact the current rate of inflation (some 13 percent in calendar year 1979) is having on all budgets. The headlines daily announce further increases in living costs, further declines in what a dollar will buy. Higher prices drive up salaries, which nevertheless lose ground overall. We're all in this together; everyone is suffering. However, in at least two areas, the inflationary spiral is having a significant adverse impact on materials and resources budgets in particular.

First, because education remains substantially a labor-intensive enterprise, the great majority of each year's budget is dedicated to salaries, fringe benefits, and similar costs over which education decision makers have limited discretion. These categories are rendered even more sacrosanct by the political realities of tenure policies and strong teacher organizations. So when inflation forces a budget crisis, the far easier decision is to hack away at supplies, materials, equipment—and these categories experience drastic reductions, far out of proportion to their percentage of the budget dollar.

Second, in addition to the inflationary burden of "normal" factors affecting salaries, rent, transportation, and other costs, the purchase price of instructional materials actually is increasing at a rate far in excess of the general inflation rate. These price hikes primarily reflect manufacturers' pass-along increases caused by sudden escalation in prices of certain raw materials, particularly petrochemicals and silver essential to the production of these materials. As an alarming example: between December 1979 and February 1980, the price of film stock alone rose 59 percent for color and as high as 92 percent for black and white. There are indications that raw materials price jumps alone could increase the price of audiovisual materials by almost 13 percent, even before the general inflationary effects are taken into account. Similarly, the cost of plastics used in the production of records, audiovisual equipment and film cases has increased 37 percent and 60 percent of this increase is attributed to rising oil prices.

The implications are obvious: an FY 1981 budget appropriation that is the same as the appropriation for FY 1980, with no allowance for inflation, is in effect a decrease because the purchasing power of those dollars have eroded. The additional $34 million we are recommending for ESEA IV-B is to give this program a chance merely to help schools hold their own in this rocky economic time.

WE NEED TO OVERCOME POLITICALLY INDUCED BUDGET REDUCTIONS.

Allocations for instructional materials, equipment, and resources are not only being squeezed by inflation, both general and superordinary; they are also being buffeted by a politically-inspired fever of budget cutting, as exemplified most notably by California's Proposition 13. And like inflation, these measures strike hardest at non-personnel sections of budgets; in California, for example, substantial cuts were made in new materials, equipment, supplies, and maintenance, while salaries and benefits went untouched.

We are thus in the untenable position of being under a public mandate to improve basic skills and to reverse declining test scores, even while being denied the instructional tools to do these vital tasks. Within the past 15 years, while school budgets in general have risen dramatically, allocations for instructional materials have declined by more than 50 percent. The national average per-pupil cost for instructional materials now is only $14, and some states spend as little as $5 per pupil. Teachers report that instructional materials structure 95 percent of classroom time, yet the nation annually allocates a paltry 1.1 percent of its annual budget for these resources. In fact, it is estimated that teachers spend at least $30 million each year out of their own pockets to buy what the schools are unable to provide.

Diminishing support for ESEA IV-B will hit hard at schools everywhere in the country. Nearly all of these funds—95 percent--are distributed among local education

agencies on the basis of enrollments; none of the funds are siphoned off for administrative or non-instructional support. And there is provision for higher per-pupil allocations to schools in areas of greater need--where poverty limits the tax money available for education, where local tax effort is higher than the state average but per-pupil expenditure is still below average, and where there are large numbers of children whose education imposes a higher than average cost per pupil (for example, children from low-income families, from families in which English is not the dominant language, or from sparsely populated areas.) Furthermore, it needs to be stressed that nonpublic schools can and do benefit greatly from ESEA IV-B funds as well. More than 96 percent of the nation's nonpublic schools participate in the ESEA IV-B program--more than in any other federal education program.

Again, the implications are evident: erosion of funding to purchase instructional tools can only threaten the quality of what takes place in classrooms, both public and private, across the nation.

WE NEED TO TACKLE PRESENT DEFICIENCIES.

Despite the progress these funds have brought about, a million students today attend schools that have NO library media center at all. Such facilities are lacking in 16.5 percent of the nation's schools--and in rural areas, more than a quarter of our schools still are without these needed resources.

We continue to fall short of funds to purchase essential supplies. The 1978 Survey of School Libraries/Media Centers, conducted by the National Center for Education Statistics (NCES), revealed that the majority of the nation's schools report insufficient financial assistance for acquiring instructional materials: 72 percent lack adequate funds for books; 58.5 percent, for periodicals; 75.7 percent, for audiovisual materials; and 72.5 percent, for audiovisual equipment. Nearly half express a strong need for additional funds to acquire audiovisual materials.

Parents recognize the value of these services, too. According to a recent Gallup poll, 92 percent of respondents believe the school library is important for their children's education, and 73 percent said their children frequently use the school library. Yet data from the National Commission on Libraries and Information Sciences (NCLIS) recounts appalling statistics: elementary and secondary school libraries have 522 million books but need an additional 526 million books to serve current student populations; school libraries have 97 million audiovisual materials but need an additional 942 million; school libraries/media centers total $364 million in operating budgets but need an additional $4.69 billion!

High on the list of unmet needs is the ability to supply students with up-to-date information on the wide range of career options open to them. Vocational and career information needs to be replaced regularly and supplemented as society and the market conditions in the world of work change. Older occupational literature,

especially, may discriminate against women and minorities, and should be replaced with newer material that does not restrict the choices of any student.

WE NEED TO USE THE MOST EFFECTIVE RESOURCES AVAILABLE.

We have evidence that instructional materials significantly influence the effectiveness of teaching and learning. Validated research shows that educational media can enable learners to achieve instructional objectives in substantially less time—as much as 25 percent less time—than conventional methods. Other studies have demonstrated that test scores improve when audiovisual media are used in conjunction with textbooks. Research conducted by Educational Turnkey Systems bears out these findings: students learn best when the same information is presented in a variety of ways.

The notion that providing adequate instructional materials will pay off in better learning was also tested in a three-year experiment in which four schools of widely varying student populations were saturated with all the instructional materials and equipment they could possibly use. Almost all of the teachers (95 percent) in "Project Discovery" reported that students showed more initiative and were more motivated to participate in classroom activities. They also reported improvements in students' skills: vocabulary, reading interest, discussion and oral expression, general information, independent study, critical judgment, and observation skills. In addition, 92 percent of the teachers said the materials had increased their own personal and professional background.

What a difference unlimited funding for instructional materials and instructional equipment could make! But that is a dream, and we are talking of realities. We are fighting here to ensure just the sustenance of present levels of support, however short of the ideal. We are urging an FY 1981 appropriation of $205 million for ESEA IV-B, in line with the constraints of federal budget difficulties, because we don't want to see the gains that have been made slip irretrievably away.

We owe it to our children and young people to provide a high-quality of education, selecting the best from the technology, materials, and other instructional tools that are available. And we owe future generations a well-educated citizenry capable of facing the difficult decisions of a rapidly changing world. We cannot afford to stint; we cannot afford to draw back from our commitment.

Attached are comments extracted from letters from educators in representative school systems in eight states around the United States: Indiana, Missouri, Oregon, Pennsylvania, South Carolina, Washington, Wisconsin and West Virginia. These comments support the arguments presented above.

I thank you for the opportunity to express the support of AECT for continuing this commitment.

IN SUPPORT OF INCREASED FUNDING FOR ESEA IV-B
INSTRUCTIONAL MATERIALS AND SCHOOL LIBRARY RESOURCES

Here is how people feel around the country:

Indiana

Media centers and classrooms in the state of Indiana need full funding to improve learning resources. Local funds are becoming more and more scarce. Too many times media programs are the first to suffer when local school districts experience budget problems.

Nancy M. Knoshel
William Henry Harrison High School
West LaFayette

Missouri

Title IV-B helps us to continue to improve the learning resources in our district. The schools need all the help in this area they can get--from whatever source. The constant inroads inflation makes on our budget each month use up any available local funds to support the programs that Title IV-B monies are used for.

James K. Tice
Cons. District No.2 of Franklin Co.
Sullivan

Title IV-B is one of the few federal programs that allows the local school district some freedom of choice. I would regret any further limitations being placed on participating school districts.

Richard Trout
Woodland School District R-IV
Lutesville

Funding school libraries/media centers should be one of the major concerns of all involved in education....Without the necessary funds, library media centers cannot hope to keep up with the knowledge explosion we have been and are experiencing, not to mention inflationary prices of materials....Our students suffer.

Marilyn Stone
David H. Hickman High School
Columbia

The concept of most school media centers today is to serve all departments (math, business, English, history, etc.). In other words, money spent in the media center/library area benefits all students whether they are gifted or remedial, black or white. A well-funded media center with a philosophy to serve all areas of a school is one of the most important assets any school can have.

Curt Fuchs
David H. Hickman High School
Columbia

Oregon

Our schools need federal help in obtaining materials and equipment so that our children may learn....We see these funds being used to improve learning resources, helping to supply audio-visual aids for the children. The funds that are raised locally are scarce. The equipment is needed for the school programs.

Charles L. Knocke
Educational Systems
Beaverton

Pennsylvania

I personally rely on IV-B funding to update the reference collections in our library/media centers and to purchase print and non-print materials to support our curricular objectives. Equipment purchases have directly been beneficial in securing instructional television equipment and prepared video programs. Without continued IV-B support, our instructional program growth will be adversely affected.

Angelo J. Speziale
William Penn School District
Yeadon

Just this year we had to write a three-year proposal as to how we intended to spend our money. Based on this, we set up a three-year plan to purchase...equipment, video tape recorders, cameras, tripods, microphones, etc. to use with students in all our schools. Because of the cost of this equipment, it is almost impossible for local districts to be able to purchase it with money from local sources....An appropriation of $200 million would seem to be more in line so that we can continue to improve the learning resources--print, AV materials, and instructional equipment--available to our children.

Hillary A. Bitting, Jr.
West Shore School District
LeMoyne

South Carolina

The State of South Carolina, like many rural southern states, must rely heavily on the use of audio-visual materials and hardware in our schools to bring the world of technology, industry, and government to each remote schoolroom in our state....We presently provide 10,800 hours of instruction per school year to the state's 1,200-plus elementary and secondary schools--with six and one-half hours of in-school television or radio provided everyday.

But not all our schools and classrooms have television or radio receivers, or they have too few sets to fully utilize the wide range of lessons available to them....The provisions of Title IV-B of the Elementary and Secondary Education Act (ESEA IV-B) helps us continue to improve our instructional efforts--especially for those sparsely populated school districts where local funds remain scarce.

Regis A. Schnupp
Department of Education
Columbia

Washington

We have been dependent upon Title IV-B funds to provide such needed learning resources, both materials and equipment, since local funding has proven inadequate. The state funding recently enacted has introduced so many program requirements that this district actually has less funds to provide for the needs of our media centers, libraries, and classrooms.

Martin Manthe
Bethel Public Schools
Spanaway

Wisconsin

As a parent, I am dismayed that, despite this nation's willingness to expend vast sums in behalf of all sectors of our society, any federal agency can take the view that instructional equipment warrants no level of priority whatsoever.

Greg Hilbert
The Highsmith Co., Inc.
Fort Atkinson

I am director of media services in an 1800-pupil high school which provides media experiences from video to books. In 1978-79, for example, video cameras were used for 1431 hours, our staff of 3 professionals taught 240 hours of media skills, and 562 classes (37 different teachers) visited the media center in addition to our regular "walk-in trade."

Marjorie Doering
Oshkosh West High School

Educational materials and equipment are becoming more popular each year in that they present a way of teaching that cannot be established through textbooks. And just as texbooks become updated, so do the educational materials. The equipment also needs to be kept in good repair and replaced as it is used over and over again.

Charlene A. Haynes
Pardeeville Area School District

ESEA IV-B funds have been a tremendous aid to our school district. With declining enrollments and inflation it is becoming more and more difficult to provide the educational materials and equipment we need. A cut in these funds will penalize our children by lowering the quality of education provided to them....We need equipment to run our programs. School districts should have the freedom to choose how these funds should be spent.

Ilene Rewerts
Eau Claire Area Public Schools

Title IV-B was an effort to help us improve learning resources. Due to already scarce local funding, all of our schools need federal help for both materials and equipment.

Carolyn Servais
Little Chute Area School District

The Cooperative Education Service Agency #14 serves 31 schools districts in southwestern Wisconsin. Over half of these districts receive less than $1500 per year in ESEA Title IV-B funds. The other half receive less than $6600. The IV-B funds have helped improve opportunities and learning resources for the children in our schools.

Rosanne Krubsack
Cooperative Educational Service Agency
Fennimore

Over the years, I have been far more supportive of federal funds designated for classroom equipment, largely because I saw the tremendous impact that the old titles had in promoting science instruction after "Sputnik"....Title IV-B does that now, and it should be increased even at the expense of some other projects.

Eric T. Becker
Unified School District
Beaver Dam

West Virginia

It is becoming increasingly impossible to improve education through the use of media with the dwindling amount of support which we are getting through our federal dollars.... It is...essential that each school have the right to spend their funds for software or hardware--whichever is necessary to meet the educational needs of the students and the objectives of the school.

Rick Williamson
Bethany College

These statements were each made to a member of the Senate, House, or Secretary of Education during December, 1979 and January and February, 1980.

Dr. MCNEIL. I am Don McNeil. I am president of the University of Mid-America. I have my paper which outlines the support for four items in the budget: Title I, NIE budget, FIPSE budget, and Corporation for Public Broadcasting.

I appear as a generalist trying to establish a link between education and telecommunications. I would like to use my 4 or 5 minutes to talk about some of the things that I think are going on in this country in education and try to relate that to telecommunications.

The first is that there is a steady State enrollment in this country. The ironic part of that is that, while we have a steady State enrollment within the institutions for a variety of reasons, there are still millions of persons out there, adults and part-time students primarily, who are not being served by these institutions.

Second, it seemed to me that there is a technological revolution going on in this country that has to do with communications and how you dispense knowledge and information.

TECHNOLOGICAL INVESTMENT

The computer and those advanced technologies—the satellite, the video disk coming down the line, the video cassette, the home education centers, and all the things that are on the market or going to be on the market in the next 5 years—when you couple that technological revolution with the fact that institutions are not serving millions of Americans, it seems to me the proper use of technology would be a wise investment on the part of the Federal Government.

It has to do with some of the things mentioned here: inflation; the energy crisis. We are going to find within the next few years people will find it difficult to travel across the country to attend classes.

But the barriers that are provided to many of the learners have to do with not only distance and being away from campuses and unable to get there because of family responsibilities, financial aid or whatever, but there are time factors.

It's offered in a traditional way. Then there are the traditional requirements of the institution. It seems to me, that for a wise investment to combat inflation and increase productivity and also to help solve this energy plight of some of the adult learners, that we have to look for cost-effective ways of disseminating education in this country at the higher education level. The cost-effective way can be through communications with the linkup of the video with the computer. There are a lot of courses and knowledge that can be disseminated in this way.

We need an access kind of model to see what can be done and can't be done. If we don't link that technology to higher education within the next 10 years, I think that many parts of higher education will move outside of the establishment and be taken over by business and labor and a lot of other agencies in society.

One may argue that that's all right, too. I think the proper linkage is between those elements and the institutions of higher education much as agriculture was wedded to the land grant system over 100 years ago.

So my support is for these four items: Title I, which we regard as sort of experimentation grants—given for telecommunications and new ways of diffusing knowledge; also the National Institute of Education with its Appalachia and Alaska and UMA project—University of Mid-America, and research based on what people learn and how. FIPSE has had wide acclaim because they have given grants that it's possible to replicate in other parts of the country; and support for the Corporation for Public Broadcasting is important as it is the channel through which Federal funds come to public broadcasting stations.

With 64 university licensees out of 170 public TV licensees in the country, there is a keen interest on the part of higher education. My feeling is that a proper linkup between technology and education will enable the establishment to move in directions they can't now do because of inflationary cost.

It will let them experiment with new methods and pave the way for cost effectiveness. More than anything else, it will provide access to millions of Americans who don't now have what they can get through technology.

Thank you.

[The statement follows:]

STATEMENT OF DONALD R. MCNEIL

Mr. Chairman, my name is Donald R. McNeil. I am President of the University of Mid-America, a consortium of 11 major universities in 7 states devoted to delivering high quality education using technology to reach distant learners in a cost-effective manner. I am here today to support appropriations for Title I of the Higher Education Act, for the National Institute of Education, and for the Corporation for Public Broadcasting.

The University of Mid-America is a major regional experiment in "open learning" or "teaching at a distance," primarily using TV and other technologies. We were created in 1974 to explore the extent to which postsecondary educational opportunities could be expanded when constraints of time and place are reduced or eliminated, high quality educational opportunities are offered on learners' own terms (and at affordable cost), and education productivity is improved through the use of technology. UMA also serves as a regional system in one geographic area which might serve as a model for development of such programs in other sections of the nation. Students, using UMA materials, enroll through the delivery systems of the member institutions. Thus the curriculum available to any student is that provided by the participating university.

The presidents of the 11 member universities plus 6 distinguished citizens serve as members of UMA's governing Board of Trustees. An Institutional Advisory Council from the institutions advises the staff and the Board on curriculum planning and course development. A National Panel of Advisors, consisting of leaders in government, education, industry, labor and philanthropy, advises the Trustees from a national perspective. Staffs which plan and direct delivery activities are located in each of the UMA states and are employees of the member universities. UMA's central office staff is headquartered in Lincoln, where course development, research and dissemination activities originate.

UMA presently distributed more than a dozen instructional media packages for adults, used increasingly by colleges and universities in all parts of the nation, as well as in the 11 UMA states. Although there are several other centers of quality mediated instruction for higher education, UMA is the only such institution which operates from a regional consortium base.

Title I, Higher Education Act

Unfortunately, Community Service and Continuing Education is budgeted for FY 1981 by the Administration at zero dollars. Currently, Title I is providing funds for hundreds of state projects, special demonstrations and technical

assistance all over the country, I believe this program has done much to aid adult learning over the years, and ought to be continued and expanded, not stopped.

Recent projects funded under Title I by the U.S. Office of Education have provided matching funds for new ways to serve adult learners in such areas as environmental health, energy conservation, rural development and new training methods for the hearing handicapped and other handicapped persons. Many more continuing education activities were aided by the states with their allocations under this program. Many of these projects expanded their outreach and effectiveness by using telecommunications technologies. Title I has proven to be a valuable experiment station for technology in education.

Serving adult learners is the only rapidly expanding portion of American education. If we are to meet this challenge of the 80s--serving the needs of adults--there is much more to be learned and tried. This program deserves the opportunity to continue in its role of leadership funds to all the states.

There is another reason for continuing and expanding this program. I recently testified in Senate hearings on the reauthorization of higher education legislation. Specifically, I spoke in support of a new Title I, now focusing even more positively on community outreach to adult learners. The legislation embodying this approach has now been reported out by the Senate Committee on Labor and Human Resources. I consider this new charter of services as extraordinarily important in the development of appropriate education for unserved and underserved adult learners. This new Title I would allow assistance by the states and the Education Department to community agencies serving adult learners, in addition to the community colleges and four-year institutions, and would focus particularly on the needs of those still unable to cross today's barriers of costs, distance, or opportunity. We are pleased at the new emphasis on telecommunications it contains also.

It could well be that this legislation will be in place later this year, certainly by next year, and thus be the follow-on authority to help adult learners. Thus the appropriations you vote this year would be able to apply to either the new opportunities which would be available, or to projects which would begin to fulfill these new possibilities under present authority.

National Institute of Education

I would also like to speak in behalf of appropriations for the National Institute of Education and for the Fund for the Improvement of Post-Secondary

Education. UMA is funded principally by NIE for $2.1 million a year. There is no question that, without the assistance of NIE funding, many new public education forces--including UMA--would simply not have come into being. As time goes on, more and more of these organizations will be providing major educational services. I believe that NIE's requested budget of $105.1 million is a very modest one in view of the nation's changing education needs. (UMA's NIE funds are scheduled to cease at the end of FY 1982, thus my testimony is not related to further UMA funding requests.)

In my view, UMA could well be used as an example of currently successful NIE investment. In our first 6 years, over 13,000 adults have enrolled in courses through UMA delivery systems. Demographic studies show that those who have enrolled constitute a new clientele in American higher education. A majority are women, many with young children at home. Their average age is 36. Nearly half have had no previous college experience, most have had no formal schooling for many years. Median family income is about $12,000. Many live in cities, isolated not be geographic distance from colleges and universities, but by such barriers as domestic demands, pressures of work, inconvenient schedules and fear of failure in the classroom. UMA's studies indicate that many adults want to determine, in the privacy of their homes, their ability to succeed in a college-level course before enrolling on a campus.

Of those who enroll, nearly two-thirds do so for credit, and say they want to obtain a college degree. More than half complete their course work, and nearly all with passing grades. Two-thirds would not have enrolled in any on-campus postsecondary institution initially, yet nearly half are continuing their education at an institution later, thus enter the world of higher education strictly through the UMA opportunity.

UMA studies also show that for every one student who enrolls for credit, hundreds of persons view UMA courses on public TV.

In the area of telecommunications elsewhere, NIE funds have assisted the Appalachian Regional Commission and the State of Alaska to experiment with broad education services by means of satellite technology for the people of these remote areas. Their results are also very encouraging.

The Fund for the Improvement of Post-Secondary Education (FIPSE) has also provided funds for a number of significant projects utilizing telecommunications. Again, FIPSE, with small grants, is one of the few again in the federal government which makes money available for experiments--including those relating to technology in education.

Eudcation research is a vital commodity. It is America's investment in its most important capital growth element: its citizens--of all ages. Most individual public and private institutions in education have too few dollars themselves for this investment. But we simply must continue to find new ways to provide our people with the knowledge they will need to keep up with tomorrow's world.

Corporation for Public Broadcasting

The Corporation for Public Broadcasting (CPB) is the agency established by the Congress to receive federal funds if matched 1-2 by local non-federal funds. It is, as you know, forward funded, such that the FY 1981 Labor-HEW appropriation will contain CPB funds for FY 1983. CPB is budgeted for FY 1983 by the Administration at $182 million. I urge the appropriation of the full authorized funding of $220 million.

CPB provides these federal funds to local PTV and radio stations as unearmarked Community Service Grants, and provides direct funding for specific programs, research and other services as well. A significant portion of these funds aid education, through the activities of the local stations, and through specific national education programming and services. As a member of the Board of the Public Broadcasting Service, I believe that the share CPB devotes to education should be greater. However, we all agree that CPB ought to receive the full funding authorized for it, provided that the people of the nation will put up their share of non-federal funds--twice the federal funding. That is the formula.

CPB has provided important support for a number of education projects, such as that for the Agency for Instructional Television's "Thinkabout" series, for important communications research, and just last week helped with funds for follow-up information and publications from our UMA Symposium on Federal Policy and the Adult Learner. We are also aware that CPB is currently discussing significant new support for higher education for adult learners. We believe that CPB's record and the promise we see for its future call for the full funding which they have requested.

Mr. Chairman, the appropriations cited here are necessary and valuable to American education. Funds from the federal government enable thousands of individuals to engage in educational opportunities that might otherwise not exist. I thank you for the opportunity to testify to you and this Subcommittee.

Donald R. McNeil
President, University of Mid-America

Donald R. McNeil became the first full-time President of the University of Mid-America, a consortium of eleven universities in seven states, in 1978.

Dr. McNeil was director of the California Postsecondary Education Commission from 1975 to 1977. The Commission coordinated and planned programs for the system which included the University of California, California State universities and colleges, and community colleges and independent and private vocational schools in the state.

Dr. McNeil served from 1969 to 1975 as chancellor of the University of Maine, a newly merged system that brought together five state colleges and the three campuses of the University of Maine.

In 1965, Dr. McNeil was named the first chancellor of the newly created University Extension, a merger of three extension divisions at the University of Wisconsin.

An historian by discipline (his Ph.D. and M.A. were in American history from the University of Wisconsin; his B.A. from the University of Oregon), Dr. McNeil began his career in higher education in 1963 at the University of Wisconsin.

Dr. McNeil has served on the Board of Directors of the Public Broadcasting Service since 1973, and also serves on the Board of the Public Service Satellite Consortium.

JOINT COUNCIL ON EDUCATIONAL TELECOMMUNICATIONS

Mr. NORWOOD. Senator, I would like to submit my written comments for the record.

Senator WEICKER. At this time, I would say that all statements in their entirety of all witnesses will be included in the record in toto.

Please feel free to synopsize.

Mr. NORWOOD. I will take my few minutes to summarize and highlight some of these.

First, let me introduce the Joint Council on Educational Telecommunications. We are a 30-year-old organization founded in 1950 by some of the leading educational organizations in Washington. At that time, the Federal Communications Commission was considering what to do about the new technology of television and the JCET was organized, as the Joint Committee on Educational Television, to lead the fight—which was successful—to persuade the Commission to set aside channels for what we then called ETV, now better known as public television.

I said in my written comments that two of the members of the JCET board are also testifying this morning. That is true.

Ms. Cooke is the former immediate past president of the JCET. Dr. Hitchins is current president. There is a third member of my board of directors who is the newest member of the JCET—Dr. McNeil, president of UMA. I am sure he will speak to me severely about this over coffee afterward.

I want to associate the Joint Council with the comments that all witnesses have made and which have been made on behalf of our other

members, such as the Corporation for Public Broadcasting, and take this opportunity just to concentrate in one area; that is, to plead for—to plead against any reduction in the proposed budgeting on those programs that are supporting important television programing in the Department of Education.

PROJECTS NEEDING FUNDING

There are several programs I would like to single out for comment. The basic skills section of the ESEA has a section 207 which provided last year, and will provide in this current 1981 budget, $2 million for television at the basic skills level.

None of that money from last year has yet been granted; but in my written testimony, I describe a project which another of our members, the Agency for Instructional Television, has mounted in which the total project cost was something on the order of $6 million—$5 million came from State departments of education and from users. There was a little over $1 million in seed money coming from the Corporation for Public Broadcasting. I think that experience indicates how a program like the new basic skills program can use a small amount of money to leverage some dollars from the rest of the educational community and can play an important role in helping to innovate in this area.

On the subject of innovation, I would like to single out two other items worth noting. One is the telecommunications demonstration program which is now in HEW and is planned to be moved to the Department of Education. It was a very modest program with only $1 million a year. Currently the 1979 funds are internally impounded and I understand from friends on the staff that there is some talk that the Department of Education will also impound the 1980 funds for $1 million.

Certainly I would oppose that and support the $1 million allocated for 1981 because this is a unique program. It's very broadbased and open to opportunities to apply new technology, communications technology, to a number of health and social applications.

I described some of these applications in my written testimony including what is called an electronic mailbox for the deaf, which is being funded by the Archdiocese of Boston where deaf and hard-of-hearing are able to use a computer terminal to deliver messages to a central computer which can be retrieved by the persons to whom they are addressed.

There are other innovative programs. Nowhere in the Federal structure is there that money for that kind of R. & D. except in this program.

FIPSE, the function for improvement of postsecondary education, is another area in which funds are available for a wide variety of innovative programs.

Some of those have involved communications. FIPSE supported a yearlong project with another of our members, the American Association for Community and Junior Colleges, which in cooperation with public broadcasting, explored further the development and use of television courses as a means of providing a basic component of university

college-level education for people, as described by Dr. McNeil, who are not able to come to the campus.

FIPSE has a proposed increase in the 1981 budget to $17 million and I would certainly urge that that increase stand.

The other programs mentioned in my written testimony are the Emergency School Aid Act, radio and television funds, and the revised special projects funds.

The special project funds are best noted for the fact they have been in support of the Sesame Street program. This is the last year in which Sesame Street gets support from the Federal Government, but other new programs like 3–2–1 Contact, also from Children's Workshop and other mentioned in my testimony, are supported by those funds.

The same is true for the ESAA TV fund which supported very important programing. These two represent a major source of funding for quality programs for children. Some of them are for school use. Many of them for afterschool viewing.

At a time when the FCC and parents are concerned more and more about the quality of children's programs on commercial television, these have special importance.

Thank you for the opportunity. I think anything I left out is covered in my written testimony.

Senator WEICKER. Thank you very much. I appreciate it.

[The statement follows:]

STATEMENT OF FRANK NORWOOD

Mr. Chairman, members of the Subcommittee, I am Frank W. Norwood, Executive of the Joint Council on Educational Telecommunications, a consortium of national and regional organizations and associations in education, public broadcasting, and library and information services. In fact, two members of our board of directors are here to testify for their organizations which are members of the Joint Council: Ms. Cooke, of the American Library Association, is the immediate past president of the JCET and Dr. Hitchens, of the Association for Educational Communications and Technology is our current president.

When the JCET was founded in 1950 as the Joint Committee on Educational Television, its purpose was to give leadership to the successful effort to have broadcast channels reserved for what is now called "public television." The JCET believed then, and believes now, that radio, television, and the emerging telecommunications technologies can be important tools for education at all levels, from pre-school to post-graduate. While our members (a list is attached to my written comments) are in broad agreement in support of the full funding of all educational programs, I want to take this opportunity to single out for attention some of those items in the budget which represent what we believe to be particularly wise investments in programs which apply telecommunications to meeting the nation's educational needs.

Educational television programming continues to be significantly supported by activities funded under the Revised Special Projects Act and the educational radio and television provisions of the Emergency School Aid Act. From the Children's Television Workshop, from which came "Sesame Street," and the "Electric Company," the new science series, "3-2-1 Contact!" is now in its first season. Series from other producers on such subjects as parenting skills ("Footsteps") career planning ("Freestyle") and how to be a critical consumer of television have already been produced with USOE aid. The critical TV skills projects have engendered an additional ten-part series, produced by WNET, New York, and produced with station and Corporation for Public Broadcasting funds, a dividend on the original investment made by USOE.

Now in production is a series called "Powerhouse," aimed at 8-to-10 year olds on the important subject of nutrition. In an age of junk foods and fad diets, television can be used to reach young people with more than the traditional "three R's."

The Emergency School Aid Act continues to support a wide variety of programs designed to demonstrate for all children the contributions made to the American

society by the many races and cultures which have enriched our common heritage. WETA's "Jump Street," and a west coast production by former Washingtonian, Topper Carew, "Rainbow Movie of the Week," will document the development of jazz and the ways in which young Americans from a variety of ethnic backgrounds cope with growing up in the U.S.A.

At a time when parents and the Federal Communications Commission are expressing increasing concern about the quality of children's programs on television, it is worth noting that a substantial majority of the in-school and after-school programs for young people on public television are funded with aid from a variety of HEW activities.

The 1979 revision of the Elementary and Secondary Education Act provided a new Title II for support of efforts to improve teaching of the basic skills. Section 207 specifically provides funds for radio and television programming. While no grants of FY '79 funds have yet been made, a parallel effort by the non-profit Agency for Instructional Television shows what can be done in this area.

With more than $3-and-a-half million from its member state departments of education and Canadian provincial ministries of education, AIT funded all of the pre-production instructional design and most of the costs of production. The Corporation for Public Broadcasting furnished $1,470,000 and the Exxon Corporation provided more than $285,000 for information to teachers and formative evaluation.

The "Thinkabout" series consists of sixty 15-minute programs designed to help strengthen the reasoning skills of fifth and sixth graders and to review and reinforce their language arts, mathematics, and study skills. By early this past January more than 200 public television stations in the U.S. and stations in several Canadian provinces had broadcast about half the programs, while the last programs in the series are being completed by producers in Virginia, South Carolina and California.

The Telecommunications Demonstrations program is funded at a modest $1-million level, but its importance and impact are greater than its meager funding level would suggest. It is specifically designed to support projects which apply communications technology in innovative ways to the solution of important educational and social problems. In Spokane, a 1978 grant of $169,000 dollars to the Spokane Schools has allowed their public television station, KSPS-TV, to serve a coordinator for programming six channels on the local commercial cable TV system with fare for a wide range of local audiences, thus multiplying the effectiveness of the local station and taping the multi-channel resources of a new communications medium which will become increasingly available to citizens as cable expands across the country.

In Boston, the Roman Catholic Archdiocese has established an "electronic mailbox" for the hearing impared. Combining computer technology with conventional telephone lines, deaf participants may type messages into a central computer, where the recipient can retrive them by typing in his name and identification code.

Other Telecommunications Demonstration projects have pioneers the use of slow-scan television over conventional telephone lines for education and social services to prisoners, for library service to rural area and for on-request medical information.

The Foundation for the Improvement of Post-Secondary Education has been another source of support for innovative programs which sometimes involve the use of modern communications means. Last year, FIPSE funded a study by the American Association of Community and Junior Colleges on Adult Learning and Public Broadcasting, bringing together leaders in both communities to encourage the development of college level courses using broadcast television series. We are pleased that the FY '81 budget includes a healthy increase for FIPSE.

The Bureau of Education for the Handicapped deserves special mention, as well, because it represents a goal-oriented program which has, over the past few years, increasingly recognized the value which radio, television, and other telecommunications technologies can be employed as valuable tools in meeting important and recognized needs. We believe that other line programs should become familiar with the contributions which technology can make. For example, Title I of the Higher Education Act, dealing with Community Outreach and Continuing Education, provides a timely example. As a supplement to these remarks, I am attaching a short article in which I have tried to show the ways in which communications technologies can provide new means for educational outreach.

Finally, we urge you to resist the tempation to make budget reductions at the expense of these programs. Most are funded at the same level as FY '80, which, in real dollars means substantial belt-tightening. In television program production, costs have shot up because of the astronomical rise in the price of silver, the basic ingredient in photographic film. Thus, any cuts in these programs will have a disproportional and disastrous effect on efforts which are increasingly proving to be among the best investments of education dollars.

Mindful of the need to economize, we nonetheless recommend funding these important programs at the levels indicated in the announced Education Department budget:

Basic Skills, Sec. 207, ESEA	$ 2-million
Revised Special Projects, P.L. 92-329	$ 6-million

FIPSE, Title III, P.L. 89-329	$17-million
Telecommunications Demonstrations, P.L. 95-567	$ 1-million
ESAA TV & Radio, P.L. 92-318	$ 6-million
Handicapped Media, P.L. 93-380	$19-million

3/80

MEMBERSHIP

Agency for Instructional Television (AIT); Bloomington, IN
American Association for Higher Education (AAHE); Washington, DC
American Association of Community and Junior Colleges (AACJC); Washington, DC
American Association of School Administrators (AASA); Rosslyn, VA
American Council on Education (ACE); Washington, DC
American Library Association (ALA); Washington, DC/Chicago, IL
Association for Educational Communications Technology (AECT); Washington, DC
Corporation for Public Broadcasting (CPB); Washington, DC
Council of Chief State School Officers (CCSSO); Washington, DC
Great Plains National Instructional Television Library (GPNITL); Lincoln, NB
Indiana Higher Educational Telecommunication System (IHETS); Indianapolis, IN
Maryland Center for Public Broadcasting (MCPB); Owings Mills, MD
Mississippi Authority for ETV; Jackson, MS
National Association of Educational Broadcasters (NAEB); Washington, DC
National Association of State Universities and Land-Grant Colleges (NASULGC); Washington, DC
National Catholic Education Association (NCEA); Washington, DC
National Education Association (NEA); Washington, DC
National Instructional Telecommunications Council (NITC); Williamburg, VA
National Public Radio (NPR); Washington, DC
National University Extension Association (NUEA); Washington, DC
Ohio Educational Television Network Commission (Ohio ETV); Columbus, OH
Pennsylvania Public Television Network (PPTN); Hershey, PA
Public Broadcasting Service (PBS); Washington, DC
Virginia Public Telecommunictions Council (VPTC); Richmond, VA
University of Mid-America (UM-A); Lincoln, NB

Communications Technologies: Means for Outreach

The potential audience for open learning encompasses a wide variety of adults who have, collectively, a very broad range of educational needs. In addition to those who look to open learning for "second chance" opportunities to pursue a college degree, there are others whose needs are as basic as functional literacy and the essential coping skills, or as wide-spread as establishing high-school equivalency. A growing number of our most highly educated citizens, no strangers to the traditional campus, now find themselves in need of recurrent education to help them keep abreast of their rapidly growing fields and to meet requirements for professional recertification.

Common to all such learners, however, is the need for education at times and places convenient to themselves. Whether students will not or cannot come to the campus on a conventional basis, open learning must be based upon institutional outreach. While television and other communications technologies may still be regarded by some as "frills" *on* the campus, they can serve open learning as powerful tools in the essential task of bridging the distance which is inherent in all "teaching at a distance."

Communications technologies should be examined to determine their potential roles in helping to overcome the disadvantages imposed upon the student by his remote and sometimes solitary existence, removed from the intellectual and social support which life on campus usually provides. Off campus or on, the principal ingredients for success will continue to be that oldest of communications technologies, the printed word, and (older still) hard intellectual work by the learner. But, for the learner at a distance, such newer devices as the computer can provide tutoring more patient than that offered by a graduate assistant or junior faculty member and can be used to individualize the student's assignments to suit his current needs. The telephone can give the distant student a means for conferring with his professor or other on-campus mentor as the resident student does during office hours or over coffee. An inbound WATS line - a toll-free "800" number—might well be used to facilitate "bull session" conference calls among classmates.

Television has figured prominently in such open learning models as the University of Mid-America and the Open University in the United Kingdom and for many years, Chicago's TV College. Television's contributions to open learning are several: not least is the fact that television is often the most visible part of the "invisible campus." While other institutions may make their impact upon the consciousness of the general public through their ivy-covered buildings or their football teams, the programming seen on television is the public's principal evidence of the use of TV by open learning institutions. Acceptance and support of such open learning institutions may well depend, not only upon the student's view of the open learning enterprise, but upon that of the general public as well.

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FORUM 76



Frank W. Norwood
Executive Secretary
Joint Council on
Educational Telecommunications

Frank W. Norwood is the Executive Secretary of the Joint Council on Educational Telecommunications, a position he has held since 1968. Before joining the JCET, he was a program associate for higher education at the Agency for Instructional Television, where he held a joint appointment on the faculty at Indiana University's Department of Radio and Television. Mr. Norwood taught for eight years at San Diego State University prior to his Indiana position, also working as television coordinator and general manager for a local station. Under the National Aeronautics and Space Administration's agreement with JCET, Mr. Norwood meets with experimenters on the joint U.S.-Canadian Communications Technology Satellite. He was also among the organizers of the Public Service Satellite Consortium, which is now promoting the development of an operational satellite service using space technology.

Broadcast television can also give open learning pace and discipline lacking in most conventional home-study programs. The on-campus student well knows the pressures of keeping up with the unremitting march of professional lectures and assignments. The solitary student, free to work entirely at his own pace, too often finds his goals receding in the distance. The University of California, San Diego, is one institution which has compared the precentage of students completing televised as opposed to conventional home-study courses. Its findings give strong evidence that students who follow the course on television are more likely to finish their work and receive credit for their efforts.

But television's essential contribution to teaching at a distance goes far beyond mere public relations or student intellectual discipline. John Cardinal Newman states: "the general principles of any study you may learn by books at home, but the detail, the color, the tone, the air, the life which makes it live in us, you must catch all these from those in whom it already lives."

Jacob Bronowski's *The Ascent of Man* provides a striking example. Television contributes its unique ability to transport the learner beyond the walls of his classroom or his home and to allow him to see with his own eyes those things about which other professors only lecture, other students only read. But, in the final analysis, the excitement of *The Ascent of Man* lies, as Newman suggests, in coming face to face with a great teacher within whom the notion that the mastery of science has lighted man's way burns so clearly as to ignite the interest of every viewer.

In public broadcasting, open learning may find a powerful and timely resource. In 1975, the Corporation for Public Broadcasting received and endorsed a report, *Public Broadcasting and Education*, from its Advisory Council of National Organizations. ACNO's recommendations to this federally supported, nongovernmental agency charged with funding public radio and television center about the theme that what we now call "public" broadcasting cannot and must not forget its heritage and responsibilities from the days of "ETV" and that public radio and television must renew their effort to provide educational as well as cultural and public affairs programming.

Noncommercial public television stations provide the "delivery system" for such open learning enterprises as the University of Mid-America. Equally significant has been the rise of yet another American model for post-secondary open learning. Such public television series as *The Ascent of Man, Classic Theatre: The Humanities in Drama*, and *The Adams Chronicles* have, with ancillary study materials developed principally by the University of California, San Diego, the Coast Community College, and Miami-Dade Community College District, become the basis for college courses in which tens of thousands of students have enrolled for credit from hundreds of American colleges. Capitalizing upon the substantial programming investments already made by others, they have demonstrated that open learning institutions need not always produce their own television programming.

But neither television, nor any other communications technology, is "The Answer" to the problems of bridging the distance between learner and institution, and among learners. The hard realities of the medium are that television programming is expensive and programming on the order of *Ascent of Man, Classic Theatre*, and the like are very expensive indeed. It follows that broadcast television is most effectively and appropriately used when the subject matter is wide interest (public or commercial, television remains essentially a mass medium). In his address to the final meeting of the Commission on Non-Traditional Study, Carnegie Corporation President Alan Pifer predicted the increasing demand for "continuing education for adults of a non-vocational, non-technical, non-specialized kind." It appears that it is in this area, close to what we once referred to as "general education" and "liberal arts," that broadcast television may make its greatest contribution.

The cost of good television—including not only the production of programs but also of the ancillary print materials which can turn mere programs into a course—is often beyond the resources of a single institution. Open learning enterprises interested in using television effectively may well look to establishing means of interinstitutional cooperation to share both the burdens and the benefits.

Public television is only, however, a part of public broadcasting. Noncommercial radio was, in fact, born at the University of Wisconsin when, in 1919, WHA began its daily broadcasts of agricultural extension programming. Once called "The Hidden Medium," public radio has continued to merit that description as far as most planners and practitioners of open learning and nontraditional study are concerned—despite the fact that many public radio stations are operated by colleges and universities.

But, however belatedly, open learning by radio is beginning to receive some of the attention it has long missed. In the Washington-Baltimore area, both American University and Baltimore Community College operate noncommercial FM stations and both include formal courses in their broadcast schedules. Purdue University, whose WBAA is almost as old as Wisconsin's WHA, has made extensive use of radio for extension education, beginning at first with the simple expedient of recording classroom lectures, coughs, asides, the scratch of chalk on blackboard and all, and later developing more sophisticated radio formats with interviews, documentary reports, and the like. In Britian, the Open University supplements its television presentations with radio, whose timeliness can be used to "up-date" the TV programming. In Richmond, Virginia Commonwealth University has been employing radio for course-work concerned with the nation's Bicentennial. National Public Radio, the interconnected network of public radio stations, recently completed a series of monthly phone-in programs, *American Issues Radio Forum*, funded under a grant from the National Endowment for the Humanities and produced in connection with one of the University of California at San Diego's courses-by-newspaper.

Radio offers some of the advantages of television and at far less cost. Most public radio stations are on the FM, rather than the standard AM, band, but the growth of FM's popularity during the past decade has all but eliminated what was once a major handicap. In fact, for open learning purposes, FM has some distinct advantages. Not only does it offer static-free high fidelity reception and the option of stereo, but FM stations can transmit a second, private program via SCA subchannel.

SCA stands for Subsidiary Communications Authoriza-

tion, the permit issued by the Federal Communications Commission for such transmissions. Typically, commercial FM stations use such SCA's to transmit background music to subscribing restaurants, offices, and other places of business. These transmissions are not, strictly speaking, broadcasts, since they cannot be heard except with the aid of special (but inexpensive) receivers, and unauthorized use of such programs is illegal.

A number of public radio stations use SCA's for such special audience services as "talking newspapers" for the visually handicapped. At Albany Medical College in New York, WAMC (FM) has long been providing continuing education to medical professionals via the station's subchannel. SCA channels may be used to transmit not only voice, but data, facsimile, and even slow-scan (still frame) television.

Other relatively untapped communications resources for open learning include the Instructional Television Fixed Service and its younger common-carrier cousin, the Multipoint Distribution Service. ITFS was established by the Federal Communications Commission in 1963. It is a "point-to-points" system for transmitting as many as four channels of black-and-white or color TV to predetermined reception points such as schools, hospitals, or industrial plants equipped with special receiving antennas. While the greatest use of ITFS has been by parochial school systems for the delivery of classroom television for elementary and secondary classes, Stanford University, the University of Southern California, and other institutions of higher education have developed ITFS as a means of providing graduate education to engineers and other professionals on an in-plant basis. Spared the difficulties of commuting to the campus, such professionals can continue their education by taking courses in a company conference room, watching their professors and classmates on the TV screen, and asking and responding to questions by telephone interconnection.

The Instructional Television Fixed Service is licensed to educational institutions, but the Multipoint Distribution Service is ITFS' technical counterpart in the common-carrier field. Developed several years ago in the expectation that business communications, including TV communications between main office and branch banks, video conferencing, and like services would soon be in demand, MDS currently finds its greatest use in delivering movies and sports events to pay television operators in high-rise apartments and on cable television. MDS' application to open learning and recurrent professional education is largely unexplored. Its major attraction lies in the fact that an open learning program can lease as few hours per week as it may need; an excellent opportunity to explore the application of this technology without making a major initial investment in ITFS hardware.

Where "real time" programming is not essential, video tape can provide a useful medium for open learning. Paralleling Stanford's and Southern California's use of ITFS for graduate engineering education is a tape-based project of Colorado State University, SURGE (for "State University Resources in Graduate Education"). Begun in 1967 with aid from the National Science Foundation, SURGE enables Colorado State to make Master's degree programs available to students throughout the United States. The University of Arizona's Microcampus Project also offers a wide variety of regular courses, plus special seminars, workshops, and short courses in specialized topics in science and engineering.

The success of the videocassettes, relatively inexpensive, easy to handle, and with *de facto* technical standardization, has made it a more attractive medium than reel-to-reel videotape might ever have become. Industry has been more alert than the educational establishment to the potential which videocassettes can offer for education and training. IBM, Xerox, Burrows, Coca-Cola, and Pepsi-Cola are among the industrial giants with established videocassette operations to keep their employers and customers abreast of the latest developments from corporate headquarters. The Ford Motor Co. has placed more than 5,000 videocassette players at local dealers.

There is a small but growing "video publishing" industry which seeks to meet the needs of business. Columbia Pictures offers *Turning Management On*, with lecturers drawn from the faculties of the Harvard Business School and the University of Chicago. Time-Life has turned to TV star Dick Cavett as the on-camera personality for its speed reading course, but content and presentation were developed for Time-Life by the director of the Rutgers University Reading Center. Advanced Systems, Inc., publishes a catalog of more than 500 videotapes in management, mathematics, and computer science. Other companies are exploring the health care field. The development by Sony of its new Betamax system promises to substantially reduce the cost of videocassette purchase and operation, and thus to give further impetus to the growth of this communications technology.

No review of the potential application of communications technologies to open learning would be complete without some attention to those long-heralded emerging technologies: cable television, video disc, satellites, and computers.

Realists will recall that only a few years ago the popular press was filled with cable television's promises of "the wired nation," and "television of abundance." Cable television entrepreneurs battled furiously to secure franchises to wire major cities, only to have the icy breath of rising costs and interest rates chill their enthusiasm. Now, cable television appears to be regaining some of its former optimism.

Those interested in open learning should note that Federal Communications Commission rules require that all cable systems serving more than 3,500 households provide opportunities for "educational access" with no cost for the use of the system. This potential resource remains largely untapped, although Purdue University has made substantial use of the cable system which serves Lafayette, Indiana, to deliver a wide variety of course offerings to off-campus viewers. Oregon State University, Corvallis, is another long-time user of cable television.

It is worth noting that a mjaor reason for cable's new life in the major metropolitan areas is the growth of pay cable—the delivery of sports events and movies sans advertising for a premium price above that charged for cable's standard services. Pay television (both over-the-air and via cable) could provide some attractive new opportunities for open learning which might, for the first time, tie fees directly to viewership. On-campus auditors have long been expected to pay fees, although at some reduced, non-

credit rate. Broadcast television, however, has always "let such auditors in" free.

The video disc is yet another "communications revolution" whose advance men and public relations agents greatly outnumber either the players or programs available to date. While it seems self-evident that low-cost video discs for home use could contribute greatly to the development and spread of open learning, there is some reason for caution.

Like pay cable, the success of video discs will depend upon their entertainment potential. Those who already own video disc players (at a cost of about $500) may well be interested in purchasing an album of French lessons, but too few would consider *that* the prime reason for buying a player to expect the video disc industry to survive on education-hungry users alone. The parallel with the LP record is clear—its educational potentials exist because Beethoven, the Beatles, and Basie have made it a common household device.

The future of the video disc is clouded by a variety of questions. The technical questions of producing a complex device on a mass production basis seem capable of solution —although they are not all solved yet. The economic questions—Can a player be sold for $500 or less? Can discs be priced at $5-$10 per hour playing time?—are less troublesome than those economic conundrums which have to do with marketing.

One video disc system, Telefunken-Decca's TeD, is already on the market in Europe and initial sales are less than encouraging. A central problem is that of software. Most consumers, before they invest in a video tape player, will expect to see a substantial number of "must have" programs on the dealer's shelf or readily available. One buyer's "must have" list may be entirely different from the next, and the probable result is that very large initial software investments will be required in order to develop the market. How big those investments must be, and how they should be made, are questions which are not yet answered.

The videocassette, in some ways a rival medium, neatly bypasses this software problem by its capacity to allow each buyer to make his own software choices by recording favorite programs off the air. Too, video disc's chances of success are hardly enhanced by the fact that the American giants of video disc, RCA and MCA-Phillips, will be offering incompatible systems.

Communications satellites, on the other hand, may be viewed as a technology already established and in operation. Such a comparison, however, is only partially correct. There is, for example, a marked contrast between the capabilities of currently available domestic satellites and those of NASA's most recent experimental satellites. Commercial systems are designed to provide twelve (twenty-four in the case of RCA's Satcom) TV channels of relatively low power. Receiving such signals requires large (30-foot antennas) and relatively expensive ($65,000) earth-stations, clearly too big and too costly for direct transmission to students at home or even at remote learning centers. From such earth-stations, however, programs can be relayed via microwave systems, MDS, ITFS, or CATV.

NASA's experimental satellites, notably Applications Technology Satellite-6 (ATS-6) and the joint U.S.-Canadian Communications Technology Satellite (CTS), demonstrate that the technology for direct broadcast satellites is already at hand. Not, it should be noted, satellite broadcasting directly to homes (technical, economic, and policy constraints make satellite-to-home broadcasting unlikely for the foreseeable future) but satellite broadcasting to community receivers. Such small earth terminals with 10-foot antennas cost from $5,000 to $12,000 each with the promise that such prices would drop considerably if large-scale production were undertaken. Still too large and too expensive for home use, such earth-stations could be located at schools, hospitals, community centers, or other public buildings. Again, a variety of systems can be used to deliver the satellite signals to students at home as well as at learning centers.

Direct broadcast satellites may well find their first dramatic application not in the United States but in the less developed countries where, as the recent SITE ("Satellite Instructional Television Experiment") project in India demonstrated, communications satellites can create "instant networks" over large areas where no communications existed previously. But, as a study group of the National Academy of Sciences pointed out some years ago, even in such communications-rich nations as our own, satellites offer the prospect of establishing low-cost networks to link what Robert Theobald has called our "invisible colleges" —widely dispersed communities of interest are, for example, the highly skilled professional fraternities which PSSC hopes to serve with its satellite-based continuing education network.

Finally, a word is in order concerning the potential of computers for open learning. The power of computer-assisted instruction is immediately evident to any who have had "hands-on" experience with such sophisticated systems as PLATO or TICCIT. The questions which only time will answer center largely on the economic issues. Both computer and terminal costs are dropping rapidly (microcomputer components which now cost less than $25 are as powerful as early IBM computers which were priced at $1,000,000) but even optimistic estimates of the cost of PLATO terminals see them as comparable to a color television set. Here, unlike pay cable and videodisc, there is no entertainment industry prepared to develop the market.

Software costs are also likely to remain high. Preparation of each computer-based course requires many hours of skilled manpower and while it may be argued that computers will allow the use of such courses by thousands—or millions—of students, the hard fact of high initial investments remains a serious problem.

In choosing communications options it is important—as it is in choosing textbooks and printed study materials —to match the medium to the purpose it is to serve. Communications technologies are not "interchangeable gadgets" and satellites are no more likely to be a substitute for CATV or video discs than broadcast television was a replacement for the phonograph.

"The audience," wrote Aristotle in the *Rhetoric*, "is the end and aim of the speech"—a healthy reminder of those of us interested in both communications technology and learner-centered nontraditional study of where our priorities should be.

Vocational Educational Panel

STATEMENTS OF:

GENE BOTTOMS, AMERICAN VOCATIONAL ASSISTANCE
ROBERT TAYLOR, NATIONAL CENTER FOR RESEARCH IN VOCATIONAL EDUCATION
EDWARD NEWMAN, EPILEPSY FOUNDATION OF AMERICA

Senator Weicker. Next on the matter of vocational education we have the American Vocational Assistance represented by Gene Bottoms; National Center for Research in Vocational Education, by Robert Taylor; Epilepsy Foundation of America, Edward Newman.

Mr. BOTTOMS. I am Gene Bottoms. We appreciate the opportunity to present our case. Our basic premise is that increased investment in vocational education can reduce selected inflationary pressures and can contribute to balancing the Federal budget.

Vocational education can have a direct impact on certain inflationary factors. Two of those most important factors are declining productivity and the scarcity of qualified, skilled workers to meet business/industry needs. While separate and distinct, those two factors are closely related.

First, vocational education raises individuals' capacity by developing their technical know-how and skills. In its reports both this year and last, the Joint Economic Committee of Congress has pointed out shortages of qualified people and the resulting competition among employers to fill jobs effectively as being an inflationary factor.

Second, despite the current 6-percent unemployment rate, the demand for skilled people remains high. A mismatch has occurred between persons available for employment and job requirements. Many Americans are not being prepared with the know-how, skills, and work orientation necessary for today's labor market.

Third, let me present some facts about vocational education which tie it to productivity and skills: Individuals who have received vocational training earn higher salaries than other workers with comparable education at every level from high school through 2 years of college—see chart 1 of statement, Lewis, et cetera, Ohio State; vocational education graduates obtain employment quicker and experience fewer and shorter periods of unemployment than other high school graduates—Project Baseline; the unemployment rate for secondary and postsecondary vocational graduates is lower than it is for graduates from other programs.

Fourth, the preventive nature of vocational education can help to reduce the Federal budget by reducing the need for 100-percent federally funded programs of a remedial or cure nature. Many States and local communities have already established, through significant expenditures, a permanent capacity to provide vocational education over the long term.

Increased investments in vocational schools/programs, especially in depressed communities where only 12 percent of existing training stations are servicing 22 percent of the population, could reduce the need for 100-percent Federal programs.

Through increased investment in vocational programs, the Federal Government can strengthen its partnership with State and local communities. Rather than bearing the burden of 100-percent Federal funds, existing programs could be expanded and improved in order to increase access and thereby increasing capacity of local communities to raise the productivity of their citizens.

Investment in vocational education eliminates the need to expand 100-percent Federal programs. The failure to invest in vocational education will cause the 100-percent programs to continue to rise and existing training capacity in local communities deteriorates further. This causes a flow of unskilled workers into the labor pool—especially in depressed areas.

Three aspects of the act would include: Expansion of vocational training stations in depressed communities and areas of high youth unemployment through cooperative—education, business, industry—programs, contracted on-the-job training, extended days/weeks/months of facilities utilization, energy conservation/technology programs, quick-start training programs, enrollment of women and minorities in nontraditional occupational areas, greater enrollment—through expanded access—of disadvantaged and handicapped students; expansion of programs in areas which meet current and emerging labor force needs—energy occupations, metal trades, health occupations, business and office, computer technology, nontraditional training for women and minorities. These are noted in the Occupational Outlook Handbook.

PROGRAM GOALS

Updating of programs is necessary in order to keep them current—equipment, instructional media, teacher training and renewal, curriculums content materials. A recent survey of 6,000 AVA members showed at least 60 percent consensus that changes were needed in materials, equipment, courses, facilities, and teachers' occupational update.

Second, through programs of national significance, vocational education can be improved and reformed in order to address national concerns. It is in the interest of the entire Nation that these programs be supported to accomplish national priorities as well as to address problems which are common among States. Long-term reform will minimize Federal administrative costs and maximize the creative potential of vocational educators.

The purpose of this program is to bring the best minds of this country—from local communities, institutions, and States—together and provide them with the resources necessary through these program strategies to develop potential national programs of vocational education to address these troublesome issues of energy, productivity, equipment, youth unemployment.

Third, through consumer and homemaking education, youth and adults of both sexes must be prepared for today's occupation of homemaking. In American homes and schools, a range of national concerns includes: One, home energy conservation; two, malnutrition and health; three, school-age pregnancy; four, parenting and family living; five, family violence; six, care of the aged; and seven, inflation resources management and consumer skills.

As the social structure moves toward dual income/career families, the responsibilities of the home and family must be shared. In order to strengthen consumer and homemaking education's impact on these national developments, programs must be improved and capacity expanded in the areas of: One, staff development; two, curriculum development; and three, supplemental materials.

Based upon 1967 constant dollars, the Federal investment in vocational education has decreased by $55 million between 1972 and 1980—going down from $395,840,000 to $340,887,000.

We recognize the difficult position which the Congress faces in attempting to reduce inflation and to balance the budget. But failure to increase appropriations for vocational education, or to further reduce the current investment, will serve only to accentuate the problems.

State and local people are choosing to place their own dollars into vocational education—the ratio of State/local to Federal dollars is averaging 10 to 1. The Federal Government should maintain its place in that partnership.

We must develop the productive capability of our citizen resources and not allow our economic and social problems to grow. As stated by Schumacher in Small Is Beautiful:

> All history points to the fact that people provide primary resources, that the key to economic development comes out of the minds of people.
>
> Education is the most vital resource for developing the minds of people. The basis for a thriving economy is education—organization and discipline.

We stand ready to assist and work with you.

Thank you.

[The statement follows:]

STATEMENT OF GENE BOTTOMS

The American Vocational Association, representing more than 57,000 educators across this country, is pleased to present a budgetary plan for your consideration for Fiscal Year 1981. Our basic premise is that increased investment in vocational education can: (1) reduce selected inflationary pressures; and (2)can contribute to balancing the federal budget.

First, vocational education can have a direct impact on certain inflationary factors. Two of those most important factors are declining productivity and the scarcity of qualified, skilled workers to meet business/industry needs. While separate and distinct, those two factors are closely related.

Vocational education raises individuals' capacity by developing their technical know-how and skills. In its reports both this year and last, the Joint Economic Committee of Congress has pointed out shortages of qualified people and the resulting competition among emloyers to fill jobs effectively as being an inflationary factor. As stated in their 1980 Summary, "Targeted programs can reduce hard-core joblessness without fanning inflation . . . Educational and job training programs should guide American youth toward occupations and industries in the private sector where there are good prospects for long-term growth."

Despite the current 6% unemployment rate, the demand for skilled people remains high. A mismatch has occurred between persons available for employment and job requirements. Many Americans are not being prepared with the know-how, skills and work orientation necessary for today's labor market.

According to a new forecast by the Department of Labor (U.S. News & World Report, Jan. 21, 1980):

> Although jobs opportunities may grow faster than the labor force, unemployment won't necessarily decline in the 1980's. The reason: Many new workers will not be properly trained for the available jobs.

Accurately trained workers would increase this country's productivity. Skilled workers are needed as American industries are updated to remain competitive in international trade. Vocational education can provide training and upgrading of skills in areas with bright forecasts, according to the Occupational Outlook Handbook, 1978-79, in emerging technological and service-oriented industries, small business management and ownership, and clerical, trade and technical jobs which will be in demand throughout this decade. As a result of vocational education, youth and adults possess the necessary basic education, technical competencies and attitudes needed to be productive workers and responsible, tax-paying citizens.

Some facts about vocational education which tie it to productivity and skills:

- Individuals who have received vocational training earn higher salaries

than other workers with comparable education at every level from high school through two years of college (see Chart 1 - Lewis, etc., Ohio State);

- Vocational education graduates obtain employment quicker and experience fewer and shorter periods of unemployment than other high school graduates (Project Baseline);
- The unemployment rate for secondary and postsecondary vocational graduates is lower than it is for graduates from other programs;

Second, the preventive nature of vocational education can help to reduce the federal budget by reducing the need for 100 percent federally-funded programs of a remedial or "cure" nature. Many states and local communities have already established, through significant expenditures, a permanent capacity to provide vocational education over the long-term. Increased investments in vocational schools/programs, especially in depressed communities where only 12% of existing training stations are servicing 22% of the population, could reduce the need for 100% federal programs.

Chart 2 contrasts the vast differentiations in federal investment between 100% federal training programs and partnership vocational education programs. These 100% federal programs continue to grow in cost and are short-term in nature. These programs are not designed to reduce the flow of unskilled and unprepared youth into the labor market.

Through increased investment in vocational programs, the federal government can strengthen its partnership with state and local communities. Rather than bearing the burden of 100% federal funds, existing programs could be expanded and improved in order to increase access and thereby increasing capacity of local communities to raise the productivity of their citizens. Investment in vocational education eliminates the need to expand 100% federal programs; the failure to invest in vocational education will cause the 100% programs to continue to rise, and existing training capacity in local communities deteriorates further. This causes the flow of unskilled workers into the labor pool - especially in depressed areas.

A final point to be made in vocational education's battle against inflation and the federal budget is related to Consumer and Homemaking Education - programs currently being mounted in energy conservation, family and health planning, resources management, and violence/crime. All of these programs have the potential to impact individuals' behavior and habits as they relate directly to the economy and society.

SPECIFICS OF REQUEST

Vocational education develops productive, tax-paying citizens. We are requesting the Senate to appropriate an additional $250 million for vocational education for FY 81. Specifically, the request is:

1. Basic State Grants - $184 million

2. Programs of National Significance - $30 million

3. Consumer and Homemaking Education - $36 million

Chart 3 indicates a line-item breakdown of the proposed funding. An investment now, in existing secondary and postsecondary institutions, will impact the problems of: shortage of skilled workers, increasing numbers of school drop-outs (especially inner-city, minority youth), high rates of youth and minority unemployment, expensive "cure" or catch-up programs, declining private sector jobs in depressed communities; demise of small businesses and special populations - disadvantaged, handicapped, minorities and women. It should be noted that some discrepancy exists as to the current unemployment rate among teenagers. While the Bureau of Labor Statistics is reporting a rate of 14.1% for all 16-21-year olds and 28% for black youth, the National Longitudinal Survey, conducted by Ohio State University's Center for Human Resource Research, reported an overall rate of 19.37% joblessness and 38.8% for black youth. For vocational graduates, however, the unemployment rate is 10.7%.

FIRST, through BASIC STATE GRANTS - outcomes would include:

1. Expansion of vocational training stations in depressed communities and areas of high youth unemployment through cooperative (education/business/industry) programs, contracted on-the-job training, extended days/weeks/months of facilities utilization, energy conservation/technology programs, quick-start training programs, enrollment of women and minorities in "non-traditional occupational areas, greater enrollment (through expanded access) of disadvantaged and handicapped students.

2. Expansion of programs in areas which meet current and emerging labor force needs - energy occupations, metal trades, health occupations, business and office, computer technology, non-traditional training for women and minorities. These are noted in the Occupational Outlook Handbook. In a major Sunday Post article (February 10, 1980) concerning the U.S. defense capabilities ("Why the U.S. Can't Rearm Fast Enough") the following is noted:

> Almost as basic as the materials lag is the manpower lag. In a recent survey by the National Machine Tool Builders Association, an important component of the defense business, 70% of its members reported worrisome shortages of technical workers. Says the Association's president, James A. Gray, 'We're facing one of the greatest skills shortages in the history of this country.'

3. Updating of programs, in order to keep them current - equipment, instructional media, teacher training and renewal, curricula content-materials. A recent survey of 6,000 AVA members showed at least 60% consensus that changes were needed in materials, equipment, courses, facilities and teachers' occupational update.

SECOND, through PROGRAMS OF NATIONAL SIGNIFICANCE, vocational education can be improved and reformed in order to address national concerns. It is in the interest of the entire nation that these programs be supported - to accomplish national priorities as well as to address problems which are common among states. Long-term reform

will minimize federal administrative costs and maximize the creative potential of vocational educators.

The four national concerns to be targeted with increased dollars are: (1) providing equal educational opportunities to all persons (increasing access to programs for special populations; (2) improving the productivity of the workforce, (basic skills, occupational competence, work attitudes and satisfaction, retraining); (3) increasing energy resources and reducing energy consumption; and (4) youth unemployment.

Specifically, expansion is called for in those program strategies which utilize more of an individualized approach to stimulate vocational education leadership. Federal assistance should be given to institutions, states, regional and national centers to continue research-related and professional development activities and to facilitate the usage of products of those activities. Incentives (such as cost-sharing and consideration for institutional capacity-building) should be judiciously employed toward those ends.

A way to effective reform is through a decentralization of efforts; "hand-me-down" approaches from Washington are no longer welcomed in total. Creative reform requires involvement of individuals at the local level--to ensure action-oriented, as opposed to paper product, approaches. This can best be achieved through investigations by researchers and practicioners themselves--to find new ways to address these national concerns.

Current programs to be continued or expanded include: (1) National and State Occupational Information Centers; (2) Graduate Leadership Development Program; (3) National Center for Research in Vocational Education; and (4) regional curriculum laboratories. New initiatives might include: (1) individual projects (field-initiated small grants); (2) instructor renewal (updating, recruiting, preparing, improving--especially many of the 300,000 vocational educators who have been on the job for several years and whose occupational competence must be upgraded); (3) a grants program (to institutions); and (4) National Occupational Information Coordinating Committee.

These programs of reform and renewal are crucial to this nation's major concerns of equal education, productivity and energy conservation. These research and development activities can attack our current problems of youth and adult unemployment/underemployment, especially in our depressed communities, our near crises of crime and violence (both in the home and on the streets), national defense, and finally, health and families.

The plan is to bring the best minds of this country, from local communities, institutions and states, together and provide them with the resources necessary, through these program strategies, to develop potential national programs of vocational education to address these troublesome issues.

THIRD, through CONSUMER AND HOMEMAKING EDUCATION, youth and adults of both sexes must be prepared for today's occupation of homemaking. In American homes and schools, a range of national concerns include: (1) home energy conservation, (2) malnutrition and health; (3) school-age pregnancy, (4) parenting and family living; (5) family violence, (6) care of the aged; and (7) inflation-resources management and consumer skills.

As the social structure moves toward dual income/career families, the responsibilities of the home and family must be shared. In order to strengthen Consumer and Homemaking Education's impact on these national developments, programs must be improved and capacity expanded in the areas of: (1) staff development; (2) curriculum development; and (3) supplemental materials.

Specifically, increased appropriations will allow for improvement/expansion in programs for: (1) school-age and single parent; (2) self-help for youth/adults in reducing energy consumption; (3) health, nutrition and drug/alcohol abuse; (4) shared roles in homemaking (reducing sex stereotyping); (5) courts and correctional institutions, (6) resource management, home repairs, and consumer skills; and (7) other special populations such as displaced homemakers.

The 70,000 professionals in this field need support in order to improve and expand programs to make them preventive rather than cure-oriented as well as to make them more available to particular populations in depressed communities. While the consumer price index has increased 40% since the passage of P.L. 94-482 in 1976, appropriations for all Consumer and Homemaking Education programs have increased a total of 6.19% for that same period.

In a review of the data on the effectiveness of Consumer and Homemaking Education programs, recently prepared by Joan McFadden and Mildred Griggs for NIE, the evidence which is available shows positive effects on learners in terms of knowledge, behavior and attitudes--especially in the areas of nutrition and consumerism. While further investigation must be done, results to date point to the increased, perceived effectiveness of individuals at specified homemaking tasks with the number of years enrolled in Consumer and Homemaking programs (see Cross, et al, USOE, 1971).

Without increased support in this vital socioeconomic area of families and personal care, we will not be able to curb the spiral effects of poor health habits, energy consumption, crime, and abuse. Consumer and Homemaking Education, if adequately supported, could lift people up from debilitating conditions and move them toward healthier, more productive lives.

CONSEQUENCES OF NO INCREASES

Based upon 1967 constant dollars, the federal investment in vocational education has DECREASED, by $50 million between 1972 and 1980 - going down from $395,840 to $340,887. Purchasing power has gone down; in effect, there have been no increases. If this trend continues, the results could be devastating to youth and adults, especially in this nation's depressed communities. Chart 4 shows the constant decline.

The federal intent in current legislation and initiatives is clear - redirect dollars to depressed areas and service particular, especially disadvantaged, populations. But without increased funding, vocational education will fall short of its charge in the battle against inflation, declining productivity and unemployment-- and a spiraling federal budget.

Slapped together band-aid approaches are expenseive and less effective. We must go to the core of our social services - to education programs - and direct that army of professionals toward self improvement and program expansion to serve those who turned away annually because of limited access. We must turn off the spigot rather than continue to try to bail out, hopelessly, from under the flood.

Simply, vocational education can no longer do what the legislation expects us to do. With increased funding, federal intent could be achieved by: better matching programs to existing/future jobs demands, providing greater access and wider services to disadvantaged youth, the handicapped, women and minorities, and updating and revitalizing staff, curriculum and equipment -- widening reform through creativity.

SUMMARY

We recognize the difficult position which the Congress faces in attempting to reduce inflation and to balance the budget. But failure to increase appropriations to vocational education, or to reduce the current investment, will serve only to accentuate the problems. State and local people are choosing to place their own dollars into vocational education (the ratio of state/local to federal dollars is averaging 10 to 1) -- the federal government should maintain its place in that partnership and support vocational education as the logical route to alleviating these severe economic conditions--inflation, youth unemployment, reduced productivity, and energy consumption.

An investment in vocational education buys the federal government into a partnership with state and local governments--there is not heavy, expensive reliance on 100% federal programs which eventually just dry up. A relatively small federal investment will keep the states and communities from pulling back their own investments and will prevent effective programs from collapsing.

We are not suggesting an overall increase, but rather a closer look at how federal dollars are currently being spent. We are suggesting a shift to programs which develop individuals' capacity to produce, increasing their income earning potential, and, in turn, increasing their contributions as taxpayers. Rather than investing in programs which lock people into "holding patterns," without any hope for substantive change over time, Congress should direct its resources to programs which play a direct role in the economic development of communities -- through the occupational/personal development of their citizens.

We must develop the productive capability of our human resources - and not allow our economic and social problems to grow. As stated by Schumacher in Small is Beautiful,

> All history points to the fact that people provide primary resources... that the key to economic development comes out of the minds of people. Education is the most vital resource for developing the mind of people...The basis for a thriving economy is education--organization and discipline.

We stand ready to assist and work with you.

Thank you.

CHART 1

Family Income by Educational Attainment of Respondents

with Two Years of College or Less, Who Had or Had Not Received Vocational Preparation

Income	Some High School		Completed High School		Attend 2-Year College		Completed 2-Year College		Total	
Ranges	Voc.	Non.	Voc.	Non.	Voc.	Non.	Voc.	Non.	Voc.	Non.
	%	%	%	%	%	%	%	%	%	%
$5,000	13	18	6	11	4	8	3	5	7	12
$5,000-9,999	33	42	28	29	22	22	12	26	26	31
$10-14,999	21	15	22	20	20	30	30	15	22	20
$15-19,999	10	13	22	18	29	16	15	23	22	17
$20-24,999	12	6	11	12	10	12	18	10	12	11
$25-29,999	10	5	9	6	14	14	15	13	11	8
$30-34,999										
$35-39,999										
$40-44,999[a]	1	1	2	2	0	0	3	3	2	2
$45-49,999										
$50,000+	0	0	0	1	0	0	3	5	.4	1
Number	52	95	125	309	49	51	33	39	259	394
Mean[a]	$10,915	$8,600	$12,429	$11,591	$13,400	$12,500	$16,450	$15,450	$12,800	$11,350
SD[a]	9,078	7,877	8,582	9,247	7,746	8,097	10,496	11,979	8,943	9,433
t	1.55, p>.05		.83, p>.05		.57, p>.05		.38, p>.05		1.98, p<.05	

Note: Percentages may not sum to one hundred due to rounding.
[a]Mean and SD calculated assuming equal distribution of responses through $5,000 intervals.

CHART 2

COMPARISONS: EMPLOYMENT AND TRAINING VS VOCATIONAL EDUCATION *

	Department of Labor (1) Employment and Training			HEW - USOE (2) Vocational Education		
r	Outlay	Enrollment	Unit Cost	Appropriations	Enrollment	Unit Cost
5	2,803,000,000	2,347,000	$1,195	514,804,000	12,056,000	$43
6	3,273,000,000	2,761,000	1,192	524,155,000	11,518,000	$46
7	3,290,000,000	2,943,000	1,111	549,028,000	15,792,000	$35
8 t)	4,775,000,000	3,963,000	1,206	601,167,000	16,000,000	$38
9 t)	5,400,000,000	4,332,000	1,248	601,167,000	17,334,000	$34

* Data represents total gross enrollments from U.S. Budget Appendix 1977 and 1979

1 Based on budget data actual and estimated outlays

2 Based on USOE estimated enrollments for 77, 78, 79 and appropriations. Excludes Home Economic and Consumer appropriations and enrollments

CHART 3

American Vocational Association
February 22, 1980

FEDERAL FUNDING FOR VOCATIONAL EDUCATION

PROGRAM	APPROPRIATED FY 80	AVA REQUEST FY 81	INCREASE	
Education Amendments of 1976 (PL 94-482)				
Basic Grants, Sec. 120	$562,266,000	$709,466,000	$147,200,000	
Program Improvement & Supportive Services, Sec. 130		. . . .		$184 million
Grants to States	124,817,000	161,617,000	36,800,000	
Programs of National Significance	10,000,000	40,000,000	30,000,000	
State Planning Grants	5,000,000	5,000,000	-0-	
Special Programs for the Disadvantaged, Sec. 140	20,000,000	20,000,000	-0-	
Consumer & Homemaking, Sec. 150	43,497,000	80,000,000	36,503,000	
Bilingual Training, Sec. 191	4,800,000	6,000,000	1,200,000	
Renovation & Remodeling Sec. 191, Urban & Rural	-0-	-0-	-0-	
State Advisory Councils Sec. 105	6,500,000	6,500,000	-0-	
Smith-Hughes Act (Permanent Appropriation)	7,161,455	7,161,455	-0-	
TOTAL:	$784,041,455	$1,035,744,455	$251,703,000	

CHART 4

FEDERAL APPROPRIATIONS FOR VOCATIONAL EDUCATION

Year	CPI	Actual Dollars (inflated)	Real(constant) dollars
1972	125.3	495,988	395,840
1973	133.1	495,988	372, 643
1974*	147.7	543,755	368,148
1974	147.7	567,624	384,308
1975	161.2	564,598	350,246
1976	170.5	565,149	331,465
1977	181.5	591,002	325,620
1978	195.4	642,161	328,639
1979	217.4	681,614	313,529
1980**	230.0	784,041	340,887

*5% withholding

** as of December 1979

Based on 1967 dollars

VOCATIONAL EDUCATION PROGRAM IMPROVEMENT

Mr. TAYLOR. My name is Bob Taylor. I direct the National Research Center in Vocational Education which was established through congressional mandate out of the 1976 amendments.

I am here to speak specifically about programs of national significance, which are the program improvement dimension of the vocational education legislation. I am concerned with the role they play with respect to quality, and relevance of programs, and the kind of instrumentalities funded out of these efforts.

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In addition to the National Center there is the National Occupational Information Coordinating Committee with the State committees, that is jointly funded by the Department of Labor which provides occupational information for program planning, for individual career planning and so on; graduate leadership programs to provide leadership personnel, teacher fellowship programs; and then several projects that are funded by the Commissioner of Education on high Federal priorities such as energy, new technology, productivity, equity access, items of that nature.

I would like to report to you there is an increasing web of evidence emerging from several studies on the support and continued need for vocational education, and also as to its effectiveness.

For example, two recent surveys of national school board members showed that vocational education is the No. 1 area of the school program that they would like to expand. This is also supported by a recent national survey of school superintendents.

In a survey of an adult cross section of America, 85 percent indicate programs of vocational education need to be improved and expanded; 55 percent would like to take adult vocational education programs.

We have two recent State studies that show minority youth who complete vocational education are employed at a far higher rate—a ratio of 4 to 1—than the national statistics.

Additionally, recent studies on earnings show that vocational education graduates earn more, that their employment rate is more consistent, less unemployment, better occupational mobility and a very important factor, better attitude toward work.

The very critical role that the set-aside for programs of national significance has in the vocational education legislation is that of trying to improve the quality and character. This impacts not only on the Federal dollars but on the 10-to-1 State and local dollars that are overmatching the Federal dollars.

In many instances the programs provide services; they provide products; curriculum; training; research; evaluation results; and planning information—critical not only to Congress, and the Federal agencies, but also to States and localities.

For example, the State of Connecticut is installing a State management and evaluation system that was developed through the research center. We have staff there today working with State guidance people on career planning and support systems.

The University of Connecticut has 1 of 18 of the advanced graduate programs located in the United States.

Additionally, we are finding through the dissemination and utilization systems that are funded here that there is a great deal of program improvement materials, growing out of State efforts and national efforts, moving more rapidly into the pipeline.

The State of Texas distributed 9,500 copies of some materials on sex fairness developed by the State of Illinois. This kind of mechanism is providing dissemination and more rapid utilization of those materials.

So in summary I would like to try to leave with you the thought that for a very modest portion of the appropriation, there is the quality assurance program improvement dimension. It does contribute to vocational education in terms of assuring better planning information with respect to new technology and changes in the work force.

It helps vocational education to continue to improve with respect to access, equity, sex fairness. And also in terms of its role of strengthening our economic system, productivity, rapid assimilation of technology, and more effective use of the output of research and development.

Thank you.

[CLERK'S NOTE.—Due to the length of the following statement, only excerpts have been printed in the record. The entire statement is in the subcommittee's files.]

STATEMENT OF ROBERT TAYLOR

It is essential that the administration's budget request of $34.7 million for Programs of National Significance be honored if vocational education is to effectively contribute to:

- o Preventing and reducing youth unemployment
- o Facilitating economic development
- o Assuring access and equity
- o Improving vocational education programs throughout the nation

These appropriations fund the National Center for Research in Vocational Education, the National and State Occupational Information Coordinating Committees, the Regional Curriculum Centers, the graduate leadership program, teacher certification program and projects supported by the Commissioner through national competition.

These programs are becoming an increasingly effective and appropriate strategy for fulfilling the national leadership role. Further, they influence the character and quality of instructional programs funded through basic state grants; by impacting on the ten state and local dollars which overmatch each federal dollar. These activities provide an effective means to focus federal, state, and local resources on such problems as youth unemployment, equity, program quality, and the responsiveness of vocational education to other national priorities such as productivity and energy. By providing essential program improvement products and services that are relevant and useful to national policy makers, administrators and to a large number of states and localities, Programs of National Significance are cost effective since they eliminate duplicative costs and accelerate program improvement. In consort, these activities are the key elements of a nationwide program improvement capacity which has demonstrated positive accomplishments.

Summary

In considering needs for appropriations on Programs of National Significance, it is essential that we think in terms of focusing our limited resources for program improvement on major interventions that promise to strengthen and enhance America's mainstream system for career oriented vocational training. Four major national priorities are:

- o reducing youth unemployment
- o promoting equity
- o increasing productivity and improved technological transfer
- o the implications of energy

I believe Programs of National Significance are the most appropriate federal investment since they influence the character and quality of other federal programs and act as a catalyst to state and local program improvement activities. Further activities under this category are cost effective. Research development, training, evaluation and planning services have addressed pervasive national problems by generating products and services which are useful and are being used in a number of states. This results in considerable savings and eliminates duplicate costs. Activities to date are making a real difference in program quality and focus.

EPILEPSY FOUNDATION ACTIVITIES

Mr. NEWMAN. Senator Weicker, I am Edward Newman. I am here with Mr. MacLib, director of the Epilepsy Foundation, on a slightly different tack, as I think you know.

The foundation is a national voluntary organization committed to the prevention and control of epilepsy and to improving the life and quality of life for the 2 million Americans who suffer from that disorder. In 1977 the Congress mandated a national commission for the control of epilepsy and its consequences to present to the Congress and the President a plan for nationwide action.

This plan contains over 400 recommendations for public and private action at the Federal, State, and local level; and the foundation established a national blueribbon volunteer task force responsible for its implementation.

The National Institute of Neurological and Communicative Disorders and Stroke, was asked by the House Appropriations Committee to develop a status report on Government-wide commission recommenda-

tions; the foundation has developed a supplementary report on the status of these efforts.

I am pleased to convey to you and the committee that report at this time.

[CLERK'S NOTE.—The report is in subcommittee's files.]

RECOMMENDATIONS

Mr. NEWMAN. The recommendations of the Epilepsy Commission fall roughly into three areas: The prevention of epilepsy; the control of epilepsy; and the rehabilitation of people with epilepsy.

I think what is significant about this is the fact that you have a national voluntary association working with the executive branch and the Congress on recommendations which the Congress asked a commission to make, and, in their way, are attempting to target the results of their immense effort among the many agencies of Government.

The coordination comes from the outside, but in a partnership way with the national association. The Epilepsy Foundation of America recommends the appropriation of $285 million for the National Institute of Neurological and Communicative Disorders and Stroke for fiscal year 1981.

Later today Representative Coelho, the first Member of Congress to acknowledge he has epilepsy—and a member of the foundation's national implementation task force—will appear before you to discuss funding for the National Institute of Neurological and Communicative Disorders and Stroke.

The $285 million figure includes $35 million to compensate for inflation, based upon the generally accepted medical research inflation index of 14.5 percent and $8 million for special projects.

The $250 million proposed by the President represents a 3-percent increase which we balanced against the 14.5-percent inflation index, which leaves an 11.5-percent reduction in purchasing power. And we urge that the committee resist further reductions if they are proposed by the administration.

The fiscal year 1980 appropriation for NINCDS provides funds for expansion of capacity for epilepsy research in the form of a comprehensive epilepsy program to be established in an urban center with a minority population. The foundation is concerned that as we begin the appropriation cycle for fiscal year 1981, the awarding of this program has yet to be announced. There is urgent need for a center of this kind to make the research possible and we are eager to see it initiated.

REHABILITATION PROGRAM FUNDS

Because the work of the National Institute addresses the first two areas of concern, prevention and control, I would focus now on the third, rehabilitation—addressing programs under the Rehabilitation Act as well as related programs under education, developmental disabilities, employment, and mental health.

The individual with epilepsy is often faced with educational, economic, and social discrimination. The result of this rejection can be

more devastating than the seizures themselves. Yet with proper assistance, most individuals with epilepsy can become full participants and contributors.

The foundation recommends an appropriation for rehabilitation services of $945 million; the full authorization level for basic State VR services; and $12 million for innovation and expansion grants.

Underemployment and unemployment are major problems for individuals with severe disabilities, and also for those with epilepsy, many of whom are severely disabled. Under RSA short-term training grants the foundation developed training for vocational rehabilitation training directors and counselors around the country.

In response to other Commission representatives RSA designated people with epilepsy as an important underserved group. We hope this designation makes a significant difference in the numbers served who because of severe disabilities have difficulty in getting work.

With respect to the new National Institute for Handicapped Research, the foundation recommends the appropriation of $45 million. One of the Epilepsy Commission's most disturbing findings was the striking paucity of research on methods for the delivery of health and rehabilitation services to people with epilepsy.

The management and coping problems go far beyond the research undertaken by NIH. NIHR, a new agency with a very broad mandate for rehabilitation research, becomes an important link in the service delivery section of national responsibility.

The foundation would like to recommend an appropriation of $45 million to implement the comprehensive centers for independent living. People who can't live entirely alone still should not be institutionalized. Independent living centers can help handicapped people to help themselves as well as receive support services which will allow them to remain independent.

The independent living program is tailormade to achieve that. If properly supported, it could be dramatically cost-effective. The foundation recommends the appropriation of at least $1 billion for Public Law 94–42 State grants, and a recommendation is made for $66 million for the preschool incentives in order to provide an expenditure of $300 per pupil.

For Head Start, the President requested $825 million to serve 86,300 children. We support the President's request in vocational education.

In light of the importance to handicapped people of vocational education programs, we recommend an appropriation of $570 million for basic State grants.

We also are concerned about the set-aside and are looking forward to more targeting upon handicapped people by the vocational education people. We would like to see the development disabilities program funded at the State formula grant level of $60 million.

Now, I would like to recommend an appropriation of $15 million for the developmental disabilities protection and advocacy system. Additional funding is needed to permit this system to protect the rights of the developmentally disabled.

You may have heard of the case of the young man with epilepsy who was arrested and beaten while having seizures despite available evidence showing the problem he was experiencing was medical. The man was acquitted of all criminal charges and with the help of the Public Law Center of Philadelphia, under protection and advocacy funding, was able to file suit for damages.

The Epilepsy Foundation of America also entered this case as co-plaintiff to prevent such incidents from happening again. There was also injunctive relief involved here.

We further recommend a $7 million increase for university-affiliated programs—that this be increased to $9 million, because the Epilepsy Commission urged that more efforts of these university-affiliated facilities be focused on problems of people with epilepsy. To do this they must be adequately funded.

The other recommendations we make are in our written statement, which we have submitted.

I would close by saying that we understand the problem of this committee in trying to make very tough choices this year on these discretionary programs. Unless there is some leadership taken in these programs, however, to begin to focus the rest of the entitlement programs and other private and local efforts, I am sure you agree we would be in more difficulty.

Thank you.

[The statement follows:]

STATEMENT OF EDWARD NEWMAN

Edward Newman, Ph.D., is Professor of Social Administration and Director of the Human Services Planning and Developmental Disabilities Center at Temple University in Philadelphia. A member of the Board of Directors and the Professional Advisory Board of the Epilepsy Foundation of America, Dr. Newman, a former Commissioner of the federal Rehabilitation Services Administration, is Chairman of the Center for Rehabilitation and Human Development at the University of Haifa, Israel, and a consultant to that country's Ministry of Labor and Social Affairs. A Board member of the Public Interest Law Center of Philadelphia, Dr. Newman also serves on that city's Goodwill Industries Board.

Mr. Chairman: The Epilepsy Foundation of America is the national voluntary organization committed to the prevention and control of epilepsy and to improving the quality of life for the 2 million Americans who suffer from that disorder.

In 1977, the congressionally mandated National Commission for the Control of Epilepsy and Its Consequences presented to the President and Congress its "Plan for Nationwide Action on Epilepsy". That plan, which contains over 400 recommendations for public and private action at the federal, state and local level was endorsed by the Epilepsy Foundation of America which established a national blue-ribbon volunteer task force responsible for its implementation. As you know, the National Institute of Neurological and Communicative Disorders and Stroke has recently produced a report on the government-wide status of efforts to implement the Commission's recommendations. We are pleased that this committee has requested a copy of that report. Since the information for the NINCDS report was gathered, the volunteers and staff of the EFA Implementation Task Force have met with representatives of many of the federal agencies which have implementation responsibility. These meetings resulted in better understanding of many recommendations and the context in which they are made. In some cases agreements on approaches to implementation resulted. In other areas, much remains to be done. Because these meetings took place after many agencies had already submitted information to NINCDS for its report, EFA has developed a supplementary report on the status of implementation efforts. I am pleased to offer that report as an attachment to this statement and request that it become a part of the record of this hearing.

The recommendations of the Epilepsy Commission fall roughly into 3 areas -- the prevention of epilepsy, the control of epilepsy and habilitation/rehabilitation for people with epilepsy. Later today, Representative Tony Coelho, the first member of Congress to acknowledge publicly that he has epilepsy, and a member of EFA's National Impementation Task Force, will appear before you to discuss funding for the National Institute of Neurological and Communicative Disorders and Stroke. Congressman Coelho will be speaking both for himself and as a representative of the Epilepsy Foundation. Our own statement regarding NINCDS appropriations is part of our written testimony.

The Epilepsy Foundation of America recommends the appropriation of $285 million for the Nationa Institute of Neurological and Communicative Disorders and Stroke for FY '81. This figure includes $35 million to compensate for inflation, based on the generally accepted medical research inflation index of 14.5%, and $8 million for special projects. The $249.8 million proposed by the President represents a 3% increase which, when balanced against the 14.5% figure leaves an 11.5% reduction in purchasing power. We hear reports that the President will

propose additional cuts of 10% for NIH. We urge you to resist such a reduction. If we are ever to reduce health care costs, adequate investment in the prevention of disease and disability must be a component of that effort. The Administration's proposal this year was based on its decision to stabilize NIH research at approximately 5000 new or competing grants. The current NIH level is 5900 such grants, although at times it has been as low as 4700. The 5000 figure, then, falls at the lower end of the recent range. The Foundation enthusiastically supports the concept of research grant base stabilization, but not at such a low level and not at the cost of training funds, an area which the Administration has given much lower priority. Understanding the function and dysfunction of the human brain represents the ultimate challenge to biomedical research, research which can be carried on only by trained researchers. To reduce our commitment to research training is to undermine the foundation of our research capacity.

The FY '80 appropriation for NINCDS provided funds for an expansion of our capacity for epilepsy research in the form of a 6th Comprehensive Epilepsy Program, to be established in an urban center with a minority population. The Foundation is concerned that, as we begin the appropriations cycle for FY '81, the awarding of that program is yet to be announced. There is urgent need for such a center and the kind of research it will make possible. We are eager to see it initiated.

In times of economic stress, such as we are currently experiencing, our national priorities must be carefully scrutinized. Allocations of resources must be made carefully and with an eye to future needs. In the face of rising health care costs -- one of the fastest growing factors in our economy -- it would be foolhardy to diminish our investment in biomedical research and training -- our best hope to reduce future medical costs and improve the nation's health.

Because the work of NINCDS addresses the first two areas of concern -- prevention and control of epilepsy -- I would like to use the time allotted to me to focus on the third -- habilitation/rehabilitation -- addressing programs under the Rehabilitation Act as well as related programs such as education, developmental disabilities, employment and mental health.

The individual with epilepsy is often faced with educational, economic and social discrimination. The result of this rejection can be infinitely more devastating than the seizures themselves. Yet with appropriate assistance, such as that offered by the programs I will discuss, most individuals with epilepsy can become full participants in our society and contributors to our nation's economy, rather than dependents on government assistance.

REHABILITATION SERVICES

The Epilepsy Foundation of America recommends the appropriation of $945 million, the full authorization level for Basic State VR Services, and $12 million for Innovation and Expansion Grants.

Unemployment and underemployment are major problems for individuals with epilepsy who have consistently proven to be one of the most difficult groups to rehabilitate. There are, however, successful vocational rehabilitation programs for people with epilepsy, which have more than doubled successful job placements. The Foundation has been working with the Rehabilitation Services Administration to implement Commission recommendations which reflect those successful experiences. Under an RSA short-term training grant, EFA developed training

materials and conducted workshops for VR training directors and counselors around the country, a first step in carrying out one of the Commission's recommendations to RSA. In response to other Commission recommendations, RSA has designated people with epilepsy an underserved group and has expressed interest in counseling for the psychological problems that are a major employment problem for people with epilepsy and in the improvement of follow-along post-placement services as well.

NATIONAL INSTITUTE FOR HANDICAPPED RESEARCH

EFA recommends the appropriation of $45 million for the National Institute for Handicapped Research. One of the Epilepsy Commission's most disturbing findings was the striking paucity of research on methods for the delivery of health and rehabilitation services to people with epilepsy. The "management" and "coping" problems of people with epilepsy go far beyond the kind of research which is undertaken by the National Institute of Neurological and Communicative Disorders and Stroke. EFA has met with representatives of NIHR to provide information on the research needs of people with epilepsy. We have nominated people with expertise in epilepsy for the National Council on the Handicapped, and eagerly await the announcement of its membership. NIHR, as a new agency with a very broad mandate to develop a comprehensive and integrated approach to rehabilitation research, and to disseminate research findings, requires additional appropriations to fulfill its mission. In view of the tremendous financial investment our government makes in direct services, scientific investigation into the effectiveness of service delivery programs and techniques is vital. The funds to support this research are an investment in encouraging maximum possible independence for handicapped individuals.

INDEPENDENT LIVING

The Foundation would like to recommend an appropriation of $45 million for FY '81 to implement the Comprehensive Centers for Independent Living program. Many people severely handicapped by epilepsy have recurring seizures that require close supervision; others have severe multiple handicaps and still others have such severe psychological and social problems that they do not presently have employment potential. Nevertheless, the ability of such individuals to become more self-reliant can be enhanced. We must experiment with ways in which people who cannot live entirely alone but should not be institutionalized, can be assisted to help themselves as well as receive supportive services which will allow them to remain independent. The Independent Living program is tailor-made to achieve just that, and if properly supported, could prove dramatically cost-effective.

EDUCATION

At the time of the passage of the Education for All Handicapped Children Act (P.L. 94-142) nearly half of the nation's 8 million handicapped children were not receiving appropriate education, and more than 1 million were excluded from public school systems entirely. This legislation mandates that all handicapped children be provided an appropriate education in the least restrictive environment possible -- ideally in a normal classroom situation.

EDUCATION FOR ALL HANDICAPPED CHILDREN - STATE GRANTS

The Epilepsy Foundation of America recommends the appropriation of at least $1 billion for P.L. 94-142 state grants. P.L. 94-142 acknowledged the problems faced by school systems in absorbing handicapped children and promised financial assistance to states in a formula designed to increase the federal contribution toward meeting those costs. In his FY '81

budget, the President, with an appropriation request of $922 million, calls for funding at the rate of 12% of the average per pupil cost in a year when the Act authorizes 40%. This request assumes that there are 3.8 million handicapped children to be served by this program. The Council on Exceptional Children suggests that figure could be as high as 4 million. Secondly, the administration has projected an inflation rate of 7%, although its own figures of last month put that rate at approximately 18%. The $922 million requested by the President might well result in less than 12% of the average per pupil expenditure. The authorizing legislation would permit an FY '81 appropriation of as much as $3 billion for this program. EFA urges the appropriation of at least $1 billion .

PRE-SCHOOL INCENTIVES

We would like to recommend that $66 million be appropriated for Pre-School Incentives in order to provide an expenditure of $300 per pupil. The value of pre-school education in enhancing the educational potential of the child has been well demonstrated by numerous studies in recent years. If a child can learn to live with a disability at an early age, he or she will develop self-confidence and be better prepared to deal with that disability throughout life. And in programs where handicapped and non-handicapped children learn together, the stigma -- the perception of the handicapped child as "different" -- can be eliminated, averting many later social difficulties for such a child. The administration has requested $25 million for Pre-School Incentives, based on the assumption of approximately 220,000 children aged 3 through 5 at a rate of less than $100 special entitlement per child. This seems an inadequate incentive to encourage states to serve these additional children.

PERSONNEL DEVELOPMENT

The Foundation recommends the appropriation of $90 million for Personnel Development. Central to the implementation of P.L. 94-142, is the provision of funds to provide fellowships, traineeships, and institutes for the training of professional personnel for educating the handicapped. The current supply of trained professionals is inadequate, and the President's request of $58 million for this program should be increased to $90 million.

HEAD START

The President has requested $825 million to serve 386,300 children in Head Start. We support the President's request. Head Start, with its requirement that 10% of enrollment be reserved for handicapped children, provides programs with immense potential for working with pre-school children who have epilepsy.

VOCATIONAL EDUCATION

In light of the importance to the handicapped of vocational education programs, we recommend an appropriation of $570 million for basic state grants. Vocational education programs operated by local school districts provide valuable opportunities for the person with epilepsy and encourage handicapped youngsters to remain in school and develop needed skills. Ten percent of each state's basic grant for vocational education is required by law to be used to finance programs for handicapped persons. The President has recommended a cut of $33 million in basic support to states for vocational education. The rationale offered for this reduction is that services would be duplicated by his proposed Youth Education/Employment Initiative. That program is yet to be authorized and it is questionable whether it would be operational in FY '81. Also, there is no guarantee that the 10% set-aside for the handicapped which exists under current vocational education legislation would be included in the new program.

DEVELOPMENTAL DISABILITIES

Many individuals with epilepsy are developmentally disabled. That is, they have a severe, chronic disability, which substantially handicaps them in important activities of daily living. Seventy-five percent of people with epilepsy develop the disorder early in life. Nearly that number have multiple handicaps. Forty-eight percent have intellectual disturbances or impairments and 54% have behavioral difficulties associated either with the epilepsy itself or their medication. Thus, for a substantial number of people with epilepsy, there is a need for a combination and sequence of special interdisciplinary care and treatment, as provided by the DD program.

DD STATE FORMULA GRANTS

EFA recommends that DD State Formula Grants be funded at $60 million. P.L. 95-602 requires that 65% or $100,000 of a state's DD formula grant, whichever is greater, be allocated to the following service priority areas: case management, alternative living arrangements, child development and non-vocational social development. The number of services which may be offered is determined by the level of funds appropriated. The current funding level permits states no more than 2 priority service activities. The President's request for the same funding level as FY '80, in the face of increasing inflation, means not only that no new priority service areas may be added, but the level of service currently provided cannot be maintained. EFA recommends that DD state grants be funded at $60 million, so that a third priority service may be added.

PROTECTION AND ADVOCACY SYSTEMS

We would like to recommend an appropriation of $15 million for the DD Protection and Advocacy Systems. Previous appropriations for the DD P&A System have allowed states to initiate only limited activities. Additional funding is vital to permit the P&A Systems to protect the rights of the developmentally disabled. As a member of the Board of the Public Interest Law Center of Philadelphia, I can tell you from firsthand knowledge of a case of a young man with epilepsy who was arrested and beaten while having a seizure, despite available evidence showing that the problem he was experiencing was medical. The man was acquitted of all criminal charges, and with the help of the Public Interest Law Center, under Protection and Advocacy funding, was able to file suit for damages. The Epilepsy Foundation of America has also entered the case to seek injunctive relief to prevent such incidents from happening again.

SPECIAL PROJECTS

The Epilepsy Foundation recommends a level of $7 million for FY '81 funding for DD Special Project Grants which support demonstration projects for expanding and improving services, promote public awareness, coordinate community resources, provide technical assistance and further the development of innovative treatment modalities for developmental disabilities.

UNIVERSITY AFFILIATED FACILITIES

EFA recommends that the President's request for $7 million for University Affiliated Facilities be increased to $9 million. P.L. 95-602 redefined and significantly extended the mission of U.A.F.s in relation to other federal and state programs to include improving the effectiveness of prevention and treatment through provision of high quality demonstration models and training to service programs, increasing primary prevention through state and regional

networks, and extending secondary prevention through increased coordination with national early screening and treatment services. The U.A.F.s that receive funds under the Developmental Disabilities Act are responsible for providing demonstration and training programs for the personnel needed to provide services for DD individuals. The Epilepsy Commission urged that more of their efforts be focused on the problems of people with epilepsy. In order to do so they must be adequately supported.

EMPLOYMENT

Employment is a major problem for the person with epilepsy. Despite the dramatic advances in treatment and rehabilitation making it possible for more than half of those with epilepsy to lead seizure-free lives, and another 35-40% to lead near-normal lives, and despite federal legislation prohibiting discrimination in hiring because of handicap, the number of unemployed persons with epilepsy remains disproportionately high -- over twice the national average. Perhaps even greater -- and far more difficult to measure -- is the number who are underemployed. The result is an immense waste of human potential among both those who have minimum disability and those who are severely handicapped. There are 2 special barriers to employment for people with epilepsy, the attitude of employers who are often reluctant to hire individuals with epilepsy because of fear and misunderstanding, and the attitude of people with epilepsy themselves. Many have behavioral, psychological and social problems which can be more of a barrier to employment than the actual seizures. Special help is needed to overcome these barriers.

CETA TITLE III -- NATIONAL PROGRAMS

The Foundation recommends an appropriation of $370 million, the amount requested by the President for CETA Title III. This includes $5.5 million for special emphasis groups, such as the handicapped, served by the Office of National Programs. There is strong evidence that a young person who does not successfully enter the job market soon after leaving high school is likely to become chronically unemployed. It is critical, therefore, that early job training be provided before the cycle of frustration and despair with unsatisfactory or no employment is begun. In support of this concept, EFA has undertaken, with a CETA Title III contract, a project to increase the employment rate of people with epilepsy, with particular emphasis on youth, by providing training and placement services with public and private employers (the TAPS Program). This program provides job skills and job seeking and keeping skills, as well as employer and community education. It also helps young men and women deal with their own and others' attitude toward their disability. Since its inception in 1977, the TAPS Program has consistently exceeded its contract goals and to date has placed over 2000 people with epilepsy in competitive employment.

CETA PUBLIC SERVICE EMPLOYMENT

We would like to recommend funding for Public Service Employment programs for FY '81 at the levels which the President has recommended -- $2,554,000,000 for Title II-D and $2,044,000,000 for Title VI. These levels are designed to provide the same number of PSE positions as in FY '80. For many people with epilepsy, PSE has provided an opportunity to prepare for competetive employment and make the transition into the job market. An additional benefit of this program is the staff PSE provides for many state and local affiliates which qualify as "Community Based Organizations". A recent survey of EFA's chapters showed that 45% of the responding chapters employ 1 or more CETA PSE people in positions ranging from clerks to job

counselors to chapter executive directors. In a number of cases, 1 or 2 such employees are the only paid full-time staff, so important to providing continuity of programs. Many chapters report that they have no other potential funding sources for these positions. These PSE placements provide a two-fold benefit -- the training and employment of the enrollee and the services provided to people with epilepsy through PSE-funded staff.

MENTAL HEALTH

EFA would like to recommend the following appropriations for the National Institute of Mental Health: (figures are in millions)

Mental Health Research.....$185
Research Training..... 31
Clinical Training..... 98.5
Linkage of Community Mental Health Centers to Community Health Centers..... 11.6
Community Mental Health Centers. 337

State Programs:
Chronically Mentally Ill...28.5
Children & Youth.....10
Prevention.....10

Formula Grants to States:
FY '80 Supplemental.....12.1
FY '81.....25

Program Support.....42.2

Possibly the least understood and most neglected aspects of epilepsy are the social, psychological and behavioral problems that are so common. The Epilepsy Commission found that little specific assistance is available for these problems, whether mild or severe, despite the needs that were so evident from the repeated testimony of people with epilepsy. From 1/6 to 1/4 of people with epilepsy have psychological problems of varying severity, and as many as 10% may have been admitted to mental hospitals at some time. Data gathered by the Commission suggests that as many as 12% of patients in mental institutions have epilepsy. Officials of ADAMHA have expressed enthusiastic interest in addressing the mental health needs of persons with epilepsy and in working cooperatively with NINCDS and other agencies in these efforts.

Of great relevance to people with epilepsy is the relationship between the availability of mental health services and medical services. The Linkage of Community Mental Health Centers and Community Health Centers is vital to ensure that the person with epilepsy with mental health problems also obtains maximum seizure control and blood-level monitoring. The architects of the Linkage program correctly understood the need to view the interdependence of health and mental health programs as central to the total health care of our citizens. This linkage is especially important for persons with chronic health problems who are in need of mental health services.

Many people with epilepsy can be productive and creative members of our society, supporting themselves, paying taxes, making an economic and social contribution to our national community. They don't want a hand-out. They want only the assistance necessary to allow them to develop their talents and abilities and the skills to be as independent and self-sufficient as possible. The programs I have discussed today were designed to do just that. I urge you to provide adequate support to allow them to accomplish their mission.

Thank you for the opportunity to appear before you today and to present the recommendations of the Epilepsy Foundation of America.

SUMMARY OF THE RECOMMENDATIONS
OF THE EPILEPSY FOUNDATION OF AMERICA
FOR FISCAL YEAR 1981
(figures are in millions)

PROGRAM	FY '80	PRESIDENT'S FY '81 REQUEST	EFA'S RECOMMENDATION
NINCDS	242	249.8	285
Rehabilitation:			
State Grants	817	854	945
I & E	11.7	-0-	12
NIHR	31.5	37	45
Independent Lvg.	15	18	45
Education:			
94-142 St. Grants	874	922	1,000+
Pre-Sch. Incent.	25	25	66
Personnel Devel.	55	58	90
Head Start	735	825	825
V.E. St. Grants	562	529	570
Developmental Disabilities:			
State Grants	43	43	60
P & A	7.5	7.5	15
Spec. Proj.	4.7	4.7	7
UAFs	7	7	9
CETA:			
Title II-D PSE	1,485	2,554	2,554
Title VI PSE	1,627	2,044	2,044
Title III	354	370	370
Mental Health	573.5	650.9	791

PUBLIC EXPRESSED PRIORITIES

Senator WEICKER. Let me say that the leadership you look for in the Congress will be no more or less than that which is requested by the constituencies. I think the time has come for not just those of you testifying here, not just you three gentlemen but all those in the room to make your voices heard as to the priorities.

The job can't be done alone. Congress is under the impression at this time, and has been for the last couple of years, that money spent in the area of human needs is either wasted money or is in the service of a constituency that doesn't care.

We have gotten to the point, as I said, where a balanced budget, regardless of the human cost, is in the mind of those in the House and Senate as the political price. I have no quarrel with fiscal responsibility but I think the vocational education program is a very good example as to exactly what we are talking about in the sense that money that is invested will bring back many, manifold assets of economic stability.

That is not money thrown away.

Traditionally vocational education, compared to other channels of education, has been underfunded and now the crunch really comes. It is my understanding that far from being level funded as is suggested in the budget as now written, this could well be one of the major areas for a major cut in the forthcoming recommendations by the administration.

So I present again, what is more important? Is the automobile more important than human beings in this country? That is exactly what is happening.

It is terribly important that you understand that this place responds to the constituency—if the constituency is heard. It has been very silent for the last couple of years.

Thank you very much, gentlemen.

EDUCATION FOR THE HANDICAPPED PANEL

STATEMENTS OF:
PETER J. SALMON, HELEN KELLER NATIONAL CENTER
WILLARD HAMPTON, HELEN KELLER NATIONAL CENTER
MARTIN ADLER, HELEN KELLER NATIONAL CENTER
VINCENT GRAY, NATIONAL ASSOCIATION FOR RETARDED CITIZENS

Senator WEICKER. Next we have education for the handicapped: Helen Keller National Center, Mr. Martin Adler and Peter J. Salmon; National Association for Retarded Citizens, Mr. Vincent Gray.

Mr. SALMON. I'm Peter Salmon, founder and administrative vice president of the Helen Keller Center.

Senator WEICKER. All right. Dr. Salmon, Mr. Gray, why don't you proceed?

ASSOCIATION FOR RETARDED CITIZENS BUDGET RECOMMENDATIONS

Mr. GRAY. I'm pleased to represent the Association for Retarded Citizens, the national organization which represents our Nation's 6 million retarded citizens.

We appear before you to express our views on the fiscal year 1981 budget as it will impact on the lives of mentally retarded people. Due to the nature of their handicap, many retarded persons require a multitude of specialized services at some point in their lives. Some require a lifetime of care. The Federal Government must continue to finance its share of these services.

Our organization is acutely aware that these are very, very difficult times as the administration and the Congress struggle to put our country's finances on a sound basis. We acknowledge your dilemma and wish you well in your efforts.

At the same time, we are all to well aware of the present impact of inflation and spiraling operating costs on programs for handicapped citizens. The Federal Government must be careful with attempting to balance the Federal budget so that the lives of mentally retarded people are not threatened. We do not exaggerate when we say that reductions in certain Federal benefits can threaten the safety and well-being of retarded citizens.

Many of the programs aiding mentally retarded persons to lead productive lives in the community are financed through the so-called controllable programs, the programs which are most likely to feel the edge of the budget cutters' axes. To remove these vital services from these vulnerable citizens will most likely foster unwarranted, unnecessary institutionalization.

The cost of such institutionalization will be much higher than the cost of care in the community, and will most probably be financed through the uncontrollable portions of our budget. The net impact,

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then, will be no cost saving to the taxpayer and, equally important, a significantly negative alteration to the lifestyle of the mentally retarded person. The ARC strongly urges you to give careful attention to this possibility.

PUBLIC LAW 94-142—EDUCATION FOR HANDICAPPED

All mentally retarded children were guaranteed a free, appropriate public education with the passage of Public Law 94-142, the Education for All Handicapped Children Act, in 1975. When it enacted this law, the Congress promised to provide fiscal support to States and local educational agencies to relieve them of a portion of the extra financial burden of educating handicapped children.

Based on the formula adopted by that law, educational agencies were led to expect approximately $3 billion in Federal support in fiscal year 1981. The President's request for the 1981-82 school year is $922 million, a $48 million increase from fiscal year 1980 funds, but less than one-third the sum promised by Public Law 94-142. The administration's rationale for their request continues the policy of funding 12 percent of the national per pupil expenditure, using a figure of 7-percent inflation and 3.8 million handicapped children to be served.

Our organization and others argue that more handicapped children will need to be served in the 1982 school year, closer to 4 million, and few will disagree that a 7-percent inflation figure is well below the current level—between 10 and 13 percent. Using moderate estimates of the children to be served and the inflation rates, it is our contention that over $1 billion will need to be appropriated to maintain the administration's 12-percent funding policy.

The ARC strongly encourages this Congress to appropriate $1.2 billion for the education for the handicapped State grant program for fiscal year 1982.

In enacting Public Law 94-142, the Congress also authorized a preschool incentive program to stimulate the States to provide educational services to children between the ages of 3 to 5. Providing services to these very young handicapped children enhances the potential for decreasing future, more costly programs while increasing the potential for significant improvement in the child's handicapping condition.

The law provides a $300 per pupil reimbursement. However, the President's proposal allows for less than a $100 reimbursement—not a very big incentive for the school system to serve them. If only 4,400 additional children were served next year along with the approximate 216,000 served last year at the $300-per-child rate, an appropriation of $66 million would be necessary.

PUBLIC LAW 95-602—DEVELOPMENTAL DISABILITIES

The 1978 amendments—Public Law 95-602, title V—to the Developmental Disabilities Act made major modifications to the basic developmental disabilities State grant program. States are now required to spend at least 65 percent of their State allocations on the new priority service areas: Case management; child development; alternative community living arrangements; and nonvocational social-developmental services.

The States are presently limited to funding up to two of the four priorities. The limitation stems from a formula in the act which allows no more than two priority areas to be funded if the annual appropriations is below $60 million.

Recent developmental disabilities State plans have clearly indicated the pressing need to expand the service in each State in all four priority areas. For this reason, the ARC strongly recommends a $60 million appropriation level for fiscal year 1981. The approximately $17 million increase will provide for: One, continued services to those developmentally disabled persons currently being served; two, expansion of the current State priorities to serve those individuals not now being served; and three, the initiation of a third priority service based upon the need as determined in the developmental disabilities State plan.

Handicapped individuals who have the ability to be trained to work receive services under the vocational rehabilitation State grant program. This program has been one of the finest examples of a Federal Government program which is cost beneficial, where clients served return in payroll taxes to the Government amounts far in excess of the Federal benefits they received while being trained.

The rehabilitiation amendments of 1978 established an entitlement formula for the rehabilitation State grant program whereby Federal funds are provided up to the authorized level if the States were able to match the Federal funds.

Unfortunately, in fiscal year 1980 and now in the administration's budget for fiscal year 1981, the amount available for this program is below the authorized level and below the level that the States are able to match. The net effect of this shortage of Federal funds is that States are running out of training funds prior to the end of the fiscal year, thereby not allowing the States to provide services to clients seeking them.

This is a most unfortunate situation which this committee should not allow to continue. Instead of reducing benefits to disabled individuals, let us provide them with the fullest opportunities to work and be contributing members of our society. At a minimum, each handicapped person deserves a chance to be rehabilitated.

When the Congress enacted title VII as part of the Rehabilitation Act Amendments of 1978, it, along with handicapped citizens and their advocates, envisioned a substantial new service program with sufficient funds to develop effective long-range plans and services. The appropriations history since the program's passage in 1978 clearly indicates that the mission of the program has not been fully met due to the serious lack of funds to implement part A—the basic State grant which is the heart of the program.

The ARC recommendation is for $45 million for fiscal year 1981—justified on the basis of a reasonable initiation of the part A comprehensive services State grant program; the continuation of ongoing efforts with centers for independent living, part B; and startup for the part C, older blind individuals program.

Thank you for the opportunity to present our views today.

[The statement follows:]

Statement of Vincent Gray

My name is Vincent Gray. I am pleased to represent the Association for Retarded Citizens, the national organization which represents our nation's six million mentally retarded citizens. We appear before you to express our views on the FY 1981 budget as it will impact on the lives of mentally retarded people. Due to the nature of their handicap, many retarded persons require a multitude of specialized services at some point in their lives. Some require a lifetime of care. The Federal Government must continue to finance its share of these services.

Our organization is acutely aware that these are very difficult times as the Administration and the Congress struggle to put our country's finances on a sound basis. We acknowledge your dilemma and wish you well in your efforts. At the same time, we are all too well aware of the present impact of inflation and spiralling operating costs on programs for handicapped citizens. The Federal Government must be careful on attempting to balance the Federal Budget so that the lives of mentally retarded people are not threatened. We do not exaggerate when we say that reductions in certain federal benefits can threaten the safety and well-being of retarded citizens.

Many of the programs aiding mentally retarded persons to lead productive lives in the community are financed through the so-called "controllable" programs, the programs which are most likely to feel the edge of the budget cutters' axes. To remove these vital services from these vulnerable citizens will likely foster unwarranted, unnecessary institutionalization.

The cost of such institutionalization will be much higher than the cost of care in the community and will most probably be financed through the "uncontrollable" portions of our budget. The net impact, then, will be no cost saving to the taxpayer and, equally important, a significantly negative alteration to the lifestyle of the mentally retarded person. The ARC strongly urges you to place careful attention to this possibility.

Since there are many federal programs which impact on the lives of mentally retarded persons, our organization does not prioritize one over the other because all of them are necessary at some time. Our organization has carefully assessed the needs of mentally retarded citizens and recommends the levels of funding for FY 1981 as listed on the summary pages.

The following narrative explains the rationale behind our recommendations for FY 1981 to provide the levels of services essential to secure meaningful lives for our mentally retarded citizens. It's important to note that these recommendations have not been solely thought out by our organization but represents the collective thoughts of over two dozen national organizations serving handicapped individuals as part of different coalitions which formed to provide sound fiscal advice to the Congress and to promote the financial needs of disabled people.

Education for the Handicapped

PROGRAM	(in millions of dollars) FY '80 Appropriation	FY '81 Admin. Request	ARC Recommendation
Educ. for the Handicapped State Grant	874	922	1,200
Pre-School Incentive Program	25	25	66
Personnel Development	55.4	58	90

All mentally retarded children were guaranteed a free, appropriate public education with the passage of P.L. 94-142, The Education for All Handicapped Children Act in 1975. When it enacted this law, the Congress promised to provide fiscal support to states and local educational agencies to relieve them of a portion of the extra financial burden of educating handicapped children. Based on the formula adopted by that law, educational agencies were led to expect approximately $3 billion in federal support in FY 1981. The President's request for the 1981-82 school year is $922 million, a $48 million increase from FY 1980 funds but less than one-third the sum promised by P.L. 94-142. The Administration's rationale for their request continues the policy of funding 12% of the national per pupil expenditure, using a figure of 7% inflation and 3.8 million handicapped children to be served.

Our organization and others argue that more handicapped children will need to be served in the 1982 school year (closer to four million) and few will disagree that a 7% inflation is well below the current level (between 10% and 13%). Using moderate estimates of children to be served and inflation rates, it is our contention that over $1 billion will need to be appropriated to maintain the Administration's 12% funding policy. The ARC strongly encourages this Congress to appropriate $1.2 billion for the Education for the Handicapped State Grant Program for FY 1982.

In enacting P.L. 94-142, the Congress also authorized a Pre-School Incentive Program to stimulate the states to provide educational services to children between the ages of three to five. Providing services to these very young handicapped children enhances the potential for decreasing future, more costly programs while increasing the potential for significant improvement in the child's handicapping condition. The law provides a $300 per pupil reimbursement. However, the President's proposal allows for less than a $100 reimbursement, not a very big incentive for school systems to serve them. If only 4,400 additional children were served next year along with the approximate 216,000 served last year at the $300 per child rate, an appropriation of $66 million is necessary.

The ARC envisions this program as the opportunity of a lifetime for such young children. The pre-school program must be regarded as a primary program for the prevention of handicapping conditions. To ignore this population deprives our country of a major tool to eradicate costly, often times, lifetime care of people who may require such care if not given training opportunities early in life. We urge a $66 million appropriation for the pre-school incentive program.

Expanding educational services to handicapped children will be very difficult, if not impossible, without an additional 85,000 special educators and related personnel. In addition to new staff, all states must initiate in-service training to current personnel in order to train teachers in regular classrooms to teach handicapped children assigned to them under the least restrictive policy of P.L. 94-142. The Congress clearly acknowledged the need for expanding special education manpower development when it authorized increased funds for personnel training in P.L. 94-142. The ARC recommends an appropriation of $90 million for such purposes in FY 1981.

Elementary & Secondary Education

(in millions of dollars)

PROGRAM	FY '80 Appropriation	FY '81 Admin. Request	ARC Recommendation
Elementary & Secondary Education			
Aid to Disadvantaged	3,170	3,370	3,370
Handicapped Set-Aside	317	337	337

Handicapped children in state operated and supported schools are major recipients of the "handicapped set-aside" in the ESEA Aid to the Disadvantaged Program (Title I). Approximately 650,000 children are served under this program. These funds are especially useful when the children leave the state schools, usually institutions, to enter community schools because the Title I money "follows the child," thereby lessening the financial impact on the local community. The ARC concurs with the Administration's request of $3.37 billion.

In addition to the appropriation increase, we suggest that the federal government study how these Title I funds can best be utilized to spur the mainstreaming of children residing in state institutions into the local school system. The ARC is also concerned that some handicapped children are being denied services funded by Title I funds. Disadvantaged handicapped children has the same right to Title I funds as disadvantaged non-handicapped children. The availability of P.L. 94-142 must not be used as an excuse to exclude handicapped children from Title I services.

Developmental Disabilities

(in millions of dollars)

PROGRAM	FY '80 Appropriations	FY '81 Admin. Request	ARC Recommendation
Developmental Disabilities			
State Grant	43.2	43.2	60
Protection & Advocacy Systems	7.5	7.5	15
University Affiliated Facilities	7	7	9
Special Projects	4.7	4.7	7

The 1978 Amendments (P.L. 95-602, Title V) to the Developmental Disabilities Act made major modifications to the basic Developmental Disabilities State Grant Program. States are now required to spend at least 65% of their state allocations on the new priority service areas:

Case Management;
Child Development;
Alternative Community Living Arrangements; and
Non-Vocational Social - Developmental Services.

The States are presently limited to fund up to two of the four priorities. The limitation stems from a formula in the Act which allows no more than two priority areas to be funded if the annual appropriations is below $60 million.

Recent Developmental Disabilities State Plans have clearly indicated the pressing need to expand the service in each state in all four priority areas. For this reason, the ARC strongly recommends a $60 million appropriation level for FY 1981. The approximately $17 million increase will provide for 1) continued services to those developmentally disabled persons currently being served; 2) expansion of the current state priorities to serve those individuals not now being served; and 3) the initiation of a third priority service based upon the need as determined in the Developmental Disabilities State Plan.

Protection & Advocacy Systems provide legal, personal, and other types of advocacy to developmentally disabled individuals who are unable to protect their own rights. The Protection & Advocacy Systems must provide state-wide services, thereby necessitating appropriate staff to handle various functions of the systems. Among the major activities Developmental Disabilities Protection & Advocacy Systems are currently involved in are:

- assisting developmentally disabled individuals and their parents with their due process rights under the Education for All Handicapped Children Act;
- zoning, barrier removal and other activities geared to provide access to community housing and other facilities;
- 504 anti-discrimination protections under the Rehabilitation Act; and
- preventing abuse and upgrading conditions in institutions.

Funds currently available to the Protection & Advocacy Agencies ($7.5 million) allow for minimal services to be provided and are certainly not sufficient to provide the state-wide services which are mandated in the law.

The ARC recommendation of $15 million is desparately needed and would significantly increase the availability and effectiveness of Protection & Advocacy services in each state.

Special Project Grants authorized under the Developmental Disabilities Act were significantly decreased in FY 1980, from $20 million to $4.7 million. The ARC endorsed this reduction on the basis that the funds would be shifted to the State Grant Program, thus giving the states more direct control over funds. The ARC requests a $2 million increase over the FY 1980 level. The special projects support demonstration projects to expand and improve services, promote public awareness, coordinate community resources, provide technical assistance, and further the development of innovative treatment modalities. The increase would be used to fund model projects in each of the new provisions of the Act (four service priorities, expanded

definition, management assessment and training, planning and evaluation) so as to avoid costly startup costs in these new areas in each of the fifty states, thus providing a cost-effective means for implementing the Act.

The ARC recommends University Affiliated Facilities Grants be funded at $9 million, an increase of $2 million. P.L. 95-602 redefined and significantly extended the mission of University Affiliated Facilities in relation to the effectiveness of other federal and state service programs. University Affiliated Facilities specifically are to improve the effectiveness of prevention and treatment of mental retardation and other disabilities through provision of high quality demonstration models and training-to-service programs funded under Maternal and Child Health, Rehabilitation Services, Developmental Disabilities, Titles XIX and XX of the Social Security Act, Head Start, and Education of the Handicapped. University Affiliated Facilities are to increase primary prevention through state and regional networks as called for in the GAO report on prevention. Secondary prevention would be extended through increased coordination with national early screening and treatment services such as those funded by the SSI-Disabled Children's Program, E.P.S.D.T., Head Start and P.L. 94-142.

The FY 1981 budget level will specifically provide administrative and operating expenses for the national University Affiliated Facility network supporting thirty-six centers and five satellites in thirty-one states. Community outreach programs would be extended, as would service to presently unserved geographical areas. As called for in P.L. 95-602, University Affiliated Facilities would also be funded to support state agencies in the development of manpower and training plans. Funds would support inservice training as well as applied research on direct improvement of the efficiency and effectiveness of existing service delivery systems.

Vocational Rehabilitation

(in millions of dollars)

PROGRAM	FY '80 Appropriation	FY '81 Admin. Request	ARC Recommendation
Vocational Rehabilitation			
State Grant	817.5	854.3	945
Innovation & Expansion	11.8	0	12
Independent Living	15	18	45
Training	28.5	25.5	35

Handicapped individuals who have the ability to be trained to work receive services under the Vocational Rehabilitation State Grant Program. This program has been one of the finest examples of a Federal Government program which is cost beneficial, where clients served return in payroll taxes to the government amounts far in excess of the federal benefits they received while being trained. The Rehabilitation Amendments of 1978 established an entitlement formula for the Rehabilitation State Grant Program whereby federal funds are provided up to the authorized level if the states are able to match the federal funds. Unfortunately, in FY 1980 and now in the Administration's budget for FY 1981, the amount available for this program is below the

authorized level and below the level that the states are able to match. The net effect of this shortage of federal funds is that states are running out of training funds prior to the end of the fiscal year, thereby not allowing the states to provide services to clients seeking them. This is a most unfortunate situation which this Committee should not allow to continue. Instead of reducing benefits to disabled individuals, let us provide them with the fullest opportunities to work and be contributing members of our society. At a minimum, each handicapped person deserves a chance to be rehabilitated.

We understand the state vocational rehabilitation agencies are now able to match the full vocational rehabilitation authorization for FY 1981. We strongly urge the Congress to appropriate $945 million for the state vocational rehabilitation program.

Innovation and expansion grants help state vocational rehabilitation agencies plan, test, and evaluate alternative approaches in improving the capacity, quality, or cost effectiveness of delivering vocational rehabilitation services. This program is currently used to serve special populations, such as the multiply handicapped, who are generally determined ineligible for vocational services because of the employment potential criteria. Many of these persons are mentally retarded. There is no sound rationale to discontinue this program at the present time. The ARC supports an appropriation of $12 million for innovation and evaluation grants.

Programs authorized by Parts A, B, and C of Title VII (Comprehensive Services for Independent Living) of the Rehabilitation Act of 1973 as amended promise better, fuller lives for our nation's severely handicapped citizens who cannot qualify for basic vocational rehabilitation services. However, the Administration's budget for fiscal year 1981 requests $18 million to fund Part B (Centers for Independent Living) and does not request funding for Part A (Grants to States for Independent Living Rehabilitation) and Part C (Independent Living Services for Older Blind Individuals), which is dependent upon Part A funding for its own financing.

When the Congress enacted Title VII as part of the Rehabilitation Act amendments of 1978, it, along with handicapped citizens and their advocates, envisioned a substantial new service program with sufficient funds to develop effective long range plans and services. The appropriations history since the program's passage in 1978 clearly indicates that the mission of the program has not been fully met due to the serious lack of funds to implement Part A, the basic state grant which is the heart of the program.

It is important to note that the only reason Part A is not implemented is the lack of appropriated funds. The time is ripe for full implementation in fiscal year 1981. The state rehabilitation agencies, which have the responsibility for program planning and implementation at the State level, have indicated a strong desire to initiate the program through their planning efforts to secure the fiscal year 1980

funds for Part B. Numerous demonstration projects in recent years have indicated the viability of the Independent Living concept.

To implement this vital program now makes inordinate sense. The state agencies and public and private service providers are prepared to deliver the services. Handicapped citizens are clamoring for the services. Without such services, severely handicapped citizens who, because of the severity of their disabilities, cannot qualify for vocational rehabiltiation services will frequently be subjected to unwanted, undesirable and very costly institutionalization. Many who are willing to work will be unable to do so due to the lack of training and support services which would be provided by the Independent Living program. Handicapped citizens want to participate in our society. Independent Living services would provide the mechanism to achieve this goal.

The ARC recommendation for $45 million for fiscal year 1981 is justified on the basis of:

- a reasonable initiation of the Part A Comprehensive Services State Grant Program;
- the continuation of ongoing efforts with Centers for Independent Living (Part B); and
- start-up for the Part C Older Blind Individuals program.

The Part A portion of the Independent Living program has never been launched due to the unavailability of appropriated funds. If all fifty states received the minimum allotment of $200,000, approximately $10.5 million is necessary. In order to launch the program equitably in the more populous states, an appropriation of approximately $25 million is suggested. That level of funds would provide approximately one third of the states with the minimum allotment, with the remaining, more populous states, receiving a larger, proportional share. This level of funding would allow the Part A program to be implemented with sufficient services available in each state to secure much needed assistance to severely handicapped individuals.

In order to provide effective rehabilitation and independent living services, state vocational rehabilitation agencies must have trained personnel to carry out the program. Additionally, direct rehabilitation program providers must also have the skills necessary to offer quality services. The congressional mandate to provide increased services to severely handicapped individuals and the new challenges of the independent living program requires, at a minimum, retraining of existing rehabilitation personnel to deal with this new clientele.

The vital role of the twenty-two Rehabilitation R&T Centers must not be diminished now, especially with the requirements cited above. The ARC recommends an appropriation of $35 million for rehabilitation training services.

National Institute on Handicapped Research

PROGRAM	FY '80 Appropriation (in millions of dollars)	FY '81 Admin. Request	ARC Recommendation
National Institute on Handicapped Research	31.5	37	45

P.L. 95-602 established a new National Institute on Handicapped Research to develop a comprehensive, coordinated approach to the administration and conduct of research, demonstration projects, and related activities including training. Such a thorough approach is to include dissemination of information, financial support for the distribution of technological devices and equipment, and increase in scientific and technological information.

In addition to extending federal support for both the Rehabilitation Engineering Center (REC) and Rehabilitation Research and Training (R&T) Centers, P.L. 95-602 earmarked a number of new research efforts, including joint projects with other federal agencies, a study of the special concerns of rural areas, special needs of persons 60 years of age and older, and support of model training centers to evaluate and develop employment potential.

The Administration's $5 million proposed increase will allow the NIHR to implement the Section 202 (g) requirement for the development and submission to Congress of a long-range plan for rehabilitation research, will ease the inflationary pressures forced upon the existing RECs and R&T Centers, and will target roughly $1 million for technology development.

However, the $5 million increase is not enough to allow the five regional rehabilitation research centers to become involved in the psycho-social areas as they are expected by statute to do, will not allow growth in the number and geographic distribution of RECs and R&T Centers, and will allow a number of P.L. 95-602 requirements to remain unaddressed.

The federal government's rehabilitation research authority has experienced no real growth in almost ten years. The FY 1978 funding level was identical to the FY 1979 level. This no-growth appropriation policy has stifled the research effort related to disability. We recommend an appropriation of $45 million to allow the new Institute to get started with sufficient funds to carry out its many functions.

National Council on the Handicapped

PROGRAM	FY '80 Appropriation (in millions of dollars)	FY '81 Admin. Request	ARC Recommendation
National Council on the Handicapped	--	.26	.26

The ARC concurs with the Administration's budget request to finance the work on the National Council on the Handicapped. The implementation of this Council is vital to the success of the NIHR, since the Council, by law, must set the policies under which the Institute must operate. We urge this Committee to appropriate the same request to fund the activities of the Council.

National Institute of Child Health and Human Development

PROGRAM	FY '80 Appropriation (in millions of dollars)	FY '81 Admin. Request	ARC Recommendation
NICHD	210	217	239

The MR-DD Branch of the NICHD is a primary locus of the federal government's research efforts on behalf of mentally retarded citizens. This program has recently had an unfortunate history of steadily eroding support, particularly within the Institute. For example, despite an overall institute appropriation increase of 7% in FY 1980, the twelve Mental Retardation Research Centers received an 11% reduction of funds.

The ARC recommends an increase for the NICHD to $239.9 million, a 14.5% increase based on the same rationale utilized with the NINCDS. Funds made available by this increase would be utilized to develop new research initiatives in:

- Genetics such as the new fragile X gene;
- Early intervention with emphasis on the interactions between mothers and their children; and
- Mentally retarded adults, where minimal research and information currently exist.

Our organization strongly urges the Congress to develop clear language in the report accompanying the appropriation bill insisting the NICHD restore the level of funds for the twelve Mental Retardation Research Centers at the FY 1979 level and at least a cost of living increase for all other programs in the Mental Retardation Branch.

National Institute of Neurological and Communicative Disorders and Stroke

PROGRAM	FY '80 Appropriation (in millions of dollars)	FY '81 Admin. Request	ARC Recommendation
NINCDS	242	250	280

The President's request for NINCDS is barely a 3% increase over the 1980 appropriation. The administration's thinking behind this increase was that the Institute had received relatively large increases in both of the previous two years, and that their payline for grants was now approximately 230 compared with an institute-wide figure of 215-220.

A proposed administration increase for NINCDS does not meet the generally accepted medical research inflation index of 14.5%, nor does it provide funds for special initiatives or any of the substantial activities of the long range plan developed last year by the Institute. This long range plan carried a price tag of $286 million for 1980 and $345 million for 1981. In view of the constraints on the federal budget and the spectrum of increases for the various institutes, our recommendation of $285 million is a modest and defensible increase. The rationale is as follows: apply a 14.5% inflation rate to the FY 1980 appropriation, then add an additional $8 million for new research efforts.

Maternal & Child Health

PROGRAM	(in millions of dollars) FY 80 Appropriation	FY '81 Admin. Request	ARC Recommendation
Maternal & Child Health			
State Grant	345.5	360.5	375
Training	26.5	25.7	30

The Maternal & Child Health Program is a vital resource to serve children with special needs and their mothers. Maternal & Child Health Training funds constitute a major resource to serve developmentally disabled children and their families through the University Affiliated Facilities. Although the Administration is seeking a small increase in the state grant program, it is not nearly enough to keep up with inflation, let alone expand services. The request for FY 1981 training is a reduction from FY 1980. Our modest requests simply allows for a cost of living increase in both programs.

Prevention

PROGRAM	(in millions of dollars) FY '80 Appropriation	FY '81 Admin. Request	ARC Recommendation
Prevention			
Immunization	30.4	30.5	32
Lead Paint Poisoning	11.3	10.8	13
Genetic Services	11.6	11.9	16

Three federal programs critical to the prevention of mental retardation are the immunization, lead paint poisoning prevention and genetic services. Each of these programs have proven their effectiveness. The small amount of monies in these programs prevent the spending of untold millions of dollars in direct services to individuals who are born or become mentally retarded. These efforts must not be reduced. Our recommended increases for these programs barely meet inflation levels. It is the least we can do to prevent mental retardation from occuring whenever it is possible to prevent it.

Child Welfare Services

PROGRAM	(in millions of dollars) FY '80 Appropriation	FY '81 Admin. Request	ARC Recommendation
Child Welfare Services	56.5	164	164

The ARC strongly supports the Administration's efforts to expand Child Welfare Services. Assistance in adoptions, increased foster care and strengthening the possibility of family care are vital services required by mentally retarded children in order for them to avoid costly institutionalization. We urge the Congress to appropriate the full $164 million requested by the Administration.

Social Services

PROGRAM	(in millions of dollars) FY '80 Appropriation	FY '81 Admin. Request	ARC Recommendation
Social Services	2,351	2,900	2,900

Again, the ARC agrees with and supports the Administration's request of $2.9 billion for Title XX Social Services. This state grant program is heavily utilized in the states to provide community based services to mentally retarded people. Any reduction in these services will place unbearable burdens on the families of mentally retarded people and possibly require long term care placement. We encourage the Congress to appropriate the full Administration's request.

ACTION

PROGRAM	(in millions of dollars) FY '80 Appropriation	FY '81 Admin. Request	ARC Recommendation
ACTION			
Foster Grandparents	46.9	46.9	49

The Foster Grandparents program, administered by the ACTION agency, delivers important services to mentally retarded residents living in institutions. Often times, the "Grandparent" is the resident's only link to the outside world aside from direct care staff. Thousands of retarded people benefit from this program. Again, we only ask a small increase to prevent reduced services from increased costs. We recommend an appropriation of $49 million.

PRESCHOOL INCENTIVES PROGRAM

Senator WEICKER. One question before going to Dr. Salmon. The preschool incentives program; now, you said it's for ages 3 to 5, for retarded children?

Mr. GRAY. For handicapped children.

Senator WEICKER. Under what program are the retarded covered?

Mr. GRAY. They would be under Public Law 91-142, along with other handicapped children. What we are attempting to say here——

Senator WEICKER. What funds would be used for the education of those children such as my son, that started from, let's say, age 1 and 2 years of age in the special education courses? What is that funded from?

Mr. GRAY. The developmental funds would be one program. In terms of education for handicapped children, we are talking about those aged 3 and up. That's the approximate age people discover this.

Senator WEICKER. Nothing below that?

Mr. GRAY. Not in 94-142.

Senator WEICKER. State and local funds, not Federal funds?

The reason I ask the question is that all of the body of knowledge in this area, whether for my particular son or others, is that the earlier the opportunities in education——

Mr. GRAY. Absolutely. That's why we have such a great concern for funding the preschool incentive program which will certainly have a decent start by the time they get to full public education program.

Mr. SALMON. Those are just for handicapped children?

Senator WEICKER. All children really that have some disadvantaged—in whatever form. It would seem to me the sooner reached, the better.

Mr. SALMON. Hugh Carey and others—title VI in the Education Act—were instrumental in getting new programs into the public schools and taking very young children. That's proceeding today.

Senator WEICKER. Is this pretty much up to the initiative of the various States, rather than any specific direction from the Federal Government?

Mr. SALMON. Well, they have the direction given in the law, but implementation is up to the States. It's a vast program.

Senator WEICKER. Counsel tells me the money still doesn't go below age 3. Of course, it's my contention, supported by a body of specific knowledge, it should go below 3. It should really start at 1 or 2.

Mr. ADLER. Given the emotional development of the child.

Senator WEICKER. Interesting. Go right ahead.

HELEN KELLER NATIONAL CENTER PROGRAMS

Mr. SALMON. I would like to say that Mr. Willard Hampton is with us today. He is a volunteer chairman on the operating committee of the Helen Keller National Center. And Mr. Adler is our very good executive director.

In the almost 11 years of the operation of the national center for blind youths and adults we have been able to rehabilitate and materially help thousands of deaf-blind persons, starting from zero. There was so little done when this program was started that it is unbelievable today that we have been able, through a great deal of cooperation, to change the image of deaf-blind persons from one of dependency to one of achievement.

The enabling legislation, I might say, was passed in 1967. It was signed October 3, 1967. It was an administration bill. One of the chief architects was Mary Switzer. We could not have gotten this legislation through but for her. She had great rapport with the Congress and everybody she dealt with.

Then we must mention immediately another great lady, Helen Keller, whose centennial will be celebrated in June this year. There will be a great many festivities and recognitions, both in the United States and abroad. We are proud to have Helen Keller as our inspiration.

Senator WEICKER. Refresh my memory. What is her association with the State of Connecticut? Is that where she had a home?

Mr. SALMON. She had a home in Connecticut called Arkhan Ridge, which was named after an estate in Scotland. I had the pleasure to visit her a great many times there. It was about 3½ acres. I saw her during the later years of her life and she was a most contented, loving woman who had labored hard. She loved people, and she had the great pleasure of having people surrounding her—the household people, the nurses, and everybody else—who loved her like nobody had ever been loved. A great woman.

Senator WEICKER. Please go ahead.

Mr. SALMON. Thank you.

NATIONAL CENTER BUDGET REQUEST

In 1967 the Industrial Home for the Blind in Brooklyn was selected by HEW to operate the national center. That's because they had labored for deaf-blind persons and spent money they didn't have. That's the only way I can explain it.

The Rehabilitation Act of 1973 recognized the national center and its services. The RSA—Rehabilitation Services Administration—monitors our program, supervises it, and we have already passed to them our budget. I might say they have been very generous to us over the years and we appreciate it.

Now, I will put the goggles on because we will get down to business. I won't go over the allotted 3½ minutes.

At this time we are submitting our request for funds in Federal fiscal year 1981 for a contract of $4,689,426. This budget request includes contractual obligations that are now, or have been, programed for some expansion of the services that are being demanded by deaf-blind individuals and agencies throughout the country.

One group that is very important are the rubella 1964–65 children who are growing up to be men and women and will need services. They have been served exclusively in the past several years by the Office of Education. But the national center wants to do whatever we can do to help.

We are conscious of the need for extra funds not provided for in the budget. We have programed funds from State departments who sent the deaf-blind individuals for training and rehabilitation to us, particularly to the center at Sand Point, and to other facilities which we have developed over the country. We are hoping very much that the committee in its best judgment will honor the budgetary request in the amount that we have stipulated as being essential for the very nominal advancement of the program—especially for being ready to help take care of these rubella children.

I think that's all. Incidentally, no deaf-blind person will get in trouble over the cost of gasoline. They don't do any driving.

Senator WEICKER. That doesn't make a difference. Too many people out there can't drive either, but are driving anyway.

All right. Thank you, Dr. Salmon and Mr. Gray, very much for your testimony.

[The statement follows:]

STATEMENT OF PETER J. SALMON

First, I hasten to express our sincere thanks to the Chairman and Members of this Committee for their understanding and support of the Helen Keller National Center for Deaf-Blind Youths and Adults, now in its eleventh year of operation, and during that time has served thousands of deaf-blind persons. We have been able to change the image of deaf-blind persons from one of dependency to one of achievement.

1980 marks the centennial year of the birth of our late beloved Helen Keller, whose life continues to be our inspiration.

The Center at Sands Point is geared to serving the most severely handicapped deaf-blind persons. In addition, we have eight regional offices, primarily in DHEW regions, which are outreach facilities which have helped to localize the program. We also provide financial assistance of approximately $100,000 per annum for thirteen rehabilitation centers in various areas of the United States, which provide services in their areas to those who are not so severely handicapped as to require the services of the main facilities of the Helen Keller National Center. This has been an unusually successful cooperative arrangement. The Center also provides specialized staff to aid these agencies as the need arises, primarily in the area of employment. The Center has a specialist who has been able to open many doors for deaf-blind persons, not only in sheltered workshops, but in competitive employment. The Center has also developed a number of aids and devices especially adapted to the daily living needs of the deaf-blind trainees, which include a vibrating alarm clock which awakens a deaf-blind person; an oscillating fan which lets them know when someone wishes to enter the room; and a Telebraille instrument that has now been subcontracted out to Telesensory Systems, Inc. and Smith-Kettlewell Institute of Visual Sciences. This Telebraille instrument, a dramatic electronic device, will enable deaf-blind individuals to communicate with one another through standard telephone systems. Another device called the residential Wrist-Com, will also provide electronic coding signals for the deaf-blind individual, notifying that person that someone is at the door, the telephone is ringing, there is a fire, or illegal entry is being made into his apartment.

We have presented in detail in this testimony, the justification of our budget requirement for Federal FY 81 amounting to $4,689,426, subject to review and approval by the Rehabilitation Services Administration.

The Helen Keller National Center for Deaf-Blind Youths and Adults is operated by The Industrial Home for the Blind under an agreement signed in 1969

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with the United States Department of Health, Education, and Welfare. The authorization for its operation is contained in Section 313, Title III, of the Rehabilitation Act of 1973, as amended, and funds for its operation are appropriated annually by Congress. It operates under the general supervision of RSA with whom we have discussed our request for funds and have received their support and encouragement. The Center, which is located in Sands Point, Long Island, New York, was constructed with Federal funding. The campus includes a training building, a residential facility for the deaf-blind trainees, and a vocational building. The cost for the construction of this facility was approximately $7,500,000. Our mandate from Congress is quite clear. We are to provide comprehensive assessment of the needs of deaf-blind youths and adults in terms of their ability to achieve meaningful contact with the environment, help them to develop an effective means of communication, participate in the home and community, enhanced employability, and any other development that would be important to their optimum rehabilitation. In addition, we provide research, both in aids and devices for the deaf-blind as well as research regarding the implications and impact of deaf-blindness. We have made a survey of the causes of deaf-blindness and have found that fifty percent of the deaf-blind persons we deal with are the result of Usher's Syndrome. Thus, for the almost eleven years of the operation of the Helen Keller National Center for Deaf-Blind Youths and Adults, meaningful impact has been provided to several thousand deaf-blind individuals, their families, and service agencies throughout the country. Although this number may appear small in terms of the numbers of other handicapped individuals, it is generally recognized that the deaf-blind have the most severe handicapping disability of all.

In order to provide the necessary professional services to those deaf-blind individuals who reside on campus and the numerous others our regional representatives work with across the nation, a trained, dedicated staff must remain available to achieve the goals of the Center. However, dedicated staff begins to lose its sense of importance and the desire to give unselfishly of itself when its monetary rewards remain near static and when program expansion is curtailed. This has been occurring for the past three years.

Management had attempted to cut back on administrative costs and at the same time to meet the mandate of Congress by seeking to increase program income from third party sources. The only third party funding source we have access to is from fees provided by the various state departments for the visually handicapped. However, there too a funding ceiling has been indirectly imposed upon HKNC for the following reasons: State departments for the visually handicapped

are not always prone to provide fees for high-risk handicapped populations that require a longer period of time within the rehabilitative process. For example, it is less expensive to provide rehabilitation for a young blind or a young deaf person. The rehabilitative process for a deaf-blind person is much more involved, more costly, and may cover a period of several years. If we raise our fees too high, many states, particularly those with relatively small budgets for rehabilitative services, will not refer deaf-blind individuals for training. Instead, most of these individuals will then remain isolated in state hospital facilities frequently for the mentally retarded or receive the most cursory services in institutions or in their homes. The cost for maintaining an individual in an institution frequently ranges from $20,000 to $38,000 per year - with no end in sight. The loss of human dignity as well as the loss to our country of perhaps more Helen Kellers, Richard Kinneys, and Bob Smithdases, coupled with the cost of maintaining individuals in institutions is far beyond what it costs to provide rehabilitative services at the Helen Keller National Center, where a rehabilitative end is in sight for the deaf-blind trainee. Unfortunately, however, it is sometimes easier for state rehabilitation personnel with limited fiscal resources to ignore the expensive rehabilitative need of one deaf-blind individual when state personnel could provide funds for several other handicapped individuals whose cost of rehabilitation would be less. This fact does tend to put a ceiling on the amount of money we could receive for training fees from the various states.

Coupled with a ceiling on program income we, like everybody else, have experienced a tremendous surge of expenses in terms of supplies and equipment. This, of course, is due to the inflationary spiral that has affected everybody. Our fuel costs have increased by 72%, our lighting costs have increased by 27%, and medical supplies and services have almost doubled. Yet our Federal appropriation has remained static for the past two fiscal years. Salary increases during Federal FY-79 and FY-80 were below 9% for the combined two years. As a result, we had frequent staff turnover, staff dissatisfaction, and eventually our entire professional, non-professional, and blue collar personnel were organized and incorporated into District 1199, National Union of Hospital and Health Care Employees, RWDSU, AFL-CIO. As a result of very careful and conservative negotiations, a 33-month contract with District 1199 was established. All HKNC personnel within the union were granted a minimum of a 7½% increase on salaries retroactive from 7/6/79 to 8/1/80. In addition, those HKNC personnel who were receiving salaries below minimum union scale had their salaries increased to minimum scale by 12/79. On 8/1/80, all union personnel will re-

ceive a 3% increase based on their 7/31/80 salaries. Minimum wages again will be readjusted upward and again on 2/1/81 there will be another 3% salary increase and again a minimum union wage increase. A further note for FY 82: There will be a 5% wage increase on 7/1/81. In addition to salary increases, overtime will consist of time-and-a-half and holidays will be two-and-a-half times normal pay. All live-in residence employees will receive an additional $500 residence allowance, and vacation time for non-professional personnel who have 3 or more years of service within HKNC will amount to anywhere from 1 to 2 additional weeks of vacation benefits. A major problem confronting us in FY 82 will be the inclusion of a health benefit package administered by District 1199 that will cost us at that time 10.9% of gross union salaries. In 3/82, a new contract with the union will have to be negotiated which, in all probability, will include a pension plan on a non-contributory basis for union personnel and perhaps an increase in the cost of the union health plan.

Because of these increased expenditures that we now have contracted for, we will be requesting to meet with appropriate congressional subcommittees, asking for a supplemental emergency amendment for Federal FY-80 (HKNC 7/1/80 - 6/30/81). We will be requesting supplemental assistance of approximately $370,000. That sum, combined with increased program income and revised administrative control of expenditures will be required if we are not to cut back on basic services.

We are responding to increased operational expenditures in the following manner: Cost center controls are being developed and all expenditures must first relate to a priority designation. Wherever possible, and if it is cheaper, we are seeking to utilize the services of other organizations, e.g. data computer services rather than continuing our own rather expensive in-house computer operation. Reorganization of our staff has already been initiated, particularly in the area of cutting back on administrative personnel, e.g. one of our two Associate Directors will be retiring on or before September 1, 1980 and his position will not be filled but, instead, will be transferred to other senior personnel within HKNC. The Director of Research position has already been eliminated and, instead, that responsibility is under the general supervision of a Research and Evaluation Supervisor. A number of other positions within the Center have also been eliminated or their responsibilities merged with other job titles.

We, therefore, feel that we have initiated and will continue to institute strict, conservative, and appropriate administrative restraints on expenditures

and, at the same time, seek to increase wherever possible funding from state resources.

While we seek to control expenditures, we are also faced with the demand to expand our service delivery program throughout the country. As we indicated previously, our Center has been in operation for almost eleven years. We have learned much about the needs of the deaf-blind of this country and our proposals for an expanded service delivery program are based upon that experience. In late December, in concert with numerous other agencies serving the blind, we submitted a white paper to the new Secretary of Education, the Honorable Shirley M. Hufstedler. We are including excerpts from this white paper for your consideration and for the record.

Our proposed funding needs for Federal FY-81 (our FY-82, 7/1/81 - 6/30/82) amount to $4,689,426. This funding request may appear as a dramatic increase from our previous budgetary submissions. May we respectfully remind the Members of the Subcommittee on Appropriations that the dramatic difference between our previous budgets and our current request is primarily because there were no increased appropriations during the past two fiscal years! Our attempts in the past to keep personnel costs down have resulted in a dramatic rise in personnel costs and fringe benefits now mandated by a union contract. An example is reflected in the following: Our costs for health care benefits prior to the union contract were approximately $25,000 per annum. On 7/1/81 our costs to participate in the union health plan will be 10.9% of gross union salaries or approximately $225,000 per annum. Further examples of the increased costs of our operation are the following: During Federal FY-79, our fringe benefit expenses were 11.8% which included Social Security, pension, disability insurance, hospital insurance, group life insurance, unemployment insurance, and workers' compensation. The cost was $184,824. The cost of comparable services for Federal FY-81 now including the union medical and health plan will be $565,685.

As we indicated in our presentation to Secretary Hufstedler, there is a need to expand our services for the deaf-blind of this country. This includes a training team operating out of headquarters at Sands Point, Long Island, New York, providing intensive training experiences at Center headquarters and in other agencies, both private and governmental, across the country. We feel it is important to develop a broader base of trained workers able to work with the deaf-blind near their home localities. Thus, the training facilities at Sands Point would be reserved for the more severely and multiply handicapped deaf-blind.

Many of the deaf-blind of our country are not aware of their civil rights or other provisions contained within the Federal and State rehabilitation laws and programs. They are indeed the silent and the unhearing. We are proposing the development of a national advocacy team that would stimulate and enable more deaf-blind individuals to raise their voices or sign for those rights and benefits most other handicapped individuals already receive. Thus, the advocacy team would also work with state agencies and private agencies, helping them to understand and, perhaps, even discover that providing rehabilitative assistance for deaf-blind individuals is a cost-saving venture instead of a cost expenditure drain.

We need to expand our readiness to deal with emergency situations in a manner that has been successfully demonstrated by community mental health centers.

We need to expand our educational program by producing video tape, conducting lectures, and demonstrations of working with the deaf-blind. We would want to produce a series of "How to" that would be distributed throughout the country. We do have a fully equipped television studio but no one skilled in that media.

We want to expand our outreach services through the development of two new regional offices (Boston and Kansas City, Mo.). The establishment of these two offices would further assist us in working with the deaf-blind in those regional areas and at the same time maintain the same geographical designations currently in force within the Rehabilitation Services Administration.

We want to also foster the development of a committee that would explore the need for, mobilize the resources for, and develop those additional facilities necessary to care for the aged deaf-blind, the deaf-blind in need of sheltered residential and workshop facilities, particularly for many of the 1964 rubella epidemic victims, and perhaps even the development of another comprehensive rehabilitation facility similar to the current facility at Sands Point, but in the mid or far west.

Our plans for expansion of services for the deaf-blind are not grandiose. We are seeking to utilize the concept of transferring our skills, experience, and knowledge to others in the field of services to the deaf-blind. We are not reinventing the wheel. We are not seeking to duplicate services. In fact, our proposals for expansion of services are really to meet the very basic needs for the deaf-blind of our country. Your consideration, your understanding, and your help are most urgently and respectfully requested.

LETTER FROM JOHN H. MAXSON, EXECUTIVE DIRECTOR, AMERICAN ASSOCIATION OF WORKERS FOR THE BLIND, INC.

January 25, 1980

Honorable Shirley M. Hufstedler
Secretary of Education
Washington, D. C. 20202

Dear Madam Secretary:

In response to your request for discussion papers listing issues and recommendations related to the establishment of the new Department of Education, I am submitting on behalf of the undersigned national organizations the attached position papers on matters of special concern in services to blind and visually handicapped persons.

These position papers were prepared following a two-day meeting in December of the key representatives of the undersigned organizations and reflect the views of the organizations on major needs in programs serving blind and visually handicapped persons to be administered by the Department of Education.

We hope that you and the members of your transition team will give our recommendations favorable consideration. Please be assured of our continued support and of our sincere desire to be helpful to you and your staff.

Respectfully yours,

John H. Maxson

John H. Maxson
Executive Director

For: Alphabetical List of Organizations

Affiliated Leadership League of and for the Blind of America
American Association of Workers for the Blind
American Council of the Blind
American Foundation for the Blind
Association for Education of the Visually Handicapped
American Printing House for the Blind
Helen Keller National Center for Deaf-Blind Youths and Adults
National Accreditation Council for Agencies Serving the Blind and Visually Handicapped
National Council of State Agencies for the Blind
National Industries for the Blind

Comprehensive Services for the Older Blind and Visually Impaired - Position Statement

Organizations and agencies of and for the blind have long recognized the growing need for services to senior citizens who are blind or visually impaired and who are not eligible for vocational rehabilitation. For more than 20 years, those organizations and agencies have sought Federal legislation with appropriate funding to establish and maintain comprehensive service programs which adequately address the needs of this underserved disability population.

Congressional recognition of the need for such programs was first manifested in the original versions of the Rehabilitation Act of 1973. Unfortunately, the compromise legislation enacted following the two vetoes by President Nixon did not include comprehensive service programs for the older blind and visually impaired. During the 95th Congress separate legislation which recognized the needs was incorporated in Title VII of the Rehabilitation Act of 1973 by Public Law 95-602. Section 731 of the Act provides "..an amount shall be made available for the purpose of carrying out the provisions of Part C of this title in an amount not in excess of 10 percent of the amount made available for carrying out the provisions of subpart 1 of Part A of this title."

- In order to implement Independent Living Services for Older Blind Individuals and visually impaired persons under Part C of Title VII, it is imperative that there be adequate funding of Part A without undue delay and that a full 10% of the sums appropriated for Part A be allocated for Part C. Anything less than 10% would not permit implementation of Part C in many states.

- Some months ago, we joined with a large group of organizations of and for the handicapped in recommending an appropriation of $125 million as the amount necessary to adequately implement Title VII. We still believe that that sum is necessary.

- We recognize that the funding for Title VII for Fiscal Year 1980 is unlikely to be increased; and we, therefore, recommend that a minimum of $45 million be appropriated for Part A of Title VII for Fiscal Year 1981, with 10% of that amount allocated for Part C. We further recommend that increasing sums be appropriated in subsequent Fiscal Years to achieve an orderly phase-in of full implementation.

Services to Deaf-Blind Persons - Position Statement

At present, the Helen Keller National Center for Deaf-Blind Youths and Adults (HKNC) at Sands Point, N.Y., is the sole agency singularly committed to provide services to deaf-blind youths and adults. The current program includes direct services, such as evaluation of the deaf-blind person and rehabilitation of the individual toward a meaningful goal; training of new or experienced workers in the field who are providing services for deaf-blind individuals; research toward the development of more effective communication aids and devices for the deaf-blind; research regarding the characteristics of the deaf-blind population in the United States; and the provision of information, training, and fiscal support for agencies willing to provide services for deaf-blind individuals.

To improve services to deaf-blind individuals, we recommend:

- Development of a specialized, mobile, comprehensive training team operating from HKNC at Sands Point to travel and provide consultation and training to workers in the field, new agencies providing services to deaf-blind persons, and one staff member in each state agency as a specialist in services to deaf-blind persons, as well as to work with families of deaf-blind persons to improve the standards of care.

- Establishment by HKNC of an emergency response unit, including an "800" number telephone system with TTY module for nationwide provision of emergency and other necessary assistance for deaf-blind persons, their families or governmental and private service agencies. Additional funds should be requested from Congress for this mission.

- Development by HKNC of a nationwide advocacy unit to assist deaf-blind persons in procuring services, technological aids, and strong consumer involvement in program planning and service delivery systems. Additional funds should be requested for the development of this unit.

- Establishment of two additional HKNC regional offices to permit location of such offices in each RSA region.

- At least one additional facility for comprehensive rehabilitation services for deaf-blind individuals located in the Midwest or Southwest, based on the HKNC (Sands Point) model. A planning committee composed of personnel from RSA's Bureau for Blind and Visually Handicapped, State Directors of agencies serving the blind, consumers from the American Association of the Deaf-Blind, and personnel from HKNC should be organized to develop the appropriate model.

- Development and construction of at least one geriatric residential facility for deaf-blind individuals. A planning committee as constituted in the preceding recommendation should be organized.

- Construction and development of a facility which would include recreational, educational, and sheltered employment opportunities for deaf-blind individuals whose disabilities are so great that they are unable to live in dignity with their family or live independently. Such a facility is required in response to the needs of the large population of the 1964 rubella epidemic victims as well as other multihandicapped deaf-blind persons.

- Provision of technical staff to state agencies desiring to develop independent living programs for deaf-blind individuals using state facilities and staff. Such technical support could be provided by HKNC through contracts with states which have obtained grants to develop independent living facilities. In effect, this requires development of a model independent living facility for various state governments to replicate within their geographic areas and requires construction and staff.

HANDICAPPED RESEARCH/VOCATIONAL REHABILITATION

STATEMENTS OF:

B. RUSSELL BAXTER, COUNCIL OF STATE ADMINISTRATORS OF VOCATIONAL REHABILITATION

MICHAEL OLIVERIO, NATIONAL REHABILITATION ASSOCIATION

JACK KITE, NATIONAL COUNCIL ON REHABILITATION EDUCATION

WILBERT FORDYCE, AMERICAN CONGRESS OF REHABILITATION MEDICINE AND AMERICAN ACADEMY OF PHYSICAL MEDICINE

ACCOMPANIED BY:

JOSEPH HONET, AMERICAN ACADEMY OF PHYSICAL MEDICINE AND REHABILITATION

CHARLES HARLES, GOODWILL INDUSTRIES OF AMERICA

Senator WEICKER. Gentlemen, you have 15 minutes. Go to it. [Laughter.]

I don't know how you are going to do it. That might be a lesson for all of us. [Laughter.]

VOCATIONAL REHABILITATION SERVICES

Mr. BAXTER. I am Russell Baxter, Commissioner of Rehabilitation Services in Arkansas, and also represent today the Council of State Administrators of Vocational Rehabilitation. This council is composed of my counterparts across the country in 50 States, plus the District and the territories.

With your indulgence I must say first we appreciate the support you personally have given the rehabilitation programs for the handicapped in the past and most recently your very significant activity in terms of

independent living legislation and appropriations. Let me assure you States are cognizant of it and many handicapped people are appreciative of it across the country.

BASIC SERVICE GRANTS

Each of us will also identify the particular section of the act that we will be emphasizing and the particular recommendations we will be making relative to budget. I will be talking about the basic service grants section: 100–B–1. This is the section that provides direct services to handicapped individuals. Those services are aimed at making employable, or enabling individuals to become employable, so they can become taxpaying citizens rather than drawing public assistance or being a financial burden of some type on public assistance programs.

The services might include evaluations, diagnoses, hospitalization, surgery, vocational training, related services, placement, placement tools, followup—anything that will enable this person to become employable.

The services might be provided to people who have mental disabilities. They might be mentally retarded. They might have heart conditions or be deaf, blind, orthopedically disabled—any condition that imposes a severe handicap to employment.

The basic State grant program of the act is the lifeblood of the vocational rehabilitation program. This is what actually enables the handicapped person to receive services that will enable him to become employed. We have difficulty, certainly, in meeting the full mandate of the act in that there are not adequate funds to provide services to all those who actually need services.

In fact, our best estimates indicate that probably 1 in 20 who are actually eligible for and in need of services are able to receive those services. Our primary emphasis in recommending the full authorization level for basic services is, of course, related to that. The cost priority is one factor. The broadness of the act itself, which is probably the most complete act in the social services arena today, has handicapped people and States excited over programs of receiving full services that will enable the handicapped to fully participate as members of our society.

So we are very concerned that we convince the Congress, if we can and are certainly working toward that, to fully implement the total authorization. This, of course, would honor the even entitlement provision that we have in our act.

This has been honored through the 1970's and previously also. It's very important to us in terms of enabling us to have adequate leadtime to properly plan for and to properly implement effective programs for the rehabilitation of the disabled.

We realize that in terms of spiraling cost and budgetary restraints that it's easy to think only of cost. Much more important, of course, is to remember that human lives and the quality of services are what we are actually talking about when discussing appropriations.

One justification for higher funding levels is simply the purpose for which the money is spent. That's the prevention of incalculable waste of human potential. We can't put a price tag on that. With this $945 million we certainly can increase the numbers we can serve and increase

the numbers of severely handicapped that we serve—which is the priority of the act.

It will reduce public assistance grants. It will enable many more to become wage-earning citizens. It will enable us to free some members of the family who can work instead of taking care of severely handicapped persons. And most of all, it will enable the handicapped person to gain some personal dignity and became a contributing member of society.

Thank you very much.

[The statement follows:]

STATEMENT OF B. RUSSELL BAXTER

The Council of State Administrators of Vocational Rehabilitation is an association composed of all the chief administrators of the public rehabilitation agencies providing services to handicapped persons in the fifty states, the District of Columbia, Guam, Puerto Rico, the Trust Territory of the Pacific Islands, and the Virgin Islands. These agencies constitute the state partners in the state-Federal program of rehabilitation services for persons with mental and physical disabilities provided by the Rehabilitation Act of 1973, P.L. 93-112, as amended. This 60-year-old program is a major resource for, and the state rehabilitation agencies are the primary providers of, rehabilitation services to the handicapped citizens of this Nation.

In order to provide state input into the State-Federal Vocational Rehabilitation Program, the Council was established by the State Directors in 1940, on the recommendation of and with the full support of the Federal Administrator of the vocational rehabilitation program. Since its inception, the Council has enjoyed quasi-official status as an active advisor to the Federal administrators in the formulation of policy and program decisions at the Federal level, and as an active force for strengthening the effectiveness of service programs for disabled Americans. It is also a forum for State Rehabilitation Administrators to study, deliberate, and act upon matters bearing upon the successful rehabilitation of handicapped persons and of national importance to disabled people.

The primary purpose of vocational rehabilitation services funded through the Rehabilitation Act is to render employable those disabled persons who, because of the severity of their handicaps, are unable to secure and hold employment. The recent amendments to the Rehabilitation Act (P.L. 95-602) broaden the scope of the Rehabilitation Program by authorizing a new program of "Comprehensive Services for Independent Living." The purpose of the Independent Living Rehabilitation Program is to assist those individuals "whose disabilities are so severe that they do not presently have the potential for employment but may benefit from . . . rehabilitation services which will enable them to live and function independently."

The Rehabilitation Act is the most complete and well-balanced legislation in the human service field. In one Act, provisions are included for a comprehensive and individually-tailored program of services to physically and mentally handicapped individuals; an innovation and expansion program; a training program; a research program; a special projects program; and a rehabilitation facility program. This balanced program embodies all the elements necessary for a successful rehabilitation program, and this balance needs to be maintained.

BASIC STATE GRANTS: VOCATIONAL REHABILITATION SERVICES (Section 110)

FY 1981 Authorization . . . . . $945,000,000 (ceiling)

FY 1981 CSAVR Recommendation $945,000,000

Basic State Grants are the lifeblood of the Vocational Rehabilitation Program. It is this section of the Act which funds the provision of vocational rehabilitation services to individuals with mental or physical handicaps.

These Federal dollars, matched with state money at a ratio of 80% to 20%, permit a state rehabilitation agency to provide individualized, comprehensive services for the purpose of rendering employable an eligible, handicapped person. Such services include evaluation, comprehensive diagnostic services, counseling, comprehensive physical restoration services, prosthetic devices, various kinds of training and training supplies, income maintenance, placement, placement tools, and equipment, initial stocks, transportation, post-employment, placement follow-up, and any other services needed to rehabilitate an individual. The people served by the program include people with heart conditions, blind persons, deaf persons, amputees, diabetics, mentally retarded persons, or any of many other disabling conditions incurred through accident, illness, or birth.

These funds are also used to pay for the administrative costs of operating the program and may be used for the establishment and construction of rehabilitation facilities, although funds for facility construction are also authorized under Title III of the Act.

In Fiscal Year 1979, the $808,000,000 appropriated for Basic State Vocational Rehabilitation Services was used by state rehabili-

tation agencies to serve 1,127,551 disabled individuals, of which 288,325 were rehabilitated. (See Appendix I) Despite this expenditure, there still are not sufficient funds to serve all those disabled persons who have the potential and desire to work and who need rehabilitation services to attain employment or self-sufficiency. In fact, even with a $47,528,000 increase in appropriations over the FY 1978 level, 3.5% fewer persons were served in FY 1979 than the preceeding year. Alarmingly enough, our best estimate is that state rehabilitation agencies are only able, on appropriation of $808,000,000, to serve one out of every twenty people who are eligible for such services.

The Council strongly urges that the Committee provide appropriations for Basic State Vocational Rehabilitation Services under Section 100(b)(1) of the Act in the amount of $945,000,000 for Fiscal Year 1981. This amount is vitally needed if the program is to expand its services to individuals with the most severe handicaps; nevertheless, even this will not allow the proper fulfillment of the mandates of the Act. However, it will permit the Federal government to make available an amount of money which the states can match and effectively use in FY 1981. (See Appendix II.)

Our recommended appropriation level for Fiscal Year 1981 represents an attempt to restore the purchasing power of the program service dollar, which has steadily eroded over the past several years due to inadequate increases in funding to meet the vast needs of severely disabled people. This recommended increase in appropriations will fund an expansion of services to a greater number of severely disabled persons.

State Rehabilitation Agencies, in carrying out the mandate of the Act to give priority of service to the rehabilitation of the severely handicapped, are finding that the costs, in terms of time, effort, and money, of serving this group are great--much greater than the cost of rehabilitating the less severely disabled. This means that the program is serving fewer people, while expending more money for adequate services, adequately trained staff, adequate equipment and adequate facilities. To illustrate, in FY 1976, the mean cost for services to severely handicapped individuals who were rehabilitated was $4,611, while it was $2,693 for non-severely

handicapped persons. In FY 1977, the cost for rehabilitating severely handicapped persons had risen to $4,718, and for non-severely handicapped persons the amount was $2,858.

In these times of spiraling costs and budgetary restraints, it is important to remember that human lives and the quality of services are what we are actually talking about when discussing appropriations. One justification for higher funding levels stems from the purpose for which the money is spent--the prevention of an incalculable waste of human potential--a purpose on which no price tag can be placed. Whether the cost is hundreds of millions or hundreds of thousands of dollars, there is no other human service program whose funds are spent in such a cost-effective fashion to help people to live more self-sufficient and productive lives. Vocational rehabilitation has continually more than paid for itself by helping handicapped people increase their earning capacity; or by freeing some other family member to work; or by decreasing the amount of welfare payments, health services, and social services they might need; and by assisting them to become taxpayers.

Essential, of course, to the continuance of a successful program is a well-funded program of comprehensive and individualized direct services to help handicapped persons become employable. But this effort must also be supplemented by research to reveal new knowledge, special demonstration projects to test this knowledge in practical settings, and trained personnel to work with handicapped people. State Rehabilitation Agencies must have the resources to initiate new programs and to expand existing programs by applying the new knowledge to new groups of handicapped individuals. Likewise, rehabilitation facilities must be developed in which severely handicapped individuals may develop their maximum potentials under the tutelage of competent rehabilitation workers. It is this balanced, comprehensive, and individualized approach that has enabled the rehabilitation movement to make the widely acclaimed progress that has been evident in recent years.

INNOVATION AND EXPANSION GRANTS (Sections 100(b)(1) and 121)

FY 1981 Authorization $55,000,000

FY 1981 CSAVR Recommendation $12,000,000

Under Sections 120 and 121 of the Rehabilitation Act, provision is made for Innovation and Expansion Grants, of up to three years in duration, to enable states to develop innovative programs and projects of service delivery or to expand services for specific classes of handicapped individuals. These projects have served as a very effective mechanism for encouraging states to develop new, different, or expanded services for handicapped groups with special problems. The favorable Federal matching rate of 90% - 10% encourages the states to move out into needed areas of services for severely handicapped individuals without having to divert dollars from basic rehabilitation services.

In previous years, these Innovation and Expansion Grants have promoted new state initiatives with mentally retarded persons, the mentally ill, and other severely handicapped groups. This mechanism affords an opportunity for the Federal government, through the Rehabilitation Services Administration, to encourage new efforts nationwide and also gives each individual state a means for initiating new endeavors on behalf of previously underserved or neglected classes of handicapped citizens. After demonstrating the effectiveness of such programs through the innovation or expansion grant effort, many states incorporate these projects into their existing rehabilitation services delivery system.

Because this section offers both a unique and proven approach to expanded and creative services for severely disabled persons, the Council of State Administrators recommends that $12,000,000 be appropriated for Innovation and Expansion Grants for Fiscal Year 1981.

COMPREHENSIVE SERVICES FOR INDEPENDENT LIVING

Section 731(a) (Parts, A, B, and C)

FY 1981 Authorization $200,000,000

FY 1981 CSAVR Recommendation $45,000,000

Title VII of P.L. 95-602 establishes a state grant program to provide Comprehensive Services for Independent Living designed to meet the current and future needs of individuals with disabilities "so severe that they do not presently have the potential for employment but may benefit from vocational rehabilitation services which will enable them to live and function independently."

The U.S. Senate Report describing this new program declared the objective of Title VII, "to build State services and service systems to increase the number of and improve the quality of services for severely handicapped individuals and to assist the States in developing and implementing comprehensive services for all severely handicapped persons." P.L. 95-602 envisions a substantial new service program with, as the Senate Report declares, "sufficient funds" available to develop "effective long-range plans and services."

The time to implement a new Comprehensive Services Program is now. No more "demonstrations" are needed; Congressional intent clearly envisioned a major new state grant service program.

The CSAVR's request for a $45 million appropriation for FY 1981 for Comprehensive Services for Independent Living is justified on the basis of devising an equitable state distribution procedure, ensuring continuation of the existing I&E independent living rehabilitation projects; allowing a continued appropriate funding base for the Centers for Independent Living and funding for the first time an Older Blind Individuals Program.

The state grant program under Title VII is based on the ratio of state population to the population of all the states, with a $200,000 or 1/3 of 1% of funds appropriated, whichever is greater, minimum allotment. If all 50 states received the minimum allotment of $200,000, a $10 million appropriation would be required. This would allow each state to hire a few professional staff to initiate the planning stage; implementation would not be possible with a $10 million appropriation.

To implement the law in its absolute narrowest sense would require at least $10,165,000. But we must do more ... now.

For all these reasons, we recommend $45 million for Fiscal Year 1981 to implement programs authorized under Parts A, B, and C of Title VII.

FACILITIES

Facilities Improvement Grants (Section 302(a))

FY 1981 Authorization . . . . . Such Sums

FY 1981 CSAVR Recommendation $10,000,000

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Because no single element in the Rehabilitation process is more important than Rehabilitation Facilities, we urge you to allow adequate funding for Section 302(a). This Section provides funding to rehabilitation facilities in order that their management might be improved, as well as the services which they provide. Also, these monies provide for the employment in facilities of additional professionals and technical personnel, as well as the purchase of specialized equipment.

The CSAVR strongly asks that Section 302(a) be funded in FY 1981 in the amount of $10,000,000.

SPECIAL PROJECTS AND DEMONSTRATIONS Title III

FY 1981 Authorization . . . . . Such Sums*

FY 1981 CSAVR Recommendation $32,000,000

*"Such sums as may be necessary" are authorized for all programs authorized under Title III, with the exception that $5 million is authorized for grants under Section 312 (Migratory Workers).

CONCLUSION

The Council has tried to present its views with respect to the need for adequate funding for the Rehabilitation Program, in order that handicapped people might continue to be served through programs of quality and substance.

As State Rehabilitation Administrators, we want to serve, and we sincerely ask that all appropriate consideration be given to our requests for these minimum amounts which we feel are necessary to allow us to provide to America's handicapped citizens the type and quality of service which they deserve, and that the Congress intends for them to have.

COUNCIL OF STATE ADMINISTRATORS OF VOCATIONAL REHABILITATION
RECOMMENDATIONS FOR APPROPRIATIONS FOR
REHABILITATION SERVICES FOR FISCAL YEAR 1981

ITEM	APPROPRIATIONS FY 1980	AUTHORIZATIONS FY 1981	CSAVR RECOMMENDATIONS FY 1981
BASIC STATE REHABILITATION SERVICES			
Section 100(b)(1)	$808.0*	$945.0	$945.0
Section 110(b)(2)	9.484	3.9	3.9
INNOVATION & EXPANSION			
Section 100(b)(2)	11.775	55.0	12.0
COMPREHENSIVE SERVICES FOR INDEPENDENT LIVING			
Section 731(a)	15.0**	200.0	45.0
NATIONAL INSTITUTE OF HANDICAPPED RESEARCH			
Section 201(a)(1)	31.5	90.0	45.0
REHABILITATION TRAINING			
Section 304(d)	28.5	45.0	35.0
PROJECTS WITH INDUSTRY			
Section 621	5.5	ss	20.0
FACILITIES IMPROVEMENTS			
Section 302(a)	0.0	ss	10.0
SPECIAL PROJECTS			
Several Sections	21.36	ss	32.0
NATIONAL COUNCIL			
Section 405	0.0	ss	.256

* - Possibility that Congress will consider a Supplemental Appropriations measure to raise to $880 million, authorized amount.

** - Monies earmarked by Congress for Part B, Centers.

APPENDIX I

TOTAL SERVED/REHABILITATED VIS-A-VIS APPROPRIATIONS
(Fiscal Years 1973-79)

FISCAL YEAR	Total Federal Appropriation	Annual Increase	Total Served	Total Rehabilitated
1973	$572,337,201		1,176,445	360,726
		$63,475,869		
1974	$635,813,070		1,201,661	361,138
		$44,186,930		
1975	$680,000,000		1,143,155	306,021
		$40,309,000		
1976	$720,309,000		1,118,713	283,906
		$20,000,000		
1977	$740,309,000		1,589,493	272,306
		$20,163,000		
1978	$760,472,000		1,167,991	294,396
		$47,528,000		
1979	$808,000,000		1,127,551	288,325

The figures are from the "State Vocational Rehabilitation Agency Fact Booklet," published annually by the Rehabilitation Services Administration. These figures represent only those individuals served and rehabilitated by Federal funds appropriated for Basic State Rehabilitation Services and do not include disabled beneficiaries served and rehabilitated by SSDI Trust Fund (Title II of the Social Security Act) and SSI (Title XVI of the Social Security Act) dollars.

SURVEY OF ALL STATE REHABILITATION AGENCIES WITH RESPECT TO AVAILABLE STATE MATCHING MONEYS FOR FISCAL YEAR 1981 FOR VOCATIONAL REHABILITATION SERVICES AT $945 MILLION FEDERAL ALLOCATION AS AUTHORIZED BY PUBLIC LAW 95-602

	ADDITIONAL FEDERAL FUNDS NEEDED		
	General	Blind	Totals
ALABAMA	3,636,000	////////////	3,636,000
ALASKA	1,000,000	////////////	1,000,000
ARIZONA	0	////////////	0
ARKANSAS	4,000,000	////////////	4,000,000
CALIFORNIA	5,000,000	////////////	5,000,000
COLORADO	700,000	////////////	700,000
CONNECTICUT	875,270	0	875,270
DELAWARE	952,400	0	952,400
DISTRICT OF COLUMBIA	1,098,400	////////////	1,098,400
FLORIDA	979,036	1,093,220	2,072,256
GEORGIA	849,804	////////////	849,804
HAWAII	0	////////////	0
IDAHO	3,133,737	819,648	3,953,385
ILLINOIS	2,500,000	////////////	2,500,000
INDIANA	n/a	////////////	n/a
IOWA	1,200,000	300,000	1,500,000
KANSAS	105,735	29,962	135,697
KENTUCKY	174,294	174,294	348,588
LOUISIANA	2,156,000	////////////	2,156,000
MAINE	118,888	////////////	118,888
MARYLAND	9,486,122	////////////	9,486,112
			40,382,800

	ADDITIONAL FEDERAL FUNDS NEEDED		
	General	Blind	Totals
MASSACHUSETTS	2,000,000	193,000	2,193,000
MICHIGAN	0	2,024,832	2,024,832
MINNESOTA	4,838,261	0	4,838,261
MISSISSIPPI	189,326	12,304	201,630
MISSOURI	0	0	0
MONTANA	60,000	160,000	220,000
NEBRASKA	80,000	237,333	317,333
NEVADA	1,394,340	////////////	1,394,340
NEW HAMPSHIRE	191,872	////////////	191,872
NEW JERSEY	4,603,151	n/a	4,603,151
NEW MEXICO	500,000	////////////	500,000
NEW YORK	0	n/a	
NORTH CAROLINA	15,481,374	0	15,481,374
NORTH DAKOTA	2,000,000	////////////	2,000,000
OHIO	529,827	////////////	529,827
OKLAHOMA	6,157,600	////////////	6,157,600
OREGON	5,867,259	460,000	6,327,259
PENNSYLVANIA	2,200,000	0	2,200,000
RHODE ISLAND	0		
SOUTH CAROLINA	3,000,000	1,000,000	4,000,000
SOUTH DAKOTA	200,000	////////////	200,000
			53,380,479

ADDITIONAL FEDERAL FUNDS NEEDED.

	General	Blind	Totals
TENNESSEE	-328,413	2,510,377	2,181,964
TEXAS	21,808,072	1,042,400	22,850,472
UTAH	500,000	0	500,000
VERMONT			18,484
VIRGINIA	1,770,000	526,850	2,296,850
WASHINGTON	1,000,000	300,000	1,300,000
WEST VIRGINIA	2,982,571	//////////	2,982,571
WISCONSIN	1,500,000	//////////	1,500,000
WYOMING	0	//////////	0
TOTALS, This Page			33,630,341
GUAM	0	//////////	0
PUERTO RICO	0	//////////	0
TRUST TERRITORY	n/a	//////////	n/a
VIRGIN ISLANDS	n/a	//////////	n/a
Totals from Pg.1			40,382,800
Totals from Pg.2			53,380,479
Totals from Pg.3			33,630,341
TOTAL	TOTAL AMOUNT OF FEDERAL DOLLARS STATES CAN MATCH AND EFFECTIVELY USE ABOVE $945 MILLION		127,393,620

VOCATIONAL REHABILITATION GRANTS

Mr. OLIVERIO. I'm Mike Oliverio. Yesterday and tomorrow I function as a rehabilitation counselor and administrator in Morgantown, W. Va.

Today I'm representing the National Rehabilitation Association, of which I am president this year—an organization of more than 25,000 individuals with a very rich history of 50 years of operating in an advocacy role for individuals with disabilities. My remarks will be identified with those of Russell Baxter who preceded me, regarding most of the funding requests, and I would like to speak to the $945 million budget request for the basic State VR programs.

That budget provides the formula grants to the States so they can provide services to the thousands of individuals who we attempt to move from unemployment to employment, from dependence to independence. During fiscal year 1980 we anticipate receiving approximately 1,422,000 individuals and of that, because of the 1973 act, we will hope to serve 45 percent of the severely disabled.

We hope to rehabilitate 257,000, of which 49 percent would be severely disabled individuals. We are all aware, it has been mentioned several times today, of the inflation factor of 13 percent. We are aware of the fact that to serve the severely disabled adequately requires anywhere from 2 to 2½ times the amount it takes to serve other handicapped individuals.

We are recommending, even though we realize it might not be enough to do the full job, $945 million for the basic State programs.

INNOVATION AND EXPANSION SERVICES

Next is the section on the innovation and expansion services where we have projects funded for no more than 5 years. These projects are divided into two basic types. One, the planning and initiation types of grants to start new programs. Second, projects to establish special programs. We feel the administration has been somewhat shortsighted in not recommending any funds. We are recommending and requesting $12 million in funds for I. & E. section 100.

This past year we saw the implementation of the National Institute on Handicapped Research that came about as a result of Public Law 95–602. This gives us a brandnew dimension to research and we are most appreciative of this.

We are recommending $45 million to help us with a good beginning for this and the continuation of current research. Section 304 deals with training. We are requesting $35 million for the training section simply because we feel there is a drastic need for very qualified individuals to do the relocation work which needs to be done for our handicapped citizens.

The faults improvement section 302: The improvement grants probably recommended some of the most cost effective Federal expenditures in our history. As part of this independent network of rehabilitating individuals, we are requesting $10 million for that.

We have listed in the formalized, comprehensive statement we have made, special projects which we are hoping will be given special merit.

INDEPENDENT LIVING PROJECTS

Last but not least we would like to speak to the issue of comprehensive services in the independent living projects which came about in recent legislation. We are requesting that at least $45 million be appropriated to move this from the current 1975 short-term projects to including it in the implementation of comprehensive services for independent living. We would appreciate $45 million being included in that.

Last but not least as has been mentioned previously we are grateful for your services and your interest in the cause we represent and are most appreciative of the opportunity to be here before you today.

Thank you.

[The statement follows:]

STATEMENT OF MICHAEL OLIVERIO

Mr. Chairman and members of the Subcommittee, my name is Michael A. Oliverio, President of the National Rehabilitation Association. On behalf of the Association, I submit the following statement in support of appropriations for programs authorized by the 1973 Rehabilitation Act, as amended.

I request that this statement be made a part of the official record.

First, Mr. Chairman, let me express the appreciation of the National Rehabilitation Association on behalf of the mentally and physically handicapped persons of this Nation and the service providers for the support given this Program by you and other Subcommittee members for so many years.

The National Rehabilitation Association, with a membership of over 25,000 professionals who work with persons with disabilities and who, for over fifty years, has been a strong and aggressive advocate for their cause, welcomes this opportunity to try to relate to you the needs and requirements for monies to adequately fund the Rehabilitation Program in Fiscal Year 1981.

Attached to this statement is a complete summary of the NRA's recommendations for appropriations for these programs. We would like, however, to discuss and highlight a few of these programs and appropriations recommendations.

BASIC STATE VOCATIONAL REHABILITATION SERVICES (Section 100(b)(1)

Mr. Chairman, there is one request paramount to all that is to follow--that is, the request for adequate monies to carry out a program of basic services to all types and catagories of persons with disabilities. In order to provide these services, the NRA recommends the full funding of this entitlement provision ($945 million).

This is not an enormous amount by any stretch of the imagination. While we hear, and certainly share, common concerns regarding our Nation's economy, we must not allow our country to deprive our most disadvantaged population of the bear minimum of hope these modest funds can provide. In times of troubled economics, the handicapped persons of this Nation have for too long suffered and shouldered more than their share of the burden.

Mr. Chairman, this is not a new program, but one that has been tried and proven. Now in operation for more than 60 years, it is one of the few successful Federal programs that you as a member of this body can point to with pride. It is one of the few programs which has not suffered from mismanagment, fraud and abuse, as exemplified by many of our latter day programs.

State governments have met the Federal challenge and have continued to over match in real dollars the Federal grants. More important, one must realize that to fail to meet this modest level of funding adds to the welfare and institutionalized costs which are currently astronomical. For the most part, this burden will be borne by the Federal government.

Mr. Chairman, good economic sense dictates that this Subcommittee fully fund this provision of Federal law. Here, as in few areas which you must address in the overall appropriations process, the need is well documented and the return to the state and Federal treasurys well known.

The Basic State Vocational Rehabilitation Program provides formula grants to the various state rehabilitation agencies for the purpose of providing direct rehabilitation services to handicapped youths and adults. The direct services program provides for a wide range of services and activities necessary to render a handicapped individual employable. Services may also be provided to families of handicapped persons when such services will contribute substantially to the rehabilitation of such individuals.

With the passage of the 1973 Rehabilitation Act and subsequent amendments, increased emphasis has been given to providing services to those individuals with the most severe handicaps. The National Rehabilitation Association enthusiastically endorses this Congressional mandate, and the state rehabilitation agencies have been doing a credible job in carrying out this emphasis. In Fiscal Year 1980, the state agencies are expected to serve approximately 1,442,000 disabled persons of which 45 percent are defined as having severe disabilities. An estimated 257,000 individuals will be rehabilitated during FY 1980 including 125,000 or 49 percent who are severely disabled.

Mr. Chairman, as you may be aware, all of these statistics represent a decrease in service to this vulnerable population. This is due, in part, to the new emphasis on serving first the severely handicapped. The increase in the number of successful rehabilitations of severely disabled individuals has occurred without significant increases in the appropriations provided for the needed services. It is generally accepted that the overall increase in inflation in the U.S. has amounted to at least 13 percent during the past. However, the increase in appropriations for programs authorized by the Rehabilitation Act has amounted to considerably less than that.

It is generally recognized that it costs from 2 to 2 1/2 times more money to rehabilitate a severely disabled person compared with the costs of rehabilitating a non-severely disabled person. Therefore the shift in emphasis to providing services to severely disabled persons has necessitated an adjustment by the rehabilitation agencies in that fewer persons are be served and fewer being successfully rehabilitated for the same amount of money. Added to this cost factor are the additional expenses created by such legislation mandates as the individualized written rehabilitation plan, family services, post-employment services, and annual reviews of ineligibility. Again, the increased demands on state rehabilitation agencies has come about without significant increases in appropriations.

The NRA recommends to the Subcommittee that Basic State Vocational Rehabilitation Services be funded in Fiscal Year 1981 at the full amount authorized, $945 million, with the full realization that this increase is still less than actually needed.

INNOVATION AND EXPANSION GRANTS (Section 100(b)(2)

The Innovation and Expansion Grant provisions authorize a formula grant program made to the states on the basis of population. States may use their allotment to fund projects for a maximum of five years, with the Federal share not to exceed 90 percent. Innovation and Expansion Grants are for two general types of projects: (1) the planning, preparation, and initiation of special programs to expand vocational rehabilitation services,

and (2) the establishment of special programs to initiate or expand services to handicapped persons who have unusual or difficult problems in connection with their rehabilitation, and whose responsibility for treatment is shared by the state rehabilitation agencies and other agencies.

Mr. Chairman, the Administration has exhibited its short sightedness and lack of understanding once again of why this provision of law exists, and has requested that this provision not be funded in FY 1981. Innovation and Expansion Grants are essential if new and expanded methods of providing services to severely disabled individuals are to be developed. Allotments granted under this authority have funded projects which have provided new knowledge relative to the services to handicapped people. These necessary and successful projects have become the "cutting edge" and have pointed the direction for rehabilitation service delivery in many instances.

The National Rehabilitation Association strongly urges this Subcommittee to again show its support for this provision by appropriating at least $12 million in FY 1981.

NATIONAL INSTITUTE OF HANDICAPPED RESEARCH (Section 201(a)(1)

Mr. Chairman, Public Law 95-602 added a dramatic dimension to research for handicapped persons, adults and youth. I speak of the authority and new beginnings of the National Insitute of Handicapped Research. We are, indeed, at a milestone, and therefore, feel that an appropriation of $45 million will provide a good beginning in its first full year of operation, while continuing to support the on-going work of the Rehabilitation Research and Training Centers and other exemplary projects.

TRAINING (Section 304)

Mr. Chairman, the NRA truly believes that if the services to handicapped persons in our public and private agencies are to continue, there must be an adequate quality and quantity of well-educated and trained professionals. We are greatly concerned at the Administration's lack of understanding of the need for providing adequate resources for this area of endeavor. For without persons trained to serve well the severely handicapped

population, it is necessary that we accept a lower quality of rehabilitation, and this, we know, that this Administration and this Subcommittee does not want to do.

I would bring to the Subcommittee's attention the fact that it is the hope of the NRA that at least $35 million can be appropriated in Fiscal Year 1981 for these needed educational services for rehabilitation professionals.

FACILITIES IMPROVEMENTS (Section 302(a)

Mr. Chairman, Facilities Improvement Grants have represented some of the most cost-effective Federal expenditures within the field of rehabilitation. Facilities are an integral part of a interdependent network of necessary services leading to successful rehabilitations. Although, facilities were mandated by the 1978 Amendments to the Rehabilitation Act of 1973, the Administration has given no recognition to the Federal mandate. One of the most important resources available for strengthening this facet of the rehabilitation process has been the Facilities Improvement Grant Program. The loss of these monies will not only weaken present services, but will also stymie the efforts of existing facilities to offer a higher quality of life to new consumers of the rehabilitation process, such as the severely disabled population and the disabled elderly. Historically, Facilities Improvement Grants have produced a major impact on the upgrading and development of services in facilities.

For these reasons, NRA feels it imperative that Facilities Improvement Grants be reestablished and funded in Fiscal Year 1981 at a level of $10 million. This money will be well used and will produce dividends to persons with disabilities served in facilities.

SPECIAL PROJECTS (Several Sections)

Many vital programs are included under the nomenclature of "Special Projects." The NRA recommends the following amounts be appropriated in Fiscal Year 1981 for this listing:

Technical Assistance Section 12	.25
Client Assistance Projects Section 112	3.5
Interpreter Training Services Section 304(d)	1.
Comprehensive Rehabilitation Centers Section 305	5.
Projects for Severely Disabled Section 311	7.
Recreation Facilities Accessibility Section 311(a)(3)	1.5
Spinal Cord Special Projects Section 311(b)	6.
Migratory Workers Section 312	1.53
Helen Keller Deaf-Blind Center Section 313	3.153
Reader Services for the Blind Section 314	2.
Interpreter Services for the Deaf Section 315	2.5
Recreation Programs Section 316	2.
Projects with Industry Section 621	20.
Business Opportunities Section 622	2.

COMPREHENSIVE SERVICES FOR INDEPENDENT LIVING (Section 731(a)

Last, but not least, Mr. Chairman, the NRA joins with other organizations in recommending $45 million be appropriated to carry out the provisions of the Act with respect to the Comprehensive Services for Independent Living Programs. This Program is designed to enable severely handicapped persons who may not be eligible for vocational rehabilitation services to live more independently with their families or in the community or to secure and maintain employment, if possible.

In addition to a continuation of the 75 projects funded in previous years, this amount will enable new starts and will allow coverage in all states. After two years on the statute books, it is time that the Administration recognize that the Congress intended that it move away from projects for Independent Living and to the implementation of comprehensive services for handicapped persons who may or may not want to receive or participate in an Independent Living Center project.

The NRA believes that services must be provided for persons living in more rural areas and smaller states where the center concept may not be as adaptable as those now found in large urban areas. While the NRA supports such centers, the concept of comprehensive services is much broader and a beginning should be

made to reflect the amendments provided through the law passed in 1978. Therefore, the NRA urges the Subcommittee to appropriate at least $45 million in FY 1981 in order to establish the Services Program in Title VII, as well as to continue to the Grants Program.

THE NATIONAL REHABILITATION ASSOCIATION
RECOMMENDATIONS
FOR
APPROPRIATIONS FOR REHABILITATION SERVICES
FOR
FISCAL YEAR 1981

ITEM	FY 1981 AUTHORIZATION	NRA RECOMMENDATION
STATE VOCATIONAL REHABILITATION		
Section 100(b)(1)	$945.0	$945.0
Section 110(b)(2)	3.9	3.9
INNOVATION & EXPANSION		
Section 100(b)(2)	55.0	12.0
NATIONAL INSTITUTE OF HANDICAPPED RESEARCH		
Section 201	90.0	45.0
FACILITIES IMPROVEMENTS		
Section 302(a)	SS	10.0
TRAINING		
Section 304(d)	45.0	35.0
NATIONAL COUNCIL		
Section 405	SS	.256
PROJECTS WITH INDUSTRY		
Section 621	SS	20.0
COMPREHENSIVE SERVICES FOR INDEPENDENT LIVING		
Section 731(a)	200.0	45.0
SPECIAL PROJECTS		
Several Sections	SS	32.0

REHABILITATION EDUCATION

Mr. KITE. I am Jack Kite, president of the National Council on Rehabilitation Education and director of the rehabilitation continuing education program at Seattle University. The NCRE represents over 72 universities and institutions throughout the country and hundreds of individuals involved in rehabilitation education and training.

I would like to say first of all our organization would like to associate itself also with the viewpoints of Mr. Baxter and Mr. Oliverio. I would like to emphasize a few points related to rehabilitation education and training.

TRAINING OF REHABILITATION PROFESSIONALS

We wish to express concern about the administration's funding for training of rehabilitation professionals: section 304. While NCRE recog-

nizes the need to reduce spending to curb inflation, we believe a cut in training will only perpetuate the problem. A reduced number of trained professionals will limit the quality and quantity of rehabilitation services not only now, but for years in the future.

These conditions will force more disabled individuals to depend on other avenues of service which have proven to be more costly—such as welfare, maintenance and institutionalization. In a recent presentation by the Urban Institute, it was projected that the level of counseling and employment in State rehabilitation agencies can be maintained over the next several years with the present level of graduates from rehabilitation counseling programs. It also stated there would be a turnover of 1,000 counselors a year in the State programs.

This estimate does not account for need in private, nonprofit rehabilitation facilities, which also provide services to rehabilitation clients. Long-term training programs and rehabilitation counseling will not be able to keep up with these needs without increasing funding.

Last year rehabilitation training received a 7-percent reduction in funds. This year the administration has recommended another 7-percent cut in funds which means we can't hope to provide the number of qualified, trained individuals necessary to provide services to disabled citizens.

We feel that it is imperative that training resources not be reduced and urge the subcommittee to recognize this importance by providing moneys at a minimum of $35 million.

One specific request this organization makes to the subcommittee is that no part of the moneys appropriated for training in section 304 of Public Law 95–602 be earmarked for any specialized facet of training or for any specific disability.

Mr. Chairman, the National Council on Rehabilitation Education appreciates the opportunity to present these views to you and we will be happy to supply any additional information to you or the subcommittee staff.

Senator WEICKER. Thank you very much.

We appreciate it.

[The statement follows:]

64-129 O - 80 - 40

STATEMENT OF JACK KITE

Mr. Chairman and members of the Subcommittee, my name is Jack Kite, President of the National Council on Rehabilitation Education. The NCRE submits the following statement in support of appropriations for Fiscal Year 1981 for program authorized by the Rehabilitation Act, as amended by Public Law 95-602.

I request that this statement become part of the official record of these proceedings and appreciate the opportunity to appear before you today.

The National Council of Rehabilitation Education represents a membership of 72 universities throughout the country, representing hundreds of individuals who work in rehabilitation education and research. The Council is vitally interested in assisting and preparing the needed manpower necessary in order to provide adequate services to the handicapped and disabled persons of this country.

The Council welcomes the challenge in the areas of training and research activities necessary to implement a truly comprehensive rehabilitation program as envisioned by the Rehabilitation Act Amendments of 1978. We need now to have adequate funding for the establishment and continuation of these much-needed programs for this Nation's disabled population.

The NCRE wishes to express its concerns about the Administration's proposed funding reductions for Training of rehabilitation professionals (Section 304). While the NCRE recognizes the need to reduce spending and curb inflation, we believe that a cut in Training will only perpetuate the problem. A reduced number of trained professionals will limit the quantity and quality of rehabilitation services in the future. These conditions will force more and more people to depend on other avenues of service which have proven to be more costly, such as welfare and maintenance and institutionalization.

Mr. Chairman, in order to carry out the mandates which the Congress has given, qualified personnel will be needed if we are to be successful in providing independent living rehabilitation programs; comprehensive services to severely disabled vocational rehabilitation clients; and addressing the increasing needs of handicapped persons with psychiatric disabilities.

In a recent presentation by the Urban Institute, it was projected that the level of counseling employment in state rehabilitation agencies will remain constant over the next several years, due to the "no growth" provided by inadequate appropriations.

It also stated that there will be a turnover of about 1,000 rehabilitation counselors per year. This estimate also does not account for needs in private, non-profit facilities which also provide services for rehabilitation clients. Current long-term training programs in rehabilitation counseling would bearly be able to keep up with these needs and will, most likely, lag behind.

The NCRE feels that it is imperative that Training resources not be reduced and urges the Subcommittee to recognize the importance of providing these monies at a minimum of $35 million in Fiscal Year 1981.

While this organization's most direct concern is the quality of training in rehabilitation, we wish to associate our members with the amounts recommended in the other provisions of the Rehabilitation Act, especially the National Institute of Handicapped Research, certainly an important compenent of Training, and those provisions which provide direct rehabilitation services to persons with disabilities--Basic Vocational Rehabilitation Services and the Comprehensive Services for Independent Living Provisions.

The one specific request that this organization makes to the Subcommittee is that no part of the monies appropriated for Training in Section 304(d) of Public Law 95-602 be earmarked for any specialized facet of training or for any specific disability.

Mr. Chairman and members of the Subcommitee, the National Council on Rehabilitation Education again would like to express its appreciation for the opportunity to present its views. If we can provide additional information to you or to the Subcommittee staff, we will be pleased to do so.

APPROPRIATION AMOUNTS TO BE SUPPORTED BY COALITION OF GROUPS FOR VARIOUS PROGRAMS AUTHORIZED BY REHABILITATION ACT (P.L. 95-602) FOR FISCAL YEAR 1981 (in millions)

BASIC VOCATIONAL REHABILITATION GRANTS	
Section 100 (b)(1)	$945
Section 110 (b)(2)	3.900.9
INNOVATION & EXPANSION	
Section 100(b)(2)	12.
COMPREHENSIVE SERVICES FOR INDEPENDENT LIVING	
Title VII	45.
NATIONAL INSTITUTE OF HANDICAPPED RESEARCH	
Section 201(a)(1)	45.
TRAINING	
Section 304	35.
FACILITIES IMPROVEMENT GRANTS	
Section 302(a)	10.
"SERVICE PROJECTS"	
So-Called in Administration's Budget	
Technical Assistance	
Section 12	.25
Client Assistance Projects	
Section 112	3.5
Interpreter Training Services	
Section 304(d)	1.
Comprehensive Rehabilitation Centers	
Section 305	5.
Projects for Severely Disabled	
Section 311	7.
Recreation Facilities Accessibility	
Section 311(a)(3)	1.5
Spinal Cord Special Projects	
Section 311(b)	6.
Migratory Workers	
Section 312	1.53
Helen Keller Deaf-Blind Center	
Section 313	3.153
Reader Services for the Blind	
Section 314	2.
Interpreter Services for the Deaf	
Section 315	2.5
Recreation Programs	
Section 316	2.
Projects with Industry	
Section 621	20.
Business Opportunities	
Section 622	2.
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APPROPRIATION AMOUNTS TO BE SUPPORTED BY COALITION OF GROUPS FOR VARIOUS PROGRAMS AUTHORIZED BY REHABILITATION ACT (P.L. 95-602) FOR FISCAL YEAR 1981

The following group of organizations concerned with programs authorized by Public Law 95-602, the Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978, have met, dicussed, and agreed upon the attached listing of appropriation amounts for the various authorities for Fiscal Year 1981.

All of the organizations listed below have agreed to these figures and to work in concert in an attempt to see that these amounts are appropriated for Fiscal Year 1981.

American Academy of Physical Medicine and Rehabilitation
American Association of Workers for the Blind
American Association on Mental Deficiency
American Coalition of Citizens with Disabilities
American Congress of Rehabilitation Medicine
American Council of the Blind
American Foundation for the Blind
Council for Exceptional Children
Council of State Administrators of Vocational Rehabilitation
Epilepsy Foundation of America
Goodwill Industries of America
Human Resources Development Institute, AFL-CIO
International Coalition of American Rehabilitation Efforts
National Association for Retarded Citizens
National Association of the Deaf
National Association of Private Residential Facilities for the Mentally Retarded
National Association of Rehabilitation Facilities
National Council of Rehabilitation Educators
National Easter Seal Society
National Multiple Sclerosis Society
National Rehabilitation Association
National Society for Autistic Children
Paralyzed Veterans of America
State Mental Retardation Program Directors Association
United Cerebral Palsy Associations

REHABILITATION MEDICINE

Dr. FORDYCE. I am Wilbert Fordyce of the American Congress of Rehabilitation Medicine. I am here today representing the American Congress of Rehabilitation Medicine, a professional association representing the health care professions involved in medical rehabilitation.

I want to address basically two points—one bearing on the National Institute of Handicapped Research and the second based on independent living.

For brief background context to what I want to say, I would observe that in my judgment the physically disabled, and particularly the severely physically disabled are almost always at risk to be the orphans of Federal policy and Federal support. It doesn't always happen, but it is a real risk.

In the course of events these groups tend to take a back seat to health care generally, to vocational rehabilitation, to socially disadvantaged, and so on. Now with the new Department of Education there is always the risk again. Because of the absolute numbers in the program, they might in a sense be swallowed up by the larger groups.

NATIONAL INSTITUTE OF HANDICAPPED MEDICINE

We are concerned about that. As you well know and have already indicated, rehabilitation programs themselves are indeed cost effective. Within that context, first let me address NIHR. In the last number of years, the research support for medical rehabilitation and for the severely disabled has ranged in the neighborhood of $32 million. That is what it was 10 years ago. For the last 3 years, it was $31.5 million. There have been no increases at all.

Now, within the National Institute of Handicapped Research and with these programs moved over into it, we have—online—22 medical rehabilitation research and training centers. They are tooled up. They have the expertise, the knowledge, the hardware to proceed and another 18 rehabilitation engineering centers also are operating on this stable but dwindling budget, because of inflation.

In addition, NIHR has an expanded research authority under its mandate but has too few funds to carry this out. We feel that scope of authority could well utilize as much as $90 million, but we share with the others the recommendation that at least for now there be appropriation of $45 million to NIHR for its research mission.

A second point about NIHR. It needs that minimum critical mass to get things going. Currently, it has a total of 32 positions authorized and for comparison we might take the National Institute of Aging, which has 3 times the staff for twice the budget of NIHR, or the National Institute of Education, which has 10 times the staff of NIHR and 3 times the budget.

We think it is essential that an additional 18 positions be authorized for NIHR so that they can bring into the program essential expertise in terms of their research mandates.

INDEPENDENT LIVING

Finally, in regard to independent living, I will be very brief about this. I simply want to say that we, too, share the conviction that in order to get this program started, there should be at least $45 million authorized so that each State can get some viable entity and thereby generate consumer support for expansion.

We very much appreciate this opportunity to bring our views to you. Thank you very much.

[The statement follows:]

STATEMENT OF WILBERT FORDYCE

I am Dr. Wilbert Fordyce, a Professor of Psychology, from the University of Washington Rehabilitation Research & Training Center and the President of the American Congress of Rehabilitation Medicine. Our organization, the American Congress of Rehabilitation Medicine, has 2500 members who are professionals from the many health fields involved with rehabilitation. Our organization includes nurses, psychologists, physical therapists, speech pathologists, occupational therapists, social workers, counselors, physicians and prosthetists and orthotists.

Our testimony today deals with the major new initiatives in the Rehabilitation Amendments of 1978, the Research Institute for the Handicapped, and the Independent Living Program, as well as the professional education and training program so important to all of our members.

As others have stated, the National Institute of Research for the Handicapped is a new agency and program of great significance. It is a new organization intended to exercise management over rehabilitation research heretofore under the auspice of the Rehabilitation Services Administration. Such programs include the Rehabilitation Research & Training Centers, spinal cord research, the Rehabilitation Engineering Centers, and project research in medical, social and vocational rehabilitation. The Institute has a broadened authority and mission, however, to deal with technology development and distribution, rehabilitation research related to the needs of the handicapped child and the aged, and to support model centers to serve pre-school handicapped children and model employment and training centers for severely disabled adults. These new missions are indicative of the thrust of the 1978 Rehabilitation Amendments; that rehabilitation is a process applicable to all severely disabled people regardless of age and vocational potential. In this respect, research can do much to improve services and care

which has as its goal greater independence of function for disabled aged or children regardless of their vocational potential.

The Institute is functioning in its first year in FY 1980. It has a Director, recently confirmed by the Senate -- Dr. Margaret Giannini, a noted pediatrician who has devoted her career to research and training related to mental retardation. The President has officially expressed his intent to nominate as Chairman of the National Council of the Handicapped, which oversees the operations of the Institute, Dr. Howard Rusk, world renowned specialist in rehabilitation medicine. With this team, we believe that the Institute has the capacity to make major advances in research for the handicapped.

The research program of the Institute is an extramural grant program which emphasizes support to rehabilitation Research & Training Centers and Engineering Centers. There are 22 Rehabilitation Research & Training Centers, and 18 Engineering Centers. These Centers account for about $23 million of the current $31.5 million program. In addition to centers, however, the Institute program includes project support and research projects in spinal cord injury, end stage renal disease, and brain trauma. New projects are to be started in the areas of rehabilitation of disabled children, including pre-school children, aged disabled, technology development including the use of telecommunications, improved services to those in rural areas, and model employment training and placement programs. Our estimate of the funds needed to support these many new initiatives and to restore capacity in the Research Centers which have had no cost-of-living increase for 3 years is $45 million.

I would like to direct myself now to the need for staff for this Institute.

The National Institute of Handicapped Research ("NIHR") has 32 positions now. The research program in rehabilitation, the predecessor to this program, had about 50 positions in the early 1970s. The positions for analogous Institutes -- the

National Institute on Aging ($75 million), and the National Institute of Education ($83 million) -- have proportionately far more personnel even correcting for the fact that NIA has intramural activity which is far in excess of the intramural functions of NIHR (disability data center, dissemination center). NIA has 303 people for a $75 million budget; 90 are for the operation of the grants program and direct activity. It has 3 times as many people for analogous functions despite a budget that for FY 1981 is only twice as large as NIHR. The NIE has about 330 personnel, or 10 times that of NIHR for similar activities as NIHR and with a budget only 3 times as large. While it supports many more projects, the projects are smaller and even accommodating for numbers of projects, NIHR would need about 65 people to be comparable to NIE.

The functions of NIHR are also expanded well beyond the functions of prior years when 50 people were needed. The agency is to support an interagency coordinating committee an effort mandated by statute, develop and update a rehabilitation research plan, operate a data center, and support research activity in 11 new areas specified by statute including major new areas such as 2 new model center programs, research related to handicapped children, research with respect to the rehabilitation of the aged who are disabled, and research related to the improved delivery of services in rural areas.

To support this substantially expanded role and to be similar in staffing capacity to NIA and NIE, analogous Institutes, a total of 50 positions, or 18 more than the President's budget provides for, is requested.

These positions would include individuals recruited from the scientific community with expertise in the various areas of research activity: medicine, engineering and health economics for example.

Rehabilitation Training

Support for professional training has been falling off

rapidly in the past five years. The dollar support for training from FY 1976 to FY 1980 has remained essentially the same or dropped for the disciplines of medicine, physical therapy, speech pathology, occupational therapy, nursing and psychology. Obviously, however, the cost of operating programs has increased during that period by about 50%. The number of grants funded in these health areas have dropped and the purchasing power of the grant is much less.

This year, $28.5 million is available for training -- $2 million less than FY 1979. In FY 1981, the President is requesting a reduction of $3 million more. This gradual erosion of the funding base for the program will eventually result in reduced numbers of individuals trained. Yet, there is no evidence that surpluses of people exist. In 1978 the White House paper on national health policy for the handicapped indicated that $25 million was necessary in the long-term training area to prevent a scarcity of health professionals in the rehabilitation field. Yet, only $21 million was expended in FY 1979 and less is expected to be expended in FY 1980 of the total $25 M requested.

A 1976 study funded by the Rehabilitation Services Administration on rehabilitation manpower surveyed employers and schools to determine the nature of the labor market in rehabilitation. The study showed that for most disciplines the number of students being produced was about that needed by employers. In general, there were still job vacancy rates of about 5% in rehabilitation facilities. In a few disciplines, the vacancy rates are about 10%: medicine and prosthetics and orthotics. The training programs are generally very dependent on Federal aid. Over 75% of training programs receive Federal support and that support makes up anywhere from 12% to 66% of the program budget of the institution.

As the White House position paper on "National Health Care Policies for the Handicapped" indicates, continued Federal training support is essential for these programs to continue to produce the current number of professionals. We are of the

strong opinion that further cuts in rehabilitation training programs will jeopardize the quality of rehabilitation services in the near future.

We would urge the Committee also to at least restore the $10 million cut in the program of assisting schools of allied health proposed by the President in his budget.

Independent Living

Title VII of the Rehabilitation Act authorizes formula grants to state agencies to support comprehensive services to severely disabled individuals who need services simply to function independently with respect to eating, dressing, mobilizing and activities of daily living. These are individuals who may never work due to the disability or age or who may work eventually if their independent function is restored. A recent survey conducted by the National Center for Health Statistics indicates that about 7 million Americans are unable to carry on major life activities without assistance. The cost savings in providing services such as health maintenance care, attendant care or homemaker services, arranging for transportation which enables a person to function in an independent setting can be dramatic. The total costs of hospitalization and long-term maintenance for spinal cord injured are conservatively $250,000. The health and social services supported under this program can enable those costs to be reduced.

At present, only the independent living centers program is supported under Part B of Title VII, not the state formula program. Part B is funded at $15 million in FY 1980. We believe that the state program must be started even if only with enough to give each state $500,000. That would provide services to at least 100 people in each state. We therefore ask for a total $45 million for Parts A and B.

Dr. HONET. I am Joseph Honet. I am president of the American Academy of Physical Medicine and Rehabilitation. I am a physician specializing in that field of medicine.

I happen to teach at Wayne State University in Detroit, where I am a professor, but my major function is as chairman of the department of rehabilitation medicine at Mt. Sinai Hospital of Detroit. There, I am the medical director of the physical medicine and rehabilitation residency training, as well as being in the private practice of medicine.

I come before you as a physician in the Department of Education because our training grants have been switched to that particular Department. Basically we are still a medical speciality and we are involved in two major kinds of problems. One is the problem of pain and the problem of motion. We deal with diseases such as chronic back pain and nerve damage.

These types of diseases make routine functions such as walking or self-care very difficult. The other major category of treatment we are involved with is the treatment of chronic disease—stroke, spinal cord injury, arthritis, amputations and many others that are part of it.

There are many other kinds of problems we deal with. Most of the patients we deal with could be characterized as handicapped patients. As a representative of this branch of medicine, I am interested in two major Government programs.

RSA TRAINING

One is the rehabilitation support by the Rehabilitation Services Administration, and the other is rehabilitation research as a function of the National Institute of Handicapped Research, which you have heard about before.

Basically, as far as research training from the point of view of a medical speciality, there are really not enough of us to practice this particular speciality. We have grown over the years and have increased our numbers in the neighborhood, from around 999, or from a total of five-tenths of 1 physician for 100,000 population in 1963, to 1,315 physicians in 1976, or a total of eight-tenths of 1 physician for 100,000 individuals.

As far as training in our particular speciality is concerned, the number of first-year residents in 1960 was 55. This increased to 161 residents in 1976. The filled residencies in our particular speciality went from 53 to 67 percent in those same years.

We are making strides increasing the number of specialists in our field of physical medicine and rehabilitation, and this help to a large extent has been from the Government research and training grants, the subject I am referring to today.

We have, however, not even scratched the surface in terms of our need for physicians. While there are approximately 1,800 physicians practicing this speciality today throughout the United States, manpower studies dictate the appropriate number of practicing physiatrists—physicians who practice physical medicine and rehabilitation—should be somewhere between 3,000 and 6,000 physicians.

The Department of Health, Education, and Welfare recommended there should be 1 physiatrist for every 77,000 individuals. The GAO report with the input of the American Academy of Physical Medicine and Rehabilitation talks about 1 per 50,000. At the present time, at most we have 1 per 125,000 population. Thus, the requirement indicates a need for at least 1,500 more physicians to practice in the help of the handicapped.

One major method that we think to train more physicians in this particular speciality is to try to introduce the speciality into more medical schools in the United States. Currently, only half the medical schools are teaching the subject and are supported in terms of granting.

But what we basically are asking for, detailed in the written testimony we have placed into your record, is $30.5 million—with $5 million earmarked for medical training. We really need the training grants and the grants to the medical schools, and perhaps even to community hospitals, to obtain the increase in the number of physicians to the needed level.

The National Institute of Handicapped Research has been detailed in other testimony, so I will do no more than add the fact we also support the level of $45 million.

I would say the bottom line I would like to leave with this committee is that there are really not enough physicians practicing the speciality of physical medicine and rehabilitation to meet the needs in the United States. There is also very much to learn and demonstrate regarding the care of handicapped individuals of all ages. We have had considerable help from the Federal Government, and certainly are very appreciative and thankful, but need a continuation of this help in order to accomplish what we must.

Our needs have not lessened; only increased.

Thank you for the opportunity of presenting this information. I will be happy to answer any other questions you might have.

Senator WEICKER. Thank you very much, Doctor.

[The statement follows:]

STATEMENT OF JOSEPH HONET

My name is Joseph Honet, and I am President of the American Academy of Physical Medicine & Rehabilitation, a professor of medicine at Wayne State University, and Chairman of the Department of Rehabilitation Medicine at Sinai Hospital of Detroit. The American Academy of Physical Medicine & Rehabilitation is a medical specialty society representing about 1300 physicians who are specialists in physical medicine and rehabilitation. It should be noted that while I represent a medical society and am here to discuss health care programs, the budget items being discussed, rehabilitation, are for the first time in a department other than Health. All rehabilitation programs were transferred to the new Department of Education in the legislation creating that Department.

My testimony is directed primarily at two points: rehabilitation training and rehabilitation research.

Rehabilitation Training

This program is one in which the Rehabilitation Services Administration makes grants to universities and state rehabilitation agencies to support long- and short-term training of professionals in the rehabilitation field including physicians, rehabilitation counselors, physical therapists, speech pathologists, occupational therapists, etc. The funding for this program was $30.5 million in both FY 1978 and FY 1979, is $28.5 million in FY 1980, and the President's budget for FY 1981 is only $25.5 million. In FY 1972 the program was $28 million. About 2/3 of the funding supports long-term degree granting activity in universities while 1/3 supports in-service training and continuing education in and by state rehabilitation agencies. Support is in the form of traineeships to students and teaching grants to universities. In the case of medicine, to which I shall speak, there is no other support for the training of professionals for this important field.

Medicine has received about $4 million for training from FY 1978 through FY 1980 and would receive a cut below that in the President's budget for FY 1981. In the early 1970s, medicine received about $5 million from this program. 56 grants

were made in FY 1980. However, this represents fewer than 1/2 of the medical schools in the country.

The shortage of physicians in the field of rehabilitation medicine is well documented. A 1972 study financed by the Commission on Rehabilitation Medicine and subsequently relied upon by the GAO, and the Bureau of Health Manpower and corroborated by the Rehabilitation Services Administration, indicated an average need for 1980 of about 4000 physicians in physical medicine and rehabilitation. Using assumptions requiring a higher but reasonable level of care, 6000 physicians were estimated as necessary. The GAO Report on Physician Distribution by specialty, May 16, 1978, uses two physician to population ratios: 1 to 50,000 recommended by the American Academy of Physical Medicine & Rehabilitation and 1 to 77,000 recommended by HEW. These ratios result in need for between 3000 and 4500 physicians in this specialty. This shortage problem was emphasized by this Subcommittee in its report on the FY 1978 and FY 1979 appropriation bill.

Most recently the Commission on Rehabilitation Medicine estimated a long range need for 1990 of 5000 specialists in rehabilitation medicine.

The GAO Report and a 1976 study by the Center for Health Services Research and Development indicate a supply of about 1700 specialists in rehabilitation medicine. Of those, only about two-thirds are board-certified specialists in physical medicine and rehabilitation. The Commission on Rehabilitation Medicine estimates a supply of 2300 for 1990.

Further information on the shortage of specialists in this field can be derived from the data of the national physician matching program for purposes of placing interns and residents. On the average, only 30% to 40% of the hospital staff positions being offered for residents or interns in rehabilitation medicine in the past 5 years have been filled. Additional traineeships for residency training in physical medicine and additional support for teaching rehabilitation medicine to undergraduates would assist in filling these positions for which there are not enough applicants now.

I would also like to direct your attention to a policy paper published by the White House on "National Health Care Policies for the Handicapped" which focuses on the shortage of personnel in the rehabilitation field and I would like to have Chapter 5 inserted in the record. That paper makes the point that about 20 million people potentially need medical rehabilitation services. That paper recommends increased training funds for rehabilitation medicine. It indicates that "without this kind of educational assistance, physical medicine and rehabilitation, as a specialty, would be seriously jeopardized". It also states that current levels of support are not adequate to attract medical students into this field in increasing numbers.

We would recommend a training budget of at least $30.5 million, which represents the FY 1978 and FY 1979 levels. Of this amount, rehabilitation medicine should receive $5 million.

Finally, a 1976 study by the Rehabilitation Services Administration in which it surveyed provider agencies such as rehabilitation facilities and hospitals, found a shortage of specialists in rehabilitation medicine to fill openings in facilities.

The National Institute for Handicapped Research

The Rehabilitation Act Amendments of 1978 created a National Institute of Research for the Handicapped ("NIHR"). That Institute is to be located in the Department of Education and its budget appears as part of the budget dealing with Special Education and Rehabilitation Services and Research. The mission of the NIHR is to foster rehabilitation research. The NIHR has succeeded to the rehabilitation research program formerly administered by the Rehabilitation Services Administration ("RSA"). The research program of the NIHR is conducted through grants to Rehabilitation Research & Training Centers and rehabilitation Engineering Centers as well as grants and contracts for individual research projects. In addition, the NIHR has a number of intramural functions such as the development of a Government-wide rehabilitation research plan, the staffing of an Interagency Coordinating Committee for rehabilitation research, the development of a program to gather, coordinate and analyze disability data from the various Federal and state agencies which collect

it and provide a sound data base on the needs of the handicapped and the provision of public education programs to educate the general public and the handicapped with respect to new research findings. The current level in fiscal year 1980 is $31.5 million for the Institute. In fiscal year 1979 and 1978 the rehabilitation research program operated by the Rehabilitation Services Administration had a budget level of $31.5 million also. The President's budget for the Institute in fiscal year 1981 is $37 million.

While the Institute was established in law in November of 1978, a Director for the Institute was not nominated until the beginning of this year and has only recently been confirmed by the Senate. However, the Institute is now in full operation with a Director and with staff transferred to it from the Rehabilitation Services Administration and with operating responsibility now transferred to it from the RSA.

The rehabilitation research program, while funded inadequately in the past, has been a very productive program. The funding level for the program was actually $32 million in fiscal years 1969 and 1970 which is higher than the actual dollar level now. If fiscal 1970 dollars were held constant, the program would have to be funded at close to $55 million just to meet the costs of inflation in the past 10 years with an assumed inflation rate of 7.5%. During those years, rehabilitation research has produced new methods of service delivery for the spinal cord injured which have resulted in the establishment of some 11 regional spinal cord injury systems throughout the country. The care delivered by those systems has been estimated to save about $23,000 in reduced hospitalization and as much as $150,000 in income support over the life of a patient. The model for this kind of service system was developed in the Rehabilitation Research & Training Centers. Likewise, much of the innovative development in the new field of independent living has been produced by research funded by the rehabilitation research program. Research projects have been supported at the Berkeley Center for Independent Living and at the Rehabilitation Research & Training Centers at the Texas Institute of Rehabilitation and

Research and Tufts-New England Medical Center. Major progress has been made in cardiac rehabilitation through research supported at the University of Colorado and the University of Minnesota. Likewise, stroke rehabilitation research regarding methods of rehabilitating severely disabled stroke victims has produced very high rates of return to work for those with that disability.

However, research in this field needs an infusion of additional funds in order to be fully productive and to meet the many new requirements placed upon it by the Rehabilitation Act Amendments of 1978. We are now into the third program year in a row in which there has been no increase in rehabilitation research funding. As mentioned earlier, the program was at a higher level in fiscal year 1970 than it is now. While the Administration's proposed budget of $37 million represents an increase of $5.5 million or about 17%, it will not adequately finance efforts to restore the capacity of existing research centers which have had 3 consecutive years with no cost-of-living increases nor will it finance adequate support for the major new research initiatives in the Rehabilitation Act Amendments of 1978.

The Rehabilitation Act Amendments of 1978 establish many new programs for rehabilitation research. The Amendments establish new programs regarding rehabilitation of the aged and of children. Under the prior rehabilitation research program, the focus of research was on working age adults only. There are major needs with regard to the rehabilitation of the aged disabled who are often suffering from two of the most prevalent disabilities: stroke and arthritis. Research is needed in order to deal with improved methods of physical restoration for those with arthritis and stroke and other disabilities common to the elderly. Much research with regard to the delivery of services is necessary to develop effective, comprehensive care programs for the disabled elderly to enable them to live in their own community. These projects should be and would be jointly funded with the National Institute of Aging and the Administration on Aging. With respect to the rehabilitation of children, much research is needed regarding the medical and developmental

rehabilitation of children with severe musculo-skeletal and neurological disabilities. While P.L. 94-142 has placed a major emphasis upon the delivery of comprehensive services to the handicapped of school age, there are no models or good examples of well-integrated medical and educational programs for severely disabled children. The Rehabilitation Act Amendments of 1978 also stress research with regard to improving the delivery of services in rural areas and the development and distribution of technology to improve the functioning of disabled individuals. In particular, the use of telecommunications systems is a new project area for research. The Rehabilitation Act Amendments of 1978 also create programs for the support of model research & demonstration centers in the areas of the rehabilitation of pre-school aged handicapped children and the employment training and placement of severely disabled adults.

The $5.5 million increase proposed by the Administration is designed to provide approximately $1.5 million of additional support to Research & Training Centers to deal with the problem of the rehabilitation of the aged disabled. However, no money is included for minimum cost-of-living protection for the Rehabilitation Research & Training Centers and Engineering Centers of which there are 50. Also, there is no new money to support new centers and there is a geographic maldistribution with regard to centers as the Senate Committee Report of last year indicated. There are no Rehabilitation Research & Training Centers at all in Region VII and there is no medical Rehabilitation Research & Training Center in Region IX which includes California.

With regard to Engineering Centers, there is an addition of $1.5 million for fiscal 1981 to focus upon the development and distribution of devices which have been proven in the laboratory. Devices falling into this category include telecommunications devices, devices designed to increase the vision of the low-vision blind, devices intended to reduce the incidence of bed sores with regard to quadriplegics and paraplegics and improved orthotic devices for paraplegics.

The $5.5 million increase also includes $2.5 million for research projects, $1 million of which will deal with the area of disseminating research results and the other $1.5 million will support projects regarding research with respect to the delivery of rehabilitation services in rural areas and model centers for employment training and placement.

However, an additional $1 million is needed simply to fully support the center for employment training and placement. Beyond that, there is no support for the program dealing with the rehabilitation of children nor is there support for the model research and demonstration center regarding comprehensive services to handicapped pre-school children.

In order to support appropriate expansion of programs to deal with the rehabilitation of children, employment placement and training, and to create 2 new Research & Training Centers as well as provide a cost-of-living increase for the 50 centers, we propose a $45 million. This budget also includes $500,000 to cover 18 needed positions for the Institute.

REHABILITATION ACT

Mr. HARLES. I represent Goodwill Industries of America. We are 1 of 26 organizations who collaborated on some funding levels that we think would be appropriate for programs under the Rehabilitation Act. We fully support those figures in our testimony.

We think under the Rehabilitation Act in general are probably some of the most cost-effective programs within the Federal Government right now. I would give you one quick example of this type of cost effectiveness.

PROJECTS WITH INDUSTRY PROGRAM

It is in the projects with industry program which you might be familiar with in the State of Connecticut. The Easter seal program in New Haven now has a new statewide program on projects there. The program last year had a budget of $4.5 million and had 50 projects nationwide, serving 6,500 handicapped clients—5,000 of these people were placed into competitive, nonsubsidized employment.

Goodwill Industries, in its grants, had projects in 11 cities serving 900 clients, placing 680 of them. The level of public support before the program was $52,000 per month for those who were getting public assistance—2 months after they went through the project, that level had been reduced to $11,000 per month.

In a project in the Midwest in Minneapolis, they again had a 75-percent placement rate. The total income of the people before they went to the program was $242—after, it was $460. The wages that the people earned were $91 per month before and $366 after.

The total public support they received was $151 per month before, $94 after. The added taxable income that year in that one project was $726,000 and the savings in public support was in excess of $15,000. This is just an example of one of many programs within the Rehabilitation Act that we think not only has a positive benefit in a general human services sense, but can also show a very positive economic benefit.

We just hope the committee will look very closely at this and other programs in this area.

Thank you.

[The statement follows:]

STATEMENT OF CHARLES HARLES

Mr. Chairman, thank you for this opportunity to come before you and the committee this morning.

Goodwill Industries does not come before this committee every year to talk about funding for rehabilitation and other human service programs. Rather we have tried to limit our testimony to those occasions when we feel it is imperative for us to speak out on these issues. This is such an occasion.

Goodwill Industries of America represents 168 locally autonomous Goodwill Industries in the United States. As one of the largest and most comprehensive sources of private, nonprofit rehabilitation services in the country, we are vitally interested in the appropriations for programs under the Rehabilitation Act of 1973 and more especially the programs added with the 1978 amendments to that Act.

Goodwill Industries of America has joined with twenty five other national organizations that represent or provide services to handicapped persons in supporting specific funding levels for FY1981. We wholeheartedly endorse the figures of this coalition.

Although we realize that this will be a difficult year for Congress to help stabalize the economy, it is imperative that this committee and Congress as a whole make sure that programs that work and have a positive benefit are not needlessly hurt by the fervor to cut and balance the budget.

We sincerely think that all of the programming under the Rehabilitation Services Administration fall into the category of beneficial and cost efficient. Over the years hundreds of thousands of physically and mentally handicapped persons have been rehabilitated and now live productive lives because of the programs. Over the past few years there have been two factors in particular which emphasize the importance of this program. One was a mandate to serve the more severely disabled and the other was a massive deinstitutionalization of tens of thousands of mentally handicapped persons. Now the rehabilitation program is dealing with clients who need more sophisticated and longer term services. In 1978 Congress took another very significant step in adding independent living services to the Rehabilitation Act. Provision of these services. This program will further speed up the

deinstitutionalization program and offer important supportive services to those already out in the community.

The sums being suggested by Goodwill Industries and the other twenty five organizations are reasonable. In many instances they fall far short of the authorization levels or are far below ideal levels.

A list of the suggested funding levels is attached and is part of our testimony. There are a few areas I would like to highlight. First is the backbone of the rehabilitation program; the basic state grants in Section 100. For the first time last year Congress failed to appropriate the full entitlement. This was done even though the states have been able to show their ability to match the funds if they were available. If adequate services are going to be provided to the handicapped citizens of this country then it is imperative that the fullest funding possible, $945 million, be appropriated.

The Administration has eliminated Innovation and Expansion grants (Sec. 100(b)(2) from its budget recommendations. This program has traditionally funded new and untried ideas in providing rehabilitation services. The Administration has said that the states could now administer this program. With a total of only $854 million being recommended for both basic state grants and Innovation and Expansion grants, when the states had the very reasonable expectation of $945 million just for the basic program, they will hardly be able to continue funding innovative or expansion grants. We would recommend a continuation of this program at the FY1980 level, $12 million.

As mentioned above independent living services was a significant addition to the Rehabilitation Act. It is obvious that the authors of this legislation envisioned a "full service" program. Authorization levels are $80 million for FY1979, $150 million for FY1980 and $200 million for FY1981. Actual appropriations have amounted to less than 10% of authorizations and only one of three parts of the program is being implemented, the centers for independent living. A coalition of thirteen organizations representing severely handicapped persons and service providers, of which Goodwill Industries is one, is suggesting a total appropriation of $45 million for independent living. $18 million, the amount requested by the Administration, would be earmarked for Section B, centers for independent living. The added $27 million would be a minimal amount to start up parts A and C, comprehensive independent living services and independent living services for older

blind individuals. Since each state would be allotted a minimum of $200,000 the sum of $25 million would be needed to treat the larger states equitably.

If the rehabilitation field is to go forward and progress there are three areas that must be adequately funded. They are training, research and facility improvement. Training is essential to provide an adequate number of trained professionals for the future. Without them the new program thrusts authored by Congress will have little chance for success. Rehabilitation research must be an ongoing function to properly utilize new technology for handicapped persons.

Rehabilitation facilities are generally considered to be an indispensible component of the national effort to prepare disabled persons for employment. Comprehensive rehabilitation centers, physical medicine and rehabilitation departments of hospitals, sheltered workshops, evaluation centers, industries for the blind, facilities for the deaf, centers for independent living, work activities centers halfway houses and others, are all included in the wide variety of rehabilitation facilities. There are over 3,000 such facilities in the U.S. Approximately 30% of all case service funds spent by state VR agencies are spent in rehabilitation facilities. The facility improvement grant (FIG) program under Section 302 is designed to provide seed money for facilities to improve and expand vocational training services, industrial programs, evaluation, work adjustment and sheltered work. The $10 million suggested by the coalition and Goodwill would restore this important program to the budget near its previous funding level.

I want to use the balance of our testimony to tell you about Projects With Industry (PWI). We and others have talked to you in past years about PWI. It continues to grow and prosper. The term "Projects With Industry" first appeared in the 1968 Amendments to the Vocational Rehabilitation Act. The purpose of the Amendments was to provide a new resource for helping the disabled to be trained on-the-job and employed in the competitive labor market. The new Amendments offered to employers the opportunity of hiring, training, and providing other necessary services to disabled individuals, and to be paid for identified costs under a contractual arrangement with the Rehabilitation Services Administration of the United States Department of Health, Education, and Welfare.

However, for one reason or another, and with a few notable exceptions, neither the business nor the rehabilitation communities availed themselves

of the new rehabilitative options available to them under the Rehabilitation Act of 1968.

It was not until the Rehabilitation Act of 1973 became law that Projects With Industry became an integral part of the program promulgated by the Department of Health, Education and Welfare. Under the impetus supplied by Mr. Thomas Fleming of the Rehabilitation Services Administration (DHEW), Projects With Industry has become one of the nation's newest and potentially dynamic program modalities. Placement rates for handicapped persons in this program have consistently exceeded 75% and the cost of the program has generally been less than $1,000 per person.

It should be emphasized that Projects with Industry has been and will continue to be a cooperative and complementary program to the state vocational rehabilitation programs as well as other manpower training programs. PWI is often dependent on other program resources, usually from state and local agencies, to do the total job. It is this cooperative relationship between rehabilitation programs, the business segment and the community at large which makes PWI unique.

Projects With Industry is a total system of rehabilitation which is aimed at preparing persons with disabilities for specific skill needs identified by the business and industrial community. This total system selects clients who will, with adequate training, be employable in pre-selected jobs in the business/industrial complex. Projects With Industry is a total system of rehabilitation with one significant difference, i.e., the training is done in the light of identified job needs. The job needs are identified before the fact.

Each Projects With Industry is directed, and the training program implemented, by an identified group of business, industrial and labor people from the local community. The body recruited and assembled is to be called an Advisory Council. It is with this Council, when it functions as it should, that the life and death of the Project resides. The Council is responsible for three essential interrelated program components: (1) identification of community employment needs; (2) the adoption and implementation of a training curriculum that will meet those needs; and (3) assisting the Projects Director in the identification of placement slots for trained clients. If the Advisory Council is not functioning as above indicated, the Project will have lost its uniqueness and its reason for being.

Another unique attribute of PWI is that approach used to achieve the basic goals of PWI may vary from one PWI project to another. In one community, the PWI may work with a particular type of industry where in another, it may concentrate on a particular type of employment.

Because PWI is administered nationally from the Rehabilitation Services Administration in Washington, several national level programs have been undertaken. These include projects with the National Restaurant Association, Goodwill Industries of America, Electronics Industry Foundation, AFL-CIO Human Resources Development Institute, and the National Association of Rehabilitation Facilities. Thus, the trade associations can and have developed thousands of jobs in the food service and electronics industries, Goodwill and NARF have identified facilities around the country who have the capacity and staff to establish PWI programs and the AFL-CIO can utilize union locals and training programs to help place handicapped persons all over the country.

Many large and well known corporations have been involved in PWI. IBM has been involved in PWI since its inception; others include Control Data, McDonald's, Sears Roebuck, Kraft, banks, insurance companies, as well as thousands of local businesses.

Industry benefits from PWI in that they obtain well-trained, pre-screened employees saving the employer some training costs. The employer also benefits from the "follow-up" services provided by the PWI program and the state vocational rehabilitation agency, especially during the probationary or transitional period. If necessary, the trainee can be returned to the rehabilitation facility for additional services if they were not considered ready for the job. The industry will also be meeting its affirmative action requirements to hire and promote handicapped persons under Section 503 of the Rehabilitation Act of similar state and local statutes.

Handicapped persons benefit from PWI in that they are trained for and placed into currently available jobs. PWI provides them with an expanded job market, including small local businesses as well as large corporations. These jobs provide handicapped persons with self-sufficiency and a better standard of living.

The bottom line for PWI has been its success. Since its inception, over 25,000 handicapped persons have been placed into unsubsidized jobs in

competitive employment. Last year, 1979, the PWI program operated on a budget of $4.5 million. Of the 6,500 clients served, 5,000 were placed into competitive jobs. There were 50 PWI projects last year, many of which had additional satellite locations. These PWI sites worked with more than 2,500 businesses.

Although a complete statistical analysis does not exist for all the clients for the PWI program, the most recent year's statistics for the Goodwill Industries of America program under an RSA grant might serve to illustrate the success and effectiveness of the PWI program. The Goodwill program was funded at $428,000 and Goodwill Industries of America administered the program through its national office in Washington, D.C. The funding was provided to eleven local Goodwill Industries. They were located in Baltimore, Tacoma, San Jose, South Bend, Colorado Springs, Kalamazoo, Winston-Salem, Miami, Columbus (Ohio), Lubbock (Texas), and Fort Worth.

A total of 906 clients were served in these facilities. 39% were minorities and they were divided equally between the sexes. 87% had a high school education or less. A wide variety of disabilities were served. 21% had an orthopedic or other functional disorder, 15% were mentally retarded and 12% were emotionally disturbed. 89% of the clients were referred from state vocational rehabilitation agencies.

Before coming into the PWI program, 37% of the handicapped persons were unemployed. More than half of those who were employed were earning less than the federal minimum wage. 28% of those entering the program had never been employed and 25% had been unemployed more than two years. After the PWI program, 70% were earning more than the federal minimum wage, 25% were not placed or dropped out, and the remaining 5% were placed into competitive employment. Of the 25% who did not complete the program, 4% were not considered ready for placement. 6% failed to attend the complete program, 2% had no transportation, 3% had family problems, and 5% dropped out due to illness.

A record was kept for all those who were on some form of public assistance when they entered the PWI program. Although not all clients were on public assistance, over 300 were, in the amount of $52,416 per month. At the end of the program year, that number had been reduced to 122 persons at $11,609 per month. Even with this substantial reduction, much of the remaining public assistance can be explained by the fact that many forms of public

assistance are not dependent on employment and others are phased out over several months.

Statistics from the Multi-Resource Center in Minneapolis are equally impressive. In 1979 220 clients were served with 166 placed into competitive employment. Information was kept on these clients both before and after they were in the PWI program. The total income per person from all sources (wages, public support, pensions, etc.) was $242.00 per month. Two months after placement the total income was up to $460.00 per month, a 90% increase. Wages were even more dramatic. Before PWI the average monthly wage was $91.00. Two months after placement it was $366.00, a 400% increase.

There was a significant decrease in public assistance. Before PWI it averaged $151.00 per month and only $94.00 after PWI. Some of the remaining public support can be explained by the fact that some public assistance is not related to employment and the follow up for these figures was only two months after placement. Some forms of assistance are phased out over a period of time and may have still been in effect. The totals for this program in Minneapolis were also impressive. The taxable income produced by these clients was $726,000. The savings in public support was over $150,000. These savings easily exceeded the cost of the program under the RSA - PWI grant.

There remains a great need for the PWI program on a national level. Even though the program has been in existence for over 10 years, there are still hundreds of facilities and organizations eager to participate in the program. There are tens of thousands of handicapped persons who could benefit from this unique placement program. It has been estimated that more than 500 applications were turned away or discouraged by RSA last year without any announcement in the Federal Register as to funding for the program.

PWI has been substantially changed and expanded by the 1978 Amendments to the Rehabilitation Act of 1973, Section 621 of Title VI. PWI can now provide supportive services, the development and modification of jobs, the distribution of special aids, appliances, and adaptive equipment and the modification of any facilities or equipment of the employer which are to be used primarily by handicapped employees. These items are in addition to the training and placement services that have been the foundation of PWI.

Because of the proven success of PWI, an identified need for the continuation and expansion of the program and an expansion in the scope of the program by P. L. 95-602, a group of twenty six national organizations representing handicapped persons and providers of services to handicapped persons is recommending to the appropriate Congressional committees that the sum of $20 million be appropriated for FY1981 for Projects With Industry (Section 621).

I thank you for this opportunity to come before the committee and I will be glad to answer any questions or provide you or your staff with additional information.

GC0320

APPROPRIATION AMOUNTS TO BE SUPPORTED BY COALITION OF GROUPS FOR VARIOUS PROGRAMS AUTHORIZED BY REHABILITATION ACT (P.L. 95-602) FOR FISCAL YEAR 1981 (in millions)

BASIC VOCATIONAL REHABILITATION GRANTS	
Section 100 (b)(1)	$945
Section 110 (b)(2)	3.900.9
INNOVATION & EXPANSION	
Section 100(b)(2)	12.
COMPREHENSIVE SERVICES FOR INDEPENDENT LIVING	
Title VII	45.
NATIONAL INSTITUTE OF HANDICAPPED RESEARCH	
Section 201(a)(1)	45.
TRAINING	
Section 304	35.
FACILITIES IMPROVEMENT GRANTS	
Section 302(a)	10.
"SERVICE PROJECTS"	
So-Called in Administration's Budget	
Technical Assistance	
Section 12	.25
Client Assistance Projects	
Section 112	3.5
Interpreter Training Services	
Section 304(d)	1.
Comprehensive Rehabilitation Centers	
Section 305	5.
Projects for Severely Disabled	
Section 311	7.
Recreation Facilities Accessibility	
Section 311(a)(3)	1.5
Spinal Cord Special Projects	
Section 311(b)	6.
Migratory Workers	
Section 312	1.53
Helen Keller Deaf-Blind Center	
Section 313	3.153
Reader Services for the Blind	
Section 314	2.
Interpreter Services for the Deaf	
Section 315	2.5
Recreation Programs	
Section 316	2.

Projects with Industry Section 621	20.
Business Opportunities Section 622	2.

NATIONAL COUNCIL ON THE HANDICAPPED

Section 400	.256

APPROPRIATION AMOUNTS TO BE SUPPORTED BY COALITION OF GROUPS FOR VARIOUS PROGRAMS AUTHORIZED BY REHABILITATION ACT (P.L. 95-602) FOR FISCAL YEAR 1981

The following group of organizations concerned with programs authorized by Public Law 95-602, the Rehabilitation, Comprehensive Services, and Developmental Disabilities Amendments of 1978, have met, dicussed, and agreed upon the attached listing of appropriation amounts for the various authorities for Fiscal Year 1981.

All of the organizations listed below have agreed to these figures and to work in concert in an attempt to see that these amounts are appropriated for Fiscal Year 1981.

American Academy of Physical Medicine and Rehabilitation
American Association of Workers for the Blind
American Association on Mental Deficiency
American Coalition of Citizens with Disabilities
American Congress of Rehabilitation Medicine
American Council of the Blind
American Foundation for the Blind
Council for Exceptional Children
Council of State Administrators of Vocational Rehabilitation
Epilepsy Foundation of America
Goodwill Industries of America
Human Resources Development Institute, AFL-CIO
International Coalition of American Rehabilitation Efforts
National Association for Retarded Citizens
National Association of the Deaf
National Association of Private Residential Facilities for the Mentally Retarded
National Association of Rehabilitation Facilities
National Council of Rehabilitation Educators
National Easter Seal Society
National Multiple Sclerosis Society
National Rehabilitation Association
National Society for Autistic Children
Paralyzed Veterans of America
State Mental Retardation Program Directors Association
United Cerebral Palsy Associations

Senator WEICKER. Thank you very much. I thank each of you gentlemen for bringing your points of view to the committee. We will certainly listen to them.

In relation to the announced time limit, you didn't do very well at all; you ran about 9 minutes over. In relation to what six U.S. Senators would have done, you did fantastic. [Laughter.]

STATEMENTS OF:

JOHN CORROZI, UNIVERSITY OF ALABAMA REGIONAL OFFICE

P. J. McDONOUGH, AMERICAN PERSONNEL AND GUIDANCE ASSOCIATION

JAMES DORLAND, NATIONAL ASSOCIATION FOR PUBLIC CONTINUING AND ADULT EDUCATION

JAMES R. KEE, NATIONAL COUNCIL OF STATE EDUCATION AGENCY COMMUNITY EDUCATORS

SANDRA TIMMERMAN, NATIONAL RETIRED TEACHERS ASSOCIATION AND AMERICAN ASSOCIATION OF RETIRED PERSONS

AMERICAN PERSONNEL AND GUIDANCE ASSOCIATION

Senator WEICKER. On the matter of higher and continuing education we have Dr. John F. Corrozi, P. J. McDonough, James Dorland, Robert Schleiger, James Kee, Sandra Timmerman.

All right, has everybody identified themselves for the reporter? Please proceed any way you wish.

Mr. McDONOUGH. I'm Patrick McDonough, associate executive vice president of the American Personnel and Guidance Association, director of public affairs.

Today, we would talk about our education needs. I don't have to tell you our concern about inflation and how we need the help and support of the Federal Government relative to our request. You're well aware of this, I know. I do want to point out in the interest of time that the requested funds the association is seeking are summarized in the first page of our testimony given here, and in addition, a brief background sheet for each program and the rationale for each of these programs, comprise the appendixes 1 to 5 at the end of our testimony. This should be helpful and may be a streamlined way of looking at some of our program terms.

GUIDANCE COUNSELING AND TESTING

I would like to highlight a couple of our program needs. Career Education Incentive Act: Besides the $20 million recommended by the Carter administration for State grants, we feel a tremendous need for the section 11 funding for postsecondary demonstration education grants. There is a tremendous increase in the number of adult men and women returning to community colleges and other postsecondary and adult education programs, as second careerists or displaced homemakers—all overcoming the effects of job obsolescence. The Bureau of Census reports that since 1976 there has been a significant increase in adults 35 years and older attending these institutions. There is now about 1,330,000 in 1978 as compared to 1,189,000 in 1976. This is a whopping 10 percent increase in the number of adults 35 and older in the postseconday institutions. This has been a neglected area in the area of career education.

We also are supportive of the President's recommendation on women's educational equity. I think it goes without saying that equal opportunity and equality for women in terms of support for their programs

has been a neglected resource. We would like to emphasize the $20 million request the Carter administration made for the women's equity program.

Information centers is another program. In the State of Connecticut, $50,000 was used for education information center programing. Some of the things they accomplished were to put together education and occupational information services. They have a directory of community referral service organizations established; all done with a minimum level of funding. We think that this program, which emphasizes information and referral services for all citizens living in rural and urban areas, should be funded again.

We also support vocational guidance and counseling. We have mentioned this and we will not gild the lily over what the vocational educators said this morning. Vocational guidance and counseling is a major part of the services. We recommend $162 million for that program.

Finally, I'd like to make a comment about the program that has been long in place with the Federal Government, and supports guidance and counseling. This is title IV–D, guidance and counseling and testing of Public Law 95–561. We seek supplemental funding of $5 million to augment the $18 million for fiscal 1978 that has been advanced for fiscal 1981, and $25 million advance funding for fiscal 1982. These are minimum amounts. Some of the documentation and support of guidance and counseling is identified in my testimony.

I would like to call to your attention three major studies: The urban high school reform initiatives that are pointed out in this study; the 11th annual Gallup poll of public attitudes toward public schools and the importance of guidance and counseling as stressed by parents; and then, a recent paper by Nancy Gibson, February 1980, which talks about some of the economic and social benefits of having established guidance and counseling programs throughout the schools and how they can benefit employability.

In the interest of time, Mr. Chairman, I thank you for your consideration in hearing our funding request for fiscal 1981 for guidance counseling and testing. This touches, or is part of the educational effort of almost every elementary and secondary vocational and postsecondary program. The association could have addressed needs in other programs, but no other advocates are doing this for these programs. Thank you for this opportunity. I would be happy to answer any questions you have.

Senator WEICKER. Thank you very much.

[The statement follows:]

STATEMENT OF PATRICK J. MCDONOUGH

My name is Patrick J. McDonough. I am the Associate Executive Vice President of the American Personnel and Guidance Association and its Director of Professional and Governmental Affairs. The American Personnel and Guidance Association is the national professional organization of over 41,000 guidance, counseling and student personnel workers. These individuals work primarily in elementary, secondary and higher education settings, but also in community and rehabilitation agencies, government and business and industry, performing counseling and guidance functions. The thirteen national divisions and 54 State Branches (District of Columbia, Puerto Rico, Latin American and Europen Branches included) of APGA span every sub-discipline and geographical area of the United States within the guidance and counseling field.

Mr. Chairman, perhaps like never before the education profession, and the discipline of guidance and counseling within the education profession, needs the assistance of the federal government in obtaining financial assistance to support ongoing educational programs and activities benefiting this nation's children, youth and adults. As you know, ordinary costs are skyrocketing, inflation is taking a tremendous toll on the purchasing power of the dollar in obtaining and maintaining routine educational services and basic staffing for our schools and other community agencies. The ordinary taxpayer and the local and state agencies that historically have borne the burden of most educational costs, are stretched to their limit. Relief is thus sought from the federal government in providing for a larger share of support for these educational programs.

Congress in its wisdom has recognized the need to support local and state educational funding through the enactment of timely and needed legislation to bring relief to these local and state agencies. Such public laws as P.L. 95-207, Career Education Incentive Act; P.L. 94-482, the Education Amendments of 1976; and P.L. 95-561, the Education Amendments of 1978, have brought new hope to education.

To bring reality and commitment to the hopes that have been raised by these landmark public laws, they need to be adequately funded for Fiscal 1981! Thus, the purpose of this testimony is to pinpoint those vitally needed guidance and counseling programs, contained within the above public laws, which need federal funding support.

The Career Education Incentive Act, P.L. 95-207 was passed by Congress by wide margins in both chambers and on December 13, 1977, President Carter signed this important piece of legislation into law.

A. Since its passage however the Career Education Incentive Act has never been funded at or near its authorized amount. In addition, there has been little or no attention paid to Section 11, the Postsecondary Educational Demonstration Projects provisions of this act.

The focus of this important act is broad -- to provide comprehensive career education activities which will assist State and Local agencies to make career education an

integral part of the elementary and secondary educational curriculum; and to incentivize higher education institutions, public agencies and non-profit organization to conduct postsecondary educational career demonstration projects. Both activities are important. The elementary and secondary dimension occurs through formula grants to state based on population as well as four statutorily determined activities -- (1) grants to outlying areas (2) evaluation of career education programs (3) a national career information effort and (4) model career education program grants. The postsecondary dimension of this Act is to be arranged by way of grant or contract.

Mr. Chairman, the transition from education to work has never been more important. P.L. 95-207 attempts to put in place the building blocks to bridge this transition. Career Education programs are developmental and needed at the elementary and secondary level but also at the postsecondary and continuing education levels to meet the tremendous need of adult women and men returning to community colleges and other postsecondary and adult education programs as second careerists or to overcome the effects of job obselescence. The Bureau of Census reports that since 1976 there has been a significant increase in adults, aged 35 years and over, attending postsecondary institutions of education -- 1,189,000 in 1976, 1,303,000 in 1978, a whopping 10% increase in adult enrollment. This is why the Association is supporting the Administration's recommendation of $20 million for the Section 4, Elementary and Secondary provisions of P.L. 95-207, but also are requesting $10 million for the Section 11, Postsecondary Educational Demonstration Projects for a total FY 1981 funding of $30 million for the Career Education Incentive Act. A rationale for these expectations and a projected expenditure by state for the elementary and secondary career education incentive grants is attached as Appendix 1.

B. The Association asks the Congress to appropriate $20 million for Title IX, Part C, Women's Educational Equity. The development of the educational potential of women has been a lost resource. According to recent National Institute of Education data, United States women, compared to women in other countries, do not occupy positions that involve higher mathematics. Lack of participation in Math begins at Junior high school and has a broad consequence of preventing women from obtaining mathematics-related jobs. The basic assumption of this study is that socio-cultural factors shape women's attitudes toward mathematics, which in turn affects women's performance in mathematics. Better and improved counseling, as well as changing attitudes on the part of teachers and parents as they relate to female students and educational excellence should be one of the outcomes of funding of Part C.

The Association supports the Carter Administration recommendations of $20 millions for WEEA. The increase in funding is especially needed in FY 1981 as in addition to the demonstration and dissemination projects at the national level, emphases this fiscal year will also be on assisting local educational agencies and institutions with Title IX compliance programs, see Appendix 2 for details on this program.

C. The American Personnel and Guidance Association recommends FY 1981 funding of $5 million for P.L. 94-482, Title I, Higher Education, Subpart 5, Section 418 A and B, Education Information Centers. Funds under this program are distributed on a state population formula relative to the appropriations for the year. In FY 1980, 41 states qualified only for the minimum amount of $50,000, based on a $3 million appropriation. Yet many valuable programs were initiated by this minimum allocation. In the State of Washington last year, for example, user needs for vocational/educational services were completed -- valuable planning activity. In addition, EIC sites were determined for maximum citizen accessibility and training workshops were developed for EIC personnel. A directory of community, referral and service organization was also prepared with this appropriation.

In Pennsylvania, a state network of EICs was established. A Toll free information telephone service of educational and occupational information was also put in place: Regional workshops were conducted and directories of various educational/career counseling services were published and disseminated.

The Association recommends funding for EICs for FY 1981 of $5 million. These centers are valuable resources to all youth and adults with barriers to education. They service rural as well as urban citizens -- women, the aged, the confused and the second careerist. These centers and their continual development are needed in all the states. The initial plans begun in Fiscal 1980 can now be carried forth in Fiscal 1981. See Appendix 3 for state allocations and rationale.

D. Program Improvement and Support Services, Vocational Guidance and Counseling, provides the principal sources of guidance and counseling funding in the states under vocational education. This program tied to Basic Grants, under Title I, Vocational Education, of P.L. 94-482, the Education Amendments of 1976, provides vitally needed vocational guidance, counseling and placement services in the states. Without this program and its set aside for vocational guidance,programs for servicing youth and adults in secondary and postsecondary institutions could not be planned or implemented. Vocational education, its facilities, personnel and equipment, are expensive but less expensive than unemployment, welfare costs in lost state and federal income taxes. Citizen productivity is promoted through good vocational education/vocational guidance. Time and time again, as pointed out by Dr. Nancy Pinson, in her recent paper "The Contribution of Guidance and Counseling to the Employability of Youth", good career and vocational guidance programs used with youth and adults, advantaged and disadvantaged, men and women, build up the self esteem and provide the employability skills needed in attaining and setting vocational goals. But more important self-worth is promoted by the individual's knowledge of skills he/she possesses.

Inflation, as in so many other programs, has increased the cost of maintaining effective vocational education. This is why the Association recommends a funding level of $162 million for Program Improvement and Supportive Services in FY 1981. Appendix 4 symopsizes some of the background and rationale for this program.

E. Finally Mr. Chairman, the American Personnel and Guidance Association seeks appropriate funding for Title IV D, Guidance, Counseling and Testing of P.L.95-561. We seek supplemental funding of $5 million to augment the $18 million FY 1980 advance funded appropriations for FY 1981 and $25 million FY 1981 advance funding for FY 1982.

The evidence from numerous sources stresses the need for these funds. The recent (September 1979) final report of U.S. Office of Education entitled The Urban High School Reform Initiatives stresses the importance of providing:

1. counseling services for all students not just those who "act out" or excel.
2. regular counselor-pupil-parent contact, including home visits by counselor
3. regular counselor-teacher exchanges
4. individualized career counseling
5. peer counseling programs
6. volunteer counseling program
7. provision of a wide variety of referral services

But with one counselor per 500-600 students these program recommendations are impossible. Nor can the Local Educational Agencies afford these needed services alone, they need federal help.

In another recent study (September 1979), The Eleventh Annual Gallup Poll of the Public's Attitudes Toward the Public Schools, in response to a question on career guidance in the schools, parents "warmly praised counselors for their help, but most of those questioned say that their child has received no career guidance. In fact, only one person in five specifically mentions that his or her child was given help in selecting a career". Mr. Chairman, funding help is needed for Title IV D to provide the kinds of training and programs needed by counselors and pupils to offer effective career guidance.

In the Pinson paper, cited earlier (February, 1980) she speaks to the tragic economic waste of not providing effective guidance and counseling programs in the states. For example, if a school counselor were successful in preventing 10 students per year from dropping out of school, the school would continue to receive the state reimbursement associated with some weighted form of Average Daily Membership. And, if the State Aid Ratio is $910 per student per year, retention of these 10 students would represent an economic benefit of $9100! This is but one example in the economic sphere cited by Pinson. And, what about the social benefits of effective and well funded guidance programs, reduction -- of future welfare payments, work loss, absenteeism, unemployability, drug use, incarceration; and improved school attendance, scholastic performance, mental health, family relationships, etc.

I urge your careful consideration of funding for Title IV D. Appendix 5 provides more rationale and data on how guidance, counseling and testing funds were allocated in previous years.

Mr. Chairman, I thank you for your consideration in hearing our funding needs for FY 1981 for guidance, counseling and testing programs. Guidance and counseling touches or is a part of the educational effort of almost every elementary and secondary, vocational and postsecondary program. The Association could have addressed needs in other programs but know other advocates will be addressing these. One final note, the Association wishes to express its support for the American Council on Education's recommendations as these particularly concern Student Financial Aid programs, particularly the full funding of BEOGS and the $170 million recommendation of funding for TRIO programs. Thank you for this opportunity, I would be happy to answer any questions you might have about the testimony.

Appendix 1

FY 1981 Appropriations

Public Law 95-207, Career Education Incentive Act

Section 4, State Grants
Section 11, Post Secondary Educational Demonstration Projects

A. Background:

The Career Education Incentive Act was signed into law on December 13, 1977. Its purpose is to assist states, local educational agencies, and institutions of postsecondary education in making education as preparation for work and as a means of relating work values to other life roles and choices a major goal of education. A contextual thread throughout this legislation is the importance of guidance and counseling in the implementation of career education programs at the state, local and postsecondary levels.

Essentially, the "Career Education Incentive Act" plans to institutionalize a new philosophy of education within a five year period. This legislation expands and broadens the federal role initiated by the Career Education Special Projects Act of the Education Amendments of 1974, P.L. 93-380. It is entering into its third year of authorization.

Emphases of this program include:

- inservice training of all educational personnel in career education practices
- curriculum revisions
- elimination of sex role stereotyping
- business, labor, education and private organization cooperative planning
- comprehensive career guidance, counseling, placement and follow-up services
- occupational and career information dissemination and evaluation
- career education demonstration projects at the postsecondary level

B. Funding:

Section 4	Requested	$ 20 million
	Authorized	$100 million
	Carter Budget	$ 20 million
Section 11	Requested	$ 10 million
	Authorized	$ 15 million
	Carter Budget	-0-

C. Rationale:

1. $20 million for State Grants is needed as it takes more money to implement programs than plan them. The intent of P.L. 95-207 is to institutionalize career education in the schools. This level appropriation for state grants will help accomplish this.

2. In 16 states only the minimum amount ($125,000) is provided -- see attached table, as money is distributed on 5-18 year old population in states. Additional funds will integrate career education program into regular educational programs.

3. Students moving from secondary institutions to Postsecondary expect continued emphasis and development of their career education plans. In addition, research on why students go to and stay in college (ACT study) show they do so for career related reasons. Yet many college and university faculties are not in touch with the ever-changing and complex labor market. The $10 million for Section 11, Postsecondary Programs would provide the bridge between these two entities.

4. Regular postsecondary students and adult second careerists are most in need for education about the world of work in order to ready themselves to compete in the labor market.

Career Education Incentive Grants to States and Outlying Areas

State or Outlying Area	1979 Actual 1/	1980 Appropriation 1/	1981 Estimate 1/
TOTAL	$ 18,700,000	$ 18,700,000	$ 18,700,000
Alabama	305,706	305,706	305,706
Alaska	125,276	125,276	125,276
Arizona	189,030	189,030	189,030
Arkansas	171,756	171,756	171,756
California	1,682,038	1,682,038	1,682,038
Colorado	210,865	210,865	210,865
Connecticut	245,412	245,412	245,412
Delaware	125,341	125,341	125,341
Florida	599,028	599,028	599,028
Georgia	422,710	422,710	422,710
Hawaii	125,518	125,518	125,518
Idaho	125,513	125,513	125,513
Illinois	907,341	907,341	907,341
Indiana	443,567	443,567	443,567
Iowa	234,658	234,658	234,658
Kansas	178,274	178,274	178,274
Kentucky	281,914	281,914	281,914
Louisiana	348,726	348,726	348,726
Maine	125,636	125,636	125,636
Maryland	340,905	340,905	340,905
Massachusetts	456,278	456,278	456,278
Michigan	777,623	777,623	777,623
Minnesota	333,735	333,735	333,735
Mississippi	212,170	212,170	212,170
Missouri	377,407	377,407	377,407
Montana	125,455	125,455	125,455
Nebraska	125,889	125,889	125,889
Nevada	125,369	125,369	125,369
New Hampshire	125,497	125,497	125,497
New Jersey	581,755	581,755	581,755
New Mexico	---	---	---
New York	1,389,694	1,389,694	1,389,694
North Carolina	444,220	444,220	444,220
North Dakota	125,388	125,388	125,388
Ohio	873,447	873,447	873,447
Oklahoma	216,080	216,080	216,080
Oregon	182,185	182,185	182,185
Pennsylvania	906,038	906,038	906,038
Rhode Island	125,522	125,522	125,522
South Carolina	244,434	244,434	244,434
South Dakota	430,281	430,281	491,131
Tennessee	2,236,752	2,236,752	2,689,797
Texas	5,500,870	5,500,870	6,662,572
Utah	470,964	470,964	540,647
Vermont	323,823	323,823	361,561
Virginia	2,373,823	2,373,823	2,856,627
Washington	1,355,785	1,355,785	1,617,567
West Virginia	1,089,943	1,089,943	1,294,009
Wisconsin	1,950,556	1,950,556	2,341,466
Wyoming	268,193	268,193	293,853
District of Columbia	478,054	478,054	549,277

State or Outlying Area	1979 Advance for 1980	1980 Advance for 1981	1981 Advance for 1982
Puerto Rico	1,743,551	1,743,661	2,089,653
American Samoa	139,265	139,265	150,101
Northern Marianas	73,172	73,172	83,732
Guam	244,720	244,720	272,726
Virgin Islands	229,392	229,392	290,965
Trust Territory	313,451	313,451	402,476

1/ Distribution of 99% distributed with a basic amount of $150,000 to each State, D.C., and Puerto Rico and the balance distributed on the basis of the population 15 and over with less than a high school diploma, April 1, 1970, with no State receiving less than 90% of its 1979 allotment.
Distribution of 1% distributed with a basic amount of $50,000 to each Outlying Area and the balance distributed on the basis of the population 15 and over with less than a high school diploma, with no Area receiving less than its 1978 allotment.

Appendix 2

FY 1981 Appropriations

Public Law 95-561, The Education Amendments of 1978

Title IX, Additional Programs

Part C, Women's Educational Equity

A. Background:

The Women's Educational Equity Act originally was a part of the Special Projects Act of P.L. 93-380, the Education Amendments of 1974. Its primary purpose is to promote educational equity for women and girls at all levels of education. The program funds grants and contracts for developmental, demonstration and dissemination projects of national significance and also provide funds to local projects which reduce sex discrimination in individual school districts and other educational institutions. In 1978, the Women's Educational Equity Act was incorporated into Title IX of P.L. 95-561. This Act has many guidance and counseling implications particularly in the development of non-discriminatory training and counseling programs as well as sex fair testing materials.

B. Funding:

- Requested $20 million
- Authorized $80 million
- Carter Budget $20 million

C. Rationale:

1. Educational opportunity and equity for girls and women is economic good sense as the United States then taps the intellectual potential of all its citizens to maximize their achievement. Girls and women have been a neglected resource in this maximization of intellectual potential.

2. Effective counseling and guidance are essential ingredients in providing girls and women educational parity but more emphases is needed on the elimination of possible sex discriminatory practices and testing instruments. Appropriate counseling helps women and girls be better aware of their personal strengths and weaknesses, and the values and skills sought by potential employers.

3. The $20 million appropriation is sought to continue important developmental, dissemination and demonstration grants but also, for the first time, emphasize local significance grants which help bring local institutions into compliance with Title IX of the Act.

Appendix 3

FY 1981 Appropriations

Public Law 94-482, The Education Amendments of 1976

Title I, Higher Education

Subpart 5, Sections 418 a & B, Education Information Centers

A. Background:

Educational Information Centers are designed to establish comprehensive regional centers to serve as reservoirs of support services, informative and education programs in order that individuals, including individuals in rural areas, are afforded reasonable access to all necessary programs. Specifically, EICs are organized to provide educational information, guidance, counseling and referral services for a geographical area. The purpose of the center is to combine the efforts and activities of professional and lay groups, communities, private and public agencies and local, state and federal government to consolidate activities into a multi-purpose and accessible single agency to mobilize the resources that impact on educational needs.

B. Funding:

- Requested $ 5 million
- Authorized $40 million
- Carter Budget -0-

C. Rationale:

1. The importance of Education Information Centers is to avoid the excessive duplication of services through a plethora of programs and consolidate such activities in a multi-purpose and accessible single agency designed to mobilize the resources of the community, state and federal government that impact educational needs. The scarcity of new fiscal resources, combined with rapid growth, inflated costs and funding plateaus mandates the necessity of sharing resources. Each state is asked to establish sufficient centers so that there is an EIC within a reasonable geographic distance of all residents of the state.

2. Vitally needed job placement, guidance and counseling, referral services and tutorial assistance is made accessible to residents of rural and urban communities through this new program.

3. Most states had an EIC program operating in FY 1980 but 41 of these only had a minimum allocation of $50,000. More funding is needed for this valuable service.

Appendix 3

STATE OBLIGATION OF FUNDS UNDER P.L. 89-329, AS AMENDED, TITLE IV-A-5-EDUCATIONAL INFORMATION CENTERS - FISCAL YEAR 1979-80

	TOTALS	$3,000,000
10	Alabama	50,000
11	Alaska	50,000
12	Arizona	50,000
13	Arkansas	50,000
14	California	136,848
15	Colorado	50,000
16	Connecticut	50,000
17	Delaware	50,000
18	District of Columbia	50,000
19	Florida	52,933
20	Georgia	-0-
21	Hawaii	50,000
22	Idaho	50,000
23	Illinois	70,203
24	Indiana	50,000
25	Iowa	50,000
26	Kansas	50,000
27	Kentucky	50,000
28	Louisiana	50,000
29	Maine	50,000
30	Maryland	50,000
31	Massachusetts	50,000
32	Michigan	57,198
33	Minnesota	50,000
34	Mississippi	50,000
35	Missouri	50,000
36	Montana	50,000
37	Nebraska	50,000
38	Nevada	-0-
39	New Hampshire	50,000
40	New Jersey	50,000
41	New Mexico	50,000
42	New York	112,119
43	North Carolina	50,000
44	North Dakota	50,000
45	Ohio	66,876
46	Oklahoma	50,000
47	Oregon	50,000
48	Pennsylvania	73,754
49	Rhode Island	50,000
50	South Carolina	50,000
51	South Dakota	50,000
52	Tennessee	50,000
53	Texas	80,069
54	Utah	50,000
55	Vermont	50,000
56	Virginia	50,000
57	Washington	50,000
58	West Virginia	50,000
59	Wisconsin	50,000
60	Wyoming	50,000
61	American Samoa	50,000
62	Tr.Terr.Pac. Isls.	50,000
63	Guam	50,000
64	Puerto Rico	50,000
66	Virgin Islands	50,000
00	No. Mariana Isls.	50,000

Appendix 4

FY 1981 Appropriations

P.L. 94-482, The Education Amendments of 1976

Title I, Vocational Education

Part A, Subpart 3, Program Improvement and Supportive Services
Section 134, Vocational Guidance and Counseling

A. Background:

Program improvement and Supportive Services provides funds for: applied research, operation of exemplary and innovative programs, curriculum development, development of innovative instructional materials, guidance and counseling services, training of vocational education personnel, and assistance to schools to overcome sex-stereotyping in occupational areas. Section 134 provides that not less than 20% of the funds available under this subpart go to support vocational guidance and counseling. The funds are made available to states to provide "expansion and improvement of the vocational and career guidance and counseling systems". The statutorily recommended guidance program and service activities include such things as "(1) initiation, implementation, and improvement of high quality vocational guidance and counseling programs and activities; (2) vocational counseling for children, youth and adults, leading to a greater understanding of educational and vocational options; (3) provision of educational job placement service ...; (4) ... training designed to acquaint guidance counselors with (several items related to overcoming sex-stereotyping)..." and so on.

B. Funding:

- Requested — $162 million (not less than 20% for guidance and counseling)
- Authorized — $282.2 million
- Carter Budget — $132.2 million

C. Rationale:

1. Increased costs for vocational education programs, and runaway inflation mandate this modest increase for Subpart 3 programs of 22%. Vocational guidance funding in the state program improvement and support service programs comprises not less than 20% of each state's Subpart 3 funds. Vocational guidance is central to effective vocational education.

2. Effective vocational education and vocational guidance programs are important means of reducing youth and adult unemployment.

Appendix 5

FY 1981 Supplemental Appropriations
and FY 1982 Advance Funding

P.L. 95-561, The Education Amendments of 1978

Title IV, Educational Improvement, Resources and Support
Part D, Guidance, Counseling and Testing

A. Background:

Title IV D was established to assist states and local educational agencies to improve their guidance and counseling programs and services. The provisions of this title include:

1. providing state leadership and supervisory services in the fields of guidance, counseling and testing;

2. grants to states for comprehensive guidance, counseling and testing programs in elementary and secondary schools.

Allocations for funds to states and local jurisdictions are by student population (ages 5-17) formula or competitive grants at an individual state's discretion.

The implementation of programs under this title has in fact assisted LEAs, IEAs, and SEAs to add and refine their guidance programs. Special impetus has come for comprehensive guidance programs at the elementary and middle school/junior high levels.

B. Funding:

	FY 1981	FY 1982 Advance Funding
° Requested	$23 million*	$25 million
° Authorized	$50 million	$50 million
° Carter Budget	$18 million	$18 million

* $5 million supplemental increase over FY 1980 Appropriations Advance Funding of $18 million for FY 1981

C. Rationale:

$18 million has not been sufficient to get the total job done; $ 5 million supplemental is needed to augment the $18 million advance funded appropriation. In addition, it is recommended that $25 million be advance funded for FY 1982.

1. In order to more adequately meet the needs of students across the country in all grade levels, increased dollars are needed. We are seeking increased dollars to assist the states and LEAs as well as for funds to be increased at the federal level to be used for the identified discretionary purposes. There are still needs for additional staffing in counseling and guidance programs; we are talking about changed roles for the counselors and guidance staffs that are in place and thus, there is an increased need for staff development; better program planning, designing, implementing, and evaluating is beginning and increased dollars would better enable us to do that; better research is needed so that districts can be better convinced that dollars spent in these activities are essential to better learning of their kids.

2. Through the impetus of this money, several trends are being brought to fruition which further enchance schools' abilitites to meet students' needs: development of comprehensive, developmental guidance curriculum; increased use of para-professionals.

3. The general public continues to place increased demands on schools to meet students' personal, social, and career needs, thus more money to expand the program is necessary.

4. The $18 million has not increased at all in ten years and yet inflation has. Considering the impact of inflation, then guidance and counseling is in a standstill-back-up position, and maintenance of program efforts is not even possible.

Elementary and Secondary Education

Guidance, Counseling, and Testing

State or Outlying Area	1979 Advance for 1980	1980 Advance for 1981	1981 Advance for 1982
TOTAL	1/	$17,273,000	$17,273,000
Alabama	—	296,947	296,947
Alaska	—	37,718	37,718
Arizona	—	183,449	183,449
Arkansas	—	166,990	166,990
California	—	1,626,594	1,626,694
Colorado	—	202,994	202,994
Connecticut	—	238,312	238,312
Delaware	—	46,291	46,291
Florida	—	579,836	579,836
Georgia	—	410,446	410,446
Hawaii	—	70,294	70,294
Idaho	—	69,608	69,608
Illinois	—	880,212	880,212
Indiana	—	429,991	429,991
Iowa	—	227,340	227,340
Kansas	—	171,448	171,448
Kentucky	—	273,288	273,288
Louisiana	—	338,781	338,781
Maine	—	85,753	85,753
Maryland	—	330,208	330,208
Massachusetts	—	440,278	440,278
Michigan	—	754,027	754,027
Minnesota	—	322,322	322,322
Mississippi	—	206,766	206,766
Missouri	—	364,498	364,498

State or Outlying Area	1979 Advance for 1980 1/	1980 Advance for 1981 2/	1981 Advance for 1982 2/
Montana	—	62,064	62,064
Nebraska	—	120,356	120,356
Nevada	—	50,749	50,749
New Hampshire	—	67,893	67,893
New Jersey	—	566,806	566,806
New Mexico	—	104,240	140,240
New York	—	1,349,975	1,349,975
North Carolina	—	429,648	429,648
North Dakota	—	52,463	52,463
Ohio	—	845,922	845,922
Oklahoma	—	208,323	208,323
Oregon	—	176,591	176,591
Pennsylvania	—	877,126	877,126
Rhode Island	—	70,979	70,979
South Carolina	—	236,598	236,598
South Dakota	—	54,863	54,863
Tennessee	—	329,522	329,522
Texas	—	1,026,285	1,026,285
Utah	—	109,384	109,384
Vermont	—	39,090	39,090
Virginia	—	393,987	393,987
Washington	—	282,546	282,546
West Virginia	—	139,558	139,558
Wisconsin	—	375,127	375,127
Wyoming	—	32,232	32,232
District of Columbia	—	48,005	48,005
Puerto Rico	---	297,633	297,633
American Samoa	—	12,139	12,139
Guam	—	36,198	36,198
N. Mariana Islands	—	5,139	5,139
Trust Territory	—	37,141	37,141
Virgin Islands	—	34,263	34,263
Bureau of Indian Affairs	—	46,160	46,160

1/ The 1979 funding for Guidance, Counseling, and Testing is contained in the School Libraries and Instructional Resources program (ESEA IV-B) in the Libraries and Learning Resources account.

2/ Estimated distribution with 1 percent of the 50 States, D.C., and Puerto Rico amount reserved for the areas and the balance distributed on the basis of the 5-17 population as of 7/1/77 for the 50 States, D.C., and Puerto Rico, with distribution for the areas made on the total public and nonpublic elementary and secondary enrollment, Fall 1977. Of the $13,000,000 requested, $725,000 is to be reserved each year for use by the Secretary for discretionary projects.

DELAWARE POST-SECONDARY EDUCATION COMMISSION

Mr. CORROZI. I appreciate the opportunity to appear before you. I'm John Corrozi, director of the Delaware Post-Secondary Education Commission.

I'm here to present testimony reflecting the views of the 55 State and territorial administrators of title I programs, community services, and continuing education. The administrators recommend funding of the EIC programs under title IV of the Higher Education Act, 1,202 commissions under title XII, and title I. The complementary nature of these three programs has been recognized in both the House and Senate bids to reauthorize the Higher Education Act.

TITLE I FUNDING

Specifically, my purpose is to present the recommendations of the State administrators for a fiscal year 1981 appropriation of $40 million

for title I of the Higher Education Act. While we do have a clear appreciation of the fiscal realities under which you're operating this year, we request the expanded support for title I on the basis of the following: Our growing adult population has needs that are not adequately being met by traditional higher education programs. Title I has a long history as a catalyst stimulating institutions to develop programs to meet those needs. Examples of the success of title I efforts are many, including the nationally recognized Delta Hospital program, energy conservation efforts, small business education, and bringing educational resources to areas of rural isolation. A hallmark of the title I programs is the expansion of access to postsecondary education for traditionally underserved groups. In my own State of Delaware title I provided the initiative for the development of educational programs to assist women who are entering or reentering the work force.

Title I demonstrated the benefits to be derived from a Federal-State partnership in higher education, a partnership that has been encouraged by Congress—stimulating the effective use of scarce resources to bring programs to new populations, to maintain institutional responsiveness to changing conditions, and to address national priorities. The effect of title I as a stimulus is illustrated by its record of attracting State and local matching funds. While a one-third match is required, States have consistently exceeded this requirement by 50 percent or more.

This partnership allowed institutions of higher education the latitude to experiment with techniques designed to meet the national and State needs of the adult population for continuing education. Title I has fostered cooperation of local organizations, Government agencies, and citizens groups by providing them with resources of higher education to meet the diverse needs of the populations they represent.

Nationally, 577 programs were funded in 1978 serving approximately 500,000 people directly and more than 24 million through mass media. These programs were supported by $15 million in Federal funds, and over $10 million in State and local matching funds. Yet it was impossible for States to support almost two-thirds of the programs that were judged by review panels to be eligible for funding.

At this time, when spending priorities must be reexamined, we are still convinced that increased funding for title I is warranted. Over the past 15 years we have recognized the vital necessity of this program. Much more can be achieved, but only through your continuing support. The National Advisory Council on Extension and Continuing Education will be submitting for the record statistical data on the title I program and State-by-State profiles of recently funded title I projects.

In addition, my colleagues, State administrators, and I will be pleased to provide you with any additional information you may require. Thank you.

NATIONAL ASSOCIATION FOR PUBLIC AND CONTINUING ADULT EDUCATION

Mr. DORLAND. I'm Jim Dorland, executive director of the National Association for Public Continuing and Adult Education. Although we are very much interested in title I, Higher Education Act, and community education, which Mr. Kee will talk about, I will simply give a

90-second commerical for the Adult Education Act, inasmuch as my testimony will be submitted for the record.

ADULT EDUCATION ACT

This is my 90-second commercial: Since it was first passed in 1966, the Adult Education Act has a solid, steady record of accomplishment. In 1978 when it was most recently amended and extended for 5 years, it was given a mandate to significantly expand the delivery system, which really means including community-based organizations to get involved in adult education, and to make available funds for such services as transportation and child care. It's a program which is successful. It's in place. It is indeed an economic stimulus.

I have included some figures from the State of Ohio indicating the savings alone through the Adult Education Act. Adult educators do have waiting lists of people trying to get into the programs when classroom spaces become available. For the first time in my memory we are supporting the President's budget request, the request he made in January, that is, of $120 million for State grant programs and $2 million for research and demonstration. We feel that it's a program of which we are prudent stewards of the funds.

The commercial is over, but finally, I notice the examples are almost always of the State of Washington when I come here to testify. Today people are talking about Connecticut.

Senator WEICKER. I notice, too. [Laughter.]

This afternoon it will be Washington. Senator Magnuson will chair.

Mr. DORLAND. Presidential material comes from the State of Connecticut. Our president of the elective association happens to be John Ryan. Thank you.

[The statement follows:]

STATEMENT OF JAMES DORLAND

Thank you for allowing me to appear before you today requesting funding of $122 million for the Adult Education Act in Fiscal Year 1981. As Executive Director it is my privilege to speak for the National Association for Public Continuing and Adult Education (NAPCAE) and for the three major groups affiliated with it--the National Council of State Directors of Adult Education, the National Council of Urban Administrators of Adult Education, and the NAPCAE Council of Affiliates. It is the thousands of members of these groups who have the primary responsibility for developing and carrying out the programs funded by the Adult Education Act across the country.

Today I am representing the NAPCAE President, Dr. Robert Rupert, Los Angeles, California; the president of the urban administrators' council, John Koruga, Seattle, Washington; the chairman of the state directors' council, Bob Allen, Austin, Texas; the president of the affiliates' council, Wayne Reed, Sheldon, Iowa; and the chairman of the NAPCAE Legislative Committee, Dr. Bob Walden, Montgomery, Alabama. NAPCAE works closely with such groups as the National Advisory Council on Adult Education and with the twenty-three national organizations which comprise the Coalition of Adult Education Organizations. Although NAPCAE is the only group on this panel which is testifying specifically on the Adult Education Act, all of us in adult education are united in our advocacy of the need for increased educational services for the millions of undereducated American adults who are potential participants in the adult education enterprise.

Ever since the Adult Education Act was passed in 1966, I have been coming to Capitol Hill with the same basic message, which is simply this: programs funded by the Adult Education Act are making possible a necessary service not provided elsewhere; these programs are highly cost effective; and the need for them throughout the nation is far greater than is being met through federal funding alone. My message does not vary this year. It is a plea which your Subcommittee has heard often, and to which you have responded favorably. In fact, without the

continuing support which has been provided by your Subcommittee over the years, adult education would never have achieved the high level of success and acceptance which it now enjoys throughout all of our states and territories. During the fourteen years of existence of the Adult Education Act--from 1966 until 1980--the federal government has exercised responsible leadership which has helped establish a completely functional funding partnership between local, state and federal governments, with none becoming completely dominant.

Each year this impressive record of partnership is documented in NAPCAE's Public Continuing and Adult Education Almanac. I am including as an attachment to my testimony a copy of our 1979 Almanac. The information found on pages 31-39 is evidence of the continuing existence of this healthy adult education partnership which exists among the three levels of government.

In addition to the information contained in our Almanac, I could offer other statistics showing how the state and local involvement in and contributions to adult education have increased steadily over the years, but I will not. I could give you a number of reasons why the national average cost of less than $2.00 for each hour of adult education instruction represents one of the greatest educational bargains of this or any other time, but I won't. I could tell you other favorable things about adult education's outreach and about the new elements in its delivery system, but I won't. The reason I choose not to do so today is because such evidence of effective accomplishment by programs funded under the auspices of the Adult Education Act is well known to this Subcommittee and to other decision makers on Capitol Hill.

Quite simply, the story of the Adult Education Act is one of solid, steady increases in funding and in impact over the years. The Act itself has been consistently amended and extended since it was first passed in 1966. The 1978 amendments, as found in Public Law 95-561, and the subsequent Rules and Regulations--which should soon be released--call for a significant expansion of the adult education delivery system, with the

emphasis continuing to be directed to those who are most in need of basic education. They are the hardest to reach and the most difficult to teach. As a result of those 1978 amendments, encouragement is being given to community-based organizations to become active in offering adult education programs. These new initiatives will be in addition to the longstanding services which will continue to be provided by local educational agencies.

In the current fiscal year the Adult Education Act is funded at a level of $105 million, with $100 million going to the state grant programs and $5 million divided between programs for adult immigrants and Indochina refugees. President Carter recommended in his January Budget Message to the Congress that the Adult Education Act should be funded at $122 million for FY 1981--$120 million for state grant programs and $2 million for federal discretionary funds to be used for the purposes of Section 309 of the Adult Education Act: research, development, dissemination, evaluation, and information clearinghouse.

We are not asking for more money than the President recommended, but we do strongly support that $122 million level of funding as a minimum level which is necessary if any headway is to be made in our fight against illiteracy. The state grant programs are geared up to reach the various special populations in addition to being targeted at the millions of "normal" but undereducated Americans who need to acquire basic education. The $2 million in federal discretionary funds can help in the development and dissemination of information about such approaches as competency-based adult education, which is one of the most promising practices in our field.

The Adult Education Act is a forward-funded program, so that the money appropriated in Fiscal Year 1981 won't actually become available until FY '82. It has an authorization level of $250 million for Fiscal Year 1981. Our request is for less than half of its authorized ceiling.

Mr. Chairman, we fully recognize that our nation faces difficult days as we try to bring our federal spending into balance as one means of fighting inflation. Those of us who are adult educators are also citizens and tax-payers. We, too,

want what is best for our country. However, we sincerely believe that this nation's small investment in the Adult Education Act is one which brings untold dividends.

To cite just one example, in my native state of Ohio it is estimated that from the Adult Education Act alone the annual savings resulting from people being removed from public assistance rolls is $2.38 million, the projected annual earnings for people who have become employable through adult education is $4.6 million, and increased earnings for people who become promoted in their jobs as a result of their participation in classes funded by the Adult Education Act is $237,000. That kind of economic benefit is replicated throughout the nation and is a direct stimulus to our economy.

To cut back on such expenditures would effectively extend the de facto disenfranchisement which is currently suffered by millions of undereducated adults. We ask that the Adult Education Act be funded at $122 million in Fiscal Year 1981. I can assure you that adult educators will be prudent stewards of those funds. The immediate beneficiaries will be those adults--many of whom are parents--who enroll in adult education programs so that they can become productive members of our society. The ultimate beneficiaries will be all of us. Thank you for hearing our testimony today. We trust that you will act favorably on our modest request that the Adult Education Act be funded in the amount of $122 million in Fiscal Year 1981.

INSTITUTE OF LIFETIME LEARNING

Dr. TIMMERMAN. I am Sandra Timmerman, head of the Institute of Lifetime Learning, which is part of the National Retired Teachers Association, and the American Association of Retired Persons. NRTA and AARP are membership organizations representing over 12 million older people.

I am also representing today a coalition of organizations who have been working together for many long months to reauthorize title I of the Higher Education Act, and two of these members are accompanying me today.

Sitting behind me are representatives from the United Auto Workers and from the College Board, and I request permission at this time to append their testimony to mine for the record.

TITLE I, TITLE IV-A, TITLE XII FUNDING

I am here today to testify in appropriations for title I of the Higher Education Act. We strongly believe that appropriations of $20 million for title I, as well as $5 million for title IV–A(b), which is educational information centers, and $5 million for title XII section 1203 for State planning grants, are critical in meeting the needs of adult learners.

As you know, the administration has requested no funds for these three programs, but funds are needed to continue them until the new legislation to reauthorize the Higher Education Act, which is S. 1849, is enacted.

We believe the new legislative initiative, which focuses on those adults whose educational needs have been inadequately served, is critical in establishing a sound national policy for adult learners. Older adults have the lowest level of educational attainment and the lowest participation in adult education, and would be well served by the new initiative.

We also believe it would be highly disruptive in this interim period to discontinue some of the excellent programs funded under current law.

An example that was mentioned earlier is Eldon Hostel, which is a network of residential learning programs for older persons on campuses throughout the country. It's flourishing because of title I funding, which is usually used to initiate the program, and then the program becomes self-supporting.

I might add, there is a fine title I program operating in New London, Conn., which trains bilingual Hispanic professionals and helps them counsel their fellow Hispanics in their county.

For these reasons, we urge you to approve appropriations of $20 million—$5 million, and $5 million for these three important programs.

TITLE IX FUNDING

I have one additional point to add. I have been asked by the National Association of Schools and Public Affairs and Administration, who are not here today but were intended to be on the panel, to request that funding be continued at $4 million for parts A and C of title IX of the Higher Education Act for public service institutional and fellowship support.

Thank you very much.

[The statements follow:]

STATEMENT OF SANDRA TIMMERMANN

Mr. Chairman, I am Dr. Sandra Timmermann, Head of the Institute of Lifetime Learning, the continuing education department of the National Retired Teachers Association and the American Association of Retired Persons. NRTA/AARP are affiliated, non-profit membership organizations representing over 12 million older persons.

I am also representing a broad-ranging coalition of organizations and institutions who have worked together for many months to reauthorize Title I of the Higher Education Act. Two of these members are accompanying me today, representatives from International Union, United Automobile, Aerospace and Agricultural Implement Workers of America-UAW and from The College Board, and I request permission to append their testimony to mine for the record.

I am here today to testify on appropriations for Title I, "Continuing Education and Community Services"; Title IV A, Subpart 5, "Education Information Centers"; and Title XII, Section 1203, "State Planning Grants." We strongly believe that appropriations of $20 million for Title I, $5 million for Education Information Centers and $5 million for State Planning Grants are crucial in meeting the needs of adult learners.

Funding has been declining for Title I in past years. This is due, in part, to a dissatisfaction with its lack of focus and its confusion of purposes; under current law, wide varieties of unrelated projects have been funded. Others have questioned the rationale for awarding funds to institutions of higher education for community service activities.

The Administration has requested no funds for Title I for Fiscal Year 1981. Further, no funds were requested for Education Information Centers or for State Planning Grants. I am here today to express my concern, and the concern of my colleagues, over the lack of funding requests for these three important programs. Funds are needed to continue these programs until the new legislation to reauthorize the Higher Education Act, S. 1849, is enacted. We strongly believe that it would be unnecessarily disruptive to let these three programs die during this interim period.

Frankly, NRTA/AARP would not be here today if it were not for the new legislative initiative. This new initiative, which strengthens

the focus on adult learners whose educational needs have been inadequately served, would enable some of the fine programs operating under current law to be continued.

Because of Title I, the Elderhostel program has flourished. Elderhostel is a network of more than 230 colleges and universities in 38 states offering older adults special low-cost, one-week residential learning programs. Persons over 60 years of age can take advantage of multiple learning experiences and interaction with their peers. Typically, the role of Title I funding has been to assist colleges in a given state in launching their own Elderhostel programs, which then become self-supporting through tuition income and institutional in-kind services.

Title I funds have also facilitated new concepts in pre-retirement education for older workers facing the transition between employment and retirement. The Institute of Aging at Portland State University, for example, has developed course modules to improve the quality and productivity of working life before retirement and to help workers plan for economic stability once they leave the workforce. These modules, when tested, will be made available to business and industry at minimal cost.

Older adults are one of the populations who traditionally have been underserved by the nation's educational system. Of all populations, persons age 65 and over have the lowest level of formal educational attainment; the average older person has completed less than nine years of formal schooling. Estimates indicate that approximately 2.5 million older adults are "functionally illiterate." Further, they are the least likely of any age group to participate in adult education activities, and, the ones who participate are likely to be better educated and of a higher socioeconomic status.

Yet, we know that adults have learning needs throughout their lives. For older persons, learning is critical to mental and physical well-being. Older persons should have access to learning opportunities which permit them to develop new skills for employment, to cope with life transitions, to help prevent illness through nutrition and physical education, and to develop expertise to be shared with all generations within their own communities. Further, as the changing demographics indicate, institutions previously serving children and young adults will need help in redirecting their focus to reflect

the needs of an older population. For the past twenty years, NRTA/AARP, through its Institute of Lifetime Learning, has provided education information and programs to older persons as well as technical assistance to those service providers working to establish learning experiences for this age group. It has also advocated for federal, state and local policies that assure that older persons are not forgotten in the nation's learning systems.

For these reasons, we have, in the past, supported the activities of Title I of the Higher Education Act, many of which have provided fine programs for older learners. However, we believe that the portion of the new legislation, as passed by the Senate Education Subcommittee, that focuses on the learning needs of underserved adults, takes a major step forward in strengthening our national policy and program in adult learning. For example, we know that both physical and psychological barriers to learning exist for a majority of older adults, including inadequate transportation, inconvenient class locations, and insecurities about lack of formal education. The new legislation recognizes that adult learning occurs in a variety of settings, not only in colleges and universities but also in public and private agencies, community organizations, and in the workplace. We also recognize that legislation which promotes equal education opportunity is a more meaningful and valid goal for Title I, particularly in times of budgetary constraint. While some excellent programs funded under current law promoted equal access, the new legislation focuses specifically on educational equity and creates a focal point for such activities by coordinating state planning, information services and demonstration grants.

During the past several months, NRTA/AARP has devoted time and energy to the reauthorization of Title I. We have taken a leadership role on behalf of a coalition of national organizations representing both learner groups and institutions of higher education. The new legislative initiative reflects the concerns of this coalition and, we believe, better meets the needs of adult learners -- women who need to return to the workforce due to inadequate income, workers who are in need of retraining and upgrading, and older persons who need skills to cope with rapid technological and social changes.

We believe that the new initiative is critical in establishing a logical and strong national policy for adult learners and for

the educational providers that serve them. We also believe that it would be disruptive and would endanger future programs focusing on the underserved adult to discontinue the programs presently funded under current law. Title I projects which are providing critical educational services to older adults must not be allowed to die. Therefore, we strongly urge that you approve appropriations of $20 million (Title I), $5 million (Title IV A, Subpart 5), and $5 million (Title XII, Section 1203) for these important programs.

STATEMENT OF PAMELA H. CHRISTOFELL, RESEARCH AND DEVELOPMENT ASSOCIATE, WASHINGTON OFFICE, COLLEGE BOARD

Mr. Chairman and members of the Subcommittee, I am pleased to submit this testimony for Fiscal Year 1981 appropriations for three programs under the Higher Education Act of 1965 as amended. To prevent program disruption and to maintain momentum, it is crucial that the following be appropriated:

- $20 million for Title I, Part A - (Continuing Education and Community Service)
- $5 million for Title IV, Part A, Subpart 5 - (Educational Information Centers)
- $5 million for Title XII, Section 1203 - (State Planning Grants)

Background

The Continuing Education program (Title I) has served over the years to link institutions of higher education in every State with their local communities through joint projects. Funding for this program has declined from a high of $18 million in FY 1978 to $10 million in FY 1980, partially in recognition that the program has lacked a clear focus. However although the Administration has requested no funds for this program this year, as they have done in seven of the last nine years, the Congress has continued the program, believing many of the continuing education/community service projects to be worthwhile.

Educational Information Centers now operate in 56 states and territories, providing much needed information and counseling about educational opportunities to all residents. The program received $3 million in Fiscal Year 1980, but the Administration has requested no Fiscal Year 1981 monies.

State planning grants have helped the "1202" higher education planning commissions in each State to prepare studies considering the future of post-

secondary education. Such planning is especially needed as we face the next decade of declining enrollments, shifting subsidies, and "new" students who will demand their education to be delivered in new ways, at new times and in new locations. This program received $3 million in Fiscal Year 1980 but again the Administration budget requests no Fiscal Year 1981 dollars.

It is especially important that the ongoing operations of these three worthwhile programs not be disrupted in Fiscal Year 1981. The established State networks and linkages to postsecondary institutions and to learners must be preserved this year, because both the Senate and House are currently engaged in consolidation and improvement of these three programs, as part of the overall reauthorization of the Higher Education Act. To discontinue these programs at this time by appropriating no Fiscal Year 1981 funds would fail to recognize the good efforts of both Senate and House Education Subcommittees to define more sharply the federal role in continuing education. In order to place the need to appropriate funds this year in context, it is important to examine the relevant Congressional reauthorization efforts.

Consolidation and a Sharpened Focus

Both the Senate and the House Education Subcommittees have consolidated the Continuing Education/Community Service Program, the Education Information Center (EIC) program, and the State planning grants into a new refocused Title I. The House and Senate subcommittee versions are very similiar, with only minor formula and other differences.* Thus we must request continued support in Fiscal Year 1981 for all three programs, recognizing that they will, in all likelihood, be consolidated in the near future.

More importantly, the new legislation focuses sharply on purposes embodied in some of the best programs funded under current law--the need to improve access to postsecondary educational opportunities for those adults whose needs have not been met in the past. Such adults include minorities and handicapped and those who are older, poor, underemployed, or unemployed. The new legislation as envisioned by the Congress would allow grants through States to a wide range of educational providers, would encourage States to plan for their own postsecondary education needs with special attention to

*The Senate Education Subcommittee has added other parts to Title I as well which do not exist in current law. But Part B of Title I as passed by the Senate subcommittee (with full Committee vote unlikely to change it) resembles closely the new Title I as passed by the House.

the needs of unserved adults, and would provide State educational information networks to serve learner needs.

Specific projects under current law already seek to meet these needs. For example, under Title I, Part A the Continuing Education Training Program for Bilingual Paraprofessionals provided training through Connecticut College in New London, Connecticut to county Hispanic paraprofessionals. They were able to upgrade their skills, and participants received training in information and referral for disadvantaged Hispanics, new counseling techniques, and career and employment data. Another example is the Coordinated Community Consumer Education Program in Terre Haute, Indiana which established a system for delivering consumer education to low-income, minority, and senior citizens. This program provided information through urban, suburban and rural sites.

The facts underlying the need for these programs, both in current law and as emphasized in the new legislation, may be simply stated. Adults who are poor, under-educated, unemployed or elderly do not enjoy equal educational opportunity. The data show this clearly, and it is worth examining in some detail.

As an area of endeavor, continuing education has undergone dramatic growth in this decade: more and more adults are participating in formal education, and more and more institutions--among them colleges and universities with an eye on the diminishing pool of traditional college-age students--are seeking to serve them. The extent of this growth is substantial.

While current participation in education by adults spans a wide range of backgrounds, previous educational experiences, and incomes, it tends to be greatest among one broad group: today's adult learners are disproportionately young, white, well-educated, and earning salaries above the national median family income. For example:

-- 15.8 percent of those between 17 and 34 years of age take advantage of adult educational opportunities (excluding those enrolled full-time in high school or postsecondary institutions), whereas only 4.4 percent of those over the age of 54 participate.
-- 12.5 percent of white adults participate in adult education, whereas only 6.5 percent of blacks participate.
-- 26.8 percent of those with four years of college or more partici-

pate, while 11.2 percent of those with only four years of high school do (and only 3.4 percent of those with less than high school diplomas).

-- 17.7 percent of those with annual family incomes of $25,000 or more participate while only 8.4 percent of those whose income is between $5,000 and $10,000 and only 5.4 percent of those with incomes below $5,000 participate.

Equally important, present research indicates that the majority of adults enrolled in education have returned to formal learning because of specific job or career related factors--to obtain or keep employment or to avoid job or skill obsolesence--or due to dislocations in their personal lives such as divorce or death of a spouse. Women are returning to the workplace in unprecedented numbers and many seek education to refresh skills or learn new ones. Older adults seek education for second careers or to help them adjust to retirement. This evidence suggests, Mr. Chairman, that adult learning programs are important to our national economy and productivity. Now is not the time to eliminate these programs.

And who are the people most in need of continuing education yet least likely to participate? They are adults who are less than well educated, poor or black, and probably living in the center city or on the farm. The less prior education, the less likely is one to participate in education as an adult. Older adults (those 55 and over) and those who reside in the central city or on the farm are less likely to participate. And, the situation is, in fact, getting worse, not better. Between 1969 and 1978, the participation of black adults in education increased only 8 percent, while their numbers in the population increased 27.2 percent. Yet at the same time, participation of white adults in education increased 40.6 percent. Between 1969 and 1978, the participation of college-educated adults in continuing education increased nearly two and one half times as fast as high school graduates, with white participation increasing five times as fast as that for blacks. Only growth in the participation of women--more than four times that of men--provided a bright spot, although much of this improvement was by white women, holding college degrees, and with family incomes of $25,000 or more. The attached table, derived from NCES data, shows the problem clearly.

College Board research and experience indicate several reasons for the lack of participation in adult learning:

- Many adults who are not now participating in education are those who did not attend school or perform well in school when they were children. They are reluctant to return to the scene of former failures.
- Others face logistical barriers--workers and homemakers find the times, places, and instructional formats of much traditional post-secondary education incompatible with the demands of their daily lives.
- Because they have been out of the educational system for years, many adults lack even the most basic information on where to find educational opportunities suited to their needs and the financial assistance to pay for it.

Evidence from NCES data indicates that only about 28 percent of adults are in formal learning programs offered by schools. The vast majority learn in non-school based settings such as on the job, or in the church or community center. The initiatives in the new legislation and selected programs under current law seek to meet these very real needs. The new law would also expand educational provider eligibility, encouraging unions, senior centers, business and industry and others, as well as postsecondary institutions and States, to improve educational opportunity.

Summary - The Need for Appropriations

Fiscal Year 1981 will be an important year of activity and preparation for the Continuing Education, EIC, and State Planning programs--preparation for the new legislation currently under consideration. It seems certain the three programs will be consolidated and improved to focus more on the learning needs of unserved adults. The programs must not be halted on the very brink of this new and important initiative. With the economy on the edge of recession we must recognize the true economic value of postsecondary education for adults. We must avoid needless and harmful disruption of State and local networks which will continue to be utilized under the new law. Good programs such as those cited here and by other witnesses before you must not go down the drain. Appropriations in the amounts of $20 million for Continuing Education (Title I), $5 million for EIC's, and $5 million for State planning grants should be enacted for Fiscal Year 1981.

A Note About the College Board

The College Board, since its inception in 1900, has addressed problems relating to access and transition to education beyond high school and has been an advocate for equal opportunity to postsecondary education in the country. Through our Future Directions for a Learning Society (FDLS) program, funded by the Exxon Education Foundation, we have been conducting a number of efforts to project future trends of adult learning, to disseminate information on the needs of adult learners and providers which serve them, to promote improved public policy on adult learning, and to establish services to improve adult access and transitions.

Appended is a recently released report from FDLS titled The Federal Role in Lifelong Learning, written by Ellen Hoffman, former aide to then--Senator Mondale. This study sets forth clearly the arguments for a more sharply focused federal role in the area of adult learning and for federal funding of these programs.

Adult Learning Participation

This table shows the participation rate in "organized instruction" for adults 17 and older who are not full-time students in high school or college. Data are from the 1978 Triennial Survey which showed that 11.8 percent of adults were participants in organized learning activities. To highlight groups that are underrepresented in adult education, those with a participation rate of 11.0 or less are underlined.

	Participation Rate [1]
Age	
17-34	15.8
35-54	13.0
55 and older	4.4
Race	
Black	6.5
White	12.5
Hispanic	8.9
Other	13.0
Sex	
Male	10.8
Female	12.6
Education attainment	
0-11 years	3.4
High School (4 years)	11.2
College (1-3 years)	17.8
College (4 or more years)	26.8

	Participation Rate [1]
Income (dollars per year)	
0-4999	5.4
5000-7499	6.8
7500-9999	10.1
10,000-14,999	11.5
15,000-24,999	14.9
25,000 and over	17.7
Employment status	
Employed	15.2
Looking for work	11.0
Keeping House	8.0
Going to School	5.1
Other	3.1

[1] Participation rate is computed from the total population base on non-institutionalized adults, 17 years of age and over. In 1978, the total population base was 154,496,000.

Source: "To Users of NCES Adult Education Data," National Center for Education Statistics, Feb. 5, 1980. K . Patricia Cross, "A Critical Review of State and National Studies of the Needs and Interests of Adult Learners," paper presented at National Institute of Education conference, September, 1977.

STATEMENT OF NORMAN J. JOHNSON, COCHAIRPERSON, GOVERNMENTAL RELATIONS COMMITTEE, NATIONAL ASSOCIATION OF SCHOOLS OF PUBLIC AFFAIRS AND ADMINISTRATION

Mr. Chairman, we are grateful for this opportunity to appear before your subcommittee on behalf of the National Association of Schools of Public Affairs and Administration (NASPAA) to urge continued funding for public service education, under the provisions of Parts "A" and "C" of Title IX, Higher Education Act (HEA) of 1968, as amended.

At the outset, we would like to express our deep appreciation for the support your Committee has given this program in the past. Without it and the support of your counterpart committee on the House side, the program would never have gotten off the ground. Although the Executive Branch professes a deep interest in improving public management, it has always been the Congress which provided support for this modest investment in public management education. We deeply appreciate that support and urge you to continue it. It is particularly critical now when there is such an obvious need for rigorous and professional public management.

We think that we have some expertise to testify on this matter. NASPAA is a ten year old professional education association representing public service education programs in 220 colleges and universities in 46 states and the District of Columbia and approximately 25 governmental agencies and public interest groups. Our Association fosters goals and standards of excellence in education for the public service and cooperates with government and professional organizations, and national public interest groups to improve the quality of public management.

INTRODUCTION

We believe effective public service delivery is critical because popular government can survive only if it retains a high level of confidence and acceptability.

Citizens everywhere are demanding that government "deliver". Inflation, a weakened dollar, and unresolved energy issues contribute to a general sense of unease. The role of government, either as culprit or potential savior, is widely debated. In one sense, that debate is irrelevant: Whether loved or unloved, appreciated or castigated, the public sector is going to be called upon to provide a wide variety of services at local, state, national and international levels. Thus, we believe deeply that the education and training of public managers must be extremely sound and rigorous because as never before people are demanding service and competence - their money's worth. Such competence does not come about by

accident. It is not a commodity to be bought ready-made on short notice. It must be sought out, nurtured, and developed. The items we are supporting today were designed just for that purpose.

Since substantially all public service delivery problems involve a partnership of federal, state, and local governments, it is only reasonable to expect some specific federal support for public service education if we are to develop programs to meet our critical management needs. The only specific source of federal encouragement and support for public service education is Parts "A" and "C" of Title IX, of the Higher Education Act (HEA) for which we are asking continued funding at the $4.0 million level for 1981.

FELLOWSHIP SUPPORT

Part "C" of this Act is designed to finance graduate fellowships for students who specifically plan and commit themselves to public management careers.

We believe that adequate and specific - categorical - federal fellowship support is crucial if we are to attract top students into public management education programs.

Students who consider careers in public management also consider careers in private management or other fields where long-term financial rewards are much greater than in the public sector. If schools of public administration and management are to gain a share of the very best students, they need to offer as much financial aid as is available in alternative programs. Few of our public administration programs can compete with the private sources of scholarship aid available to schools that train managers for the private sector. The federal government can make an important contribution by making this modest effort under Part "C" to attract the most accomplished students of all backgrounds into the public service.

While we are pleased that the Administration has developed a new Graduate and Professional Opportunities Program under Part "B" of Title IX of the HEA, we do not believe that program is substitutable for Parts "A" and "C". That program, the Graduate and Professional Opportunities Program is designed for all professions with special emphasis on education for the doctoral degree, while Parts "A" and "C" are specifically designed to meet a specific national need better public management education.

If we are correct in our assumption that popular government will survive only so long as it retains a high level of confidence and acceptability, it would be a tragic mistake to limit career opportunities in public service management

only to those who can personally afford it or to those who lose out in the competition in other professional fields. We believe that our public management needs are so critical that public service management education needs to be specifically and categorically available to highly qualified persons who are willing to make a commitment to a professional career in the public service. We believe there is need to provide specific developmental and fellowship assistance at that master's degree level for outstanding students aspiring to careers in public management. Part "B" does not do this. This is the reason we believe so strongly that Parts "A" and "C" must be specifically funded.

Improving educational opportunities for minorities and women. We certainly recognize the necessity of making this categorical public administration education support available to all qualified and committed students and we believe that our record on that score is outstanding. Many of our member institutions have used these funds to conduct recruiting and educational efforts which have brought minorities and women into the mainstream of public management. We have succeeded in these efforts.

Our record in this regard is good. It indicates that the number of Blacks, Hispanics and other minorities awarded public service fellowships through this program exceeds the percentage of Blacks, Hispanics, and other minorities in

- the general population by 87%
- graduate school enrollment generally by 150%
- our own NASPAA enrollments by 20%

With regard to women, the record is as follows:

Women in U.S. population (1977)	51.4%
Women enrolled in graduate schools (1977)	45.0%
Women enrolled in NASPAA program (1977)	22.0%
Women enrolled as Title IX Fellows	48.0%

Thus, we contend that our member institutions have done very well in emphasizing affirmative action in their recruitment, particularly since the fellowship awards have historically been announced so late in the year that effective recruitment has been difficult.

STRENGTHENING PUBLIC MANAGEMENT EDUCATION PROGRAMS

Under Part "A" of this Act, a number of university-based programs are seeking to strengthen the nation's system of public management. The results are encouraging and the promise of continued improvement real. These programs are mainly supported

by state and private funds. But a modest investment of federal funds has forged a federal partnership in education for improved public management and has allowed these programs to press some initiatives they would otherwise have been unable to take.

The educational initiatives being taken by those programs, as a result of this federal contribution, are directed toward four main goals:

1. Improving service delivery.
2. Strengthening financial management.
3. Improving intergovernmental relations.
4. Strengthening program development and evaluation in areas of critical national need, such as energy, environment, etc.

These goals run through a series of changes in programs for the training of able people who are attracted to careers in government, for the training of those who are already engaged in governmental careers, and for the development of improved practices of program management that can be used by government.

Improving service delivery. No aspect of the public's business is in more need of improved management than the human and social service delivery programs that have vastly expanded in recent years. These inherently require a partnership of several levels of government, and are the target of so much criticism about government expenditure and performance. A number of innovations introduced with funding from the Education for Public Service Program has sought to improve the management of service delivery by government.

The Graduate School of Administration at the Riverside campus of the University of California has used its grants to develop a program in the measurement and improvement of productivity in local governments. Students in the program have combined intensive course work on the background of the problem (including some units developed with federal funding) with field experience in San Diego and several local jurisdictions. Three, for example, helped to implement a Total Performance Measurement System as a first step toward a continuing and institutionalized means of improving the productivity of local government programs in Long Beach. The experience has profoundly influenced career goals, as well as directly assisted the efforts of selected governments to enhance the management of service delivery.

Efforts supported by the Education for Public Service Program to focus training on the management of service delivery have in some cases helped to shape the

training goals of related fields. For example, the Human/Social Service Administration Project mounted by the Institute of Government at the University of Georgia has heightened interest at Georgia in developing a joint master's program in public administration and social work to expose a somewhat different set of professionals to the means of improving the management of government service delivery programs.

Strengthening financial management. In an era of tightened resources at all levels of government and of fiscal crisis for many of our cities, a number of the developments made possible by the Education for Public Service grants have sought to give those who are entering or pursuing careers in government a stronger grasp of the tools of financial management. For example, the public administration faculty at the University of Georgia has used its institutional grants to create a budget simulation laboratory to increase the skill of students in developing and analyzing local government budgets. People with broad experience in public budgeting prepared the laboratory manuals and conducted the simulation exercises that closely paralleled many of the decision situations students would face in a government setting. Student and faculty response to this innovation has been outstanding. Far more effective financial managers are going on to careers in government, and other educational institutions have shown a keen interest in this approach.

Princeton's Center for New Jersey Affairs, established by the Woodrow Wilson School with its grants under the Education for Public Service Programs, has made an intensive effort to equip those who are entering a career in state and local government with the tools of financial management and to help to alleviate the severe fiscal problems of the state. The Treasurer of the State of New Jersey, himself a graduate of the School, who was appointed at the start of the administration of the current governor, has assisted this effort by teaching state and local finance in the School. He has undertaken an analysis of "fiscal federalism" as a Senior Fellow in the Center after completing a fundamental reform of the state tax system and the fiscal relationship of state and local government in New Jersey. Fiscal problems are at the core of a public management workshop taught in the Center by a former governor of the state. In addition, the Center has established a clearinghouse for the sharing of financial information among the budget officers of the principal cities of the state, and it has launched a basic study of the capital market for housing in the declining urban areas of New Jersey and a number of other states.

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Improving intergovernmental relations. Coordinating the efforts of government at the different levels of the federal system has guided the changes in several programs. For example, the University of Southern California's School of Public administration is using its Education for Public Service funds to pioneer an internship program that gives those who are entering or pursuing careers in government a deeper understanding of the problems of service delivery programs at all three levels of government — federal, state, and local. For this purpose, the School has established an intergovernmental network of campuses for education in public management, including its home campus in the City of Los Angeles and a Sacramento Center oriented toward the state government. This revolving structure provides the base for a master's program in Intergovernmental Management, in which students take a semester of course-work and internship at each of the three campuses. With service delivery programs increasingly involving a partnership of the federal government with state and local government, this experience gives a remarkable comparative view of the problems of mounting and managing such programs from the perspective of all three of these levels of government.

The school's grant under Part "A" of Title IX HEA have allowed the faculty and administration to undertake the significant added effort of curriculum development, intern placement, and intercampus coordination that the Intergovernmental Management Master's Program requires. The comparative experience offered by the program has had a strong influence on its students, with a marked carryover to their career experience.

Strengthening the development and evaluation of programs in areas of critical national need. Other innovations in university-based programs induced by the Education for Public Service Program grants have centered on the management of programs in critical policy or problem areas. These are typified by examples from energy and the environment. The Public Administration Division of the University of New Mexico used its institutional grants to establish a program in Energy Management to respond to a rising demand from state and federal agencies for professionals trained in the management of energy programs. Rich in uranium, coal, and natural gas, New Mexico was keenly aware of the need for public managers with a background in energy technology. Federal funding acted as a catalyst for faculty from several fields to develop an energy management track in the master's program in public administration. Those who have earned the new Certificate in

Energy Management have taken significant state and federal positions in the management of energy related programs.

The public administration program of the University of West Florida extended its educational emphasis on Coastal Zone Management. This effort has a significance reaching beyond Florida, since a substantial fraction of the nation lives in fragile coastal zones presenting common management problems. The Education for Public Service Program grants permitted the program to forge an effective, interdisciplinary track in Coastal Zone Management which was recognized by the higher education authorities of the state as the "program of national distinction" on the University campus. The demand for its graduates has led the public administration program to join a new track in Energy Management and one in Soil and Water Management to the original emphasis on Coastal Zone Management.

CONCLUSION

Strengthening the educational basis for the nation's public management is a task that must involve a partnership of the federal government with the states and localities. The national government has a clear stake in attracting into its own departments and agencies gifted individuals who are specifically trained for and committed to public management. The national government has an equally strong stake in the development of high calibre young managers at the state and local level because state and local agencies administer so many nationally funded programs. The case for a federal partnership in strengthening this educational base is enhanced by the fact that many of those who are trained for careers in public management will move geographically between states and "intergovernmentally" between the several levels of the federal system.

Members of Congress have recognized the need for this partnership since 1975, when they appropriated a modest $4.0 million to finance this program in the face of Administration opposition. You have shown your commitment by continued funding at that level, generally in the face of Administration neglect or opposition.

Once again, no funding has been recommended for either of these programs in the FY 1981 budget. This omission strikes us as highly inconsistent in view of the President's constant pledges to improve government management and public service delivery, and of the public's deep concern about the state of government management and service delivery.

The record on all counts justifies support - the program has improved public management education and the evidence certainly indicates that it has been administered in a just, effective and prudent manner.

So once again, we are here asking you to continue funding for Parts "A" and "C" of Title IX of the HEA at the same level in FY 1981 as in 1980 - $4.0 million. This amount is inadequate, but we recognize that you are faced again with particularly stringent budget problems. We sincerely believe, however, that this is a long-term investment you cannot afford to neglect.

STATEMENT OF CARROLL M. HUTTON, DIRECTOR, DEPARTMENT OF EDUCATION, INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE, AND AGRICULTURAL IMPLEMENT WORKERS OF AMERICA

Thank you for the opportunity to present our views on "Higher and Continuing Education." For forty-five years, since the founding convention of our union, we have actively supported a wide range of public education programs including higher and continuing education.

The American Labor Movement, of course, has long supported the cause of increased educational opportunities. As early as 1828, working men's parties were demanding free tax supported schools. Since then, organized labor has continued to support public education by word, by resolution, and by action. Today, formal education has become a primary state function, and has helped make our society more democratic and more just. Education today has become the major route to social mobility.

Unfortunately, the benefits of education have not been accessible to all our citizens. Historically, educational programs have served the young who could devote their full time and attention to the pursuit of an education. Those who have been unable to follow this route have frequently found themselves denied access to further education, and thus barred from many occupational opportunities. Many disadvantaged adults today are now serving lifetime sentences of low income and unemployment because they were unable to take advantage of educational opportunities when they were young.

The need for increased educational opportunities for these disadvantaged adults is even more compelling because of the changes occurring in American society. The nature and pace of economic, technological and social change require access to lifelong learning for all our citizens, but especially for those disadvantaged adults who have been historically underserved by our educational system.

Organized labor, representing over 22 million members--80 million people if we include the families of union members, has long been concerned with reducing the many barriers to educational opportunity that affect many of our members. Many unions, for example, have negotiated tuition refund benefits for their members to help defray the high cost of education. Most UAW members are now entitled to $1,000 a year in tuition refund benefits. Today, there are more than one million UAW members who have this benefit--potentially worth more than $1 billion a year. Nationwide, negotiated tuition aid benefits cover workers under 198 different plans--with the numbers covered by such contract clauses multiplying each year.

Education and training within industry and labor is a large but still poorly comprehended role that industry and labor play in worker education. Many people in training industry argue that in terms of outlay levels and learner population served, it is equal to or surpassing public education levels. Outlay estimates have been given by some to reach $100 billion. There are also estimates that between 61 percent and 88 percent of the 600 largest corporations offer education and training programs.

In the UAW, we believe that in future bargaining we will further improve our tuition refund program. We look forward, as well, to winning paid educational leave for our members. In Canada, as of January 1, 1980, 254 UAW collective bargaining agreements covering 112,646 members have paid educational leave provisions. We expect to gain similar provisions for our members in the United States. We look forward to the day when all workers will have the right to paid educational leave.

We have learned, however, that more is required than to win tuition refund benefits. This is reflected in the fact that less than four percent of the workers covered take advantage of these benefits. Much more needs to be done if we are to insure the promise which these benefits represent.

Certainly our colleges and universities must develop new and innovative programs which take into account the special needs and lifestyles of workers. This is especially true of our urban institutions. It is our urban areas, after all, where most of our members and their families live and work.

In Detroit, we have worked closely with Wayne State University in the development of a program specially designed to meet the educational needs of workers. This program, University Studies and Weekend

College, is currently serving over 1,500 working adults--most of them union members, and with an average age of 37.

There are, I think, three important features to this program: its delivery system, its curriculum, and its approach to student services. The delivery system enables workers to earn their bachelor's degree through a combination of TV courses, once-a-week workshops, and weekend conferences. The TV courses are shown at a variety of times so that workers can watch them at home, at their convenience. The workshops meet once a week at times and locations as convenient as possible for the students. At our UAW locals, for example, classes are scheduled around shift changes.

The curriculum takes a problem-oriented, interdisciplinary approach to issues directly relevant to the lives of working people. The social science curriculum, for example, is organized around such issues as culture, community and identity, work and labor, and conflict and social change.

Especially important to the success of this program has been its approach to student services. Counselors from the University work closely with local union officers to hold orientation and registration sessions right at the locals. Workers, then, are admitted to the university and registered for classes in their own union halls. Usually, they take their classes there as well.

The success of this program has demonstrated that it is possible to overcome many of the obstacles that have traditionally denied workers access to higher education. We hope for similar results from our demonstration project with the College Board. With support from the U. S. Office of Career Education, we are attempting to see if the Swedish concept of "study organizer" can be adapted to the American setting. In Sweden, these union education recruiters/counselors have been extremely successful in increasing worker participation in adult education and training programs. We anticipate similar results in our experiment at Hagerstown, Maryland. Clearly, we need to support imaginative demonstration projects which will address the many barriers which have traditionally denied workers (and others) equal educational opportunities.

The need for increased educational opportunities for workers is paralleled by the need for expanded opportunities in labor education. Many of the changes which have made lifelong learning imperative for our entire society have placed new and increased demands on union leadership. The complexity of contract language today places an ever increasing burden of responsibility upon the shop steward, committeeperson and local union officer charged with making the contract work. The edu-

cation and training required for effective local union leadership has become an awesome challenge for all unions.

UAW President Douglas A. Fraser described the problem in this way:

> "The role of a union leader is an enormously complicated and responsible one. It requires a deep understanding of the philosophy and the nature of the organized labor movement. And it requires knowledge and training in a great many fields.
>
> "In today's complex bargaining, a union leader needs at least a working knowledge of time study and job evaluation; of pension, health, and welfare plans, of economic data and how to interpret it; of preparing cases for arbitration. The leader needs to know something about labor law and its administration, and about the operation of government agencies with which he or she must deal. The leader should be trained in organizing techniques, and in ways to teaching groups of workers who have traditionally considered themselves outside the labor movement.
>
> "Union leaders need a thorough understanding of the operation and the politics of their democratic union, and of the necessity for actions taken by the union. As important as technical training and the so-called tool subjects are, they alone are not enough. There is a need for broader programs to develop greater understanding of how labor unions relate to the rest of our society, and of the trends which are working in that society. Technical proficiency alone is not enough."

Especially important is the need to provide leadership training for women and minority members who are becoming an increasing part of the trade union membership. In Michigan, with Title I assistance, we have been able to develop a statewide leadership training program for union minorities and women. Operated by a consortium of six Michigan universities and Michigan labor organizations, we hope this will serve as a model for other states as well.

Our experience in Michigan has confirmed the need for federal legislation supporting the expansion of labor education, training and technical assistance programs. As society grows more complex, the new generation of labor leaders must be educationally equipped to deal with the complexities of modern society and the increasing intricacy of trade union organization and administration.

Unfortunately, the expansion of labor education in the last decades has been small compared to rural extension programs and business education. This has been especially true in those "right-to-work" states where powerful interest groups have long opposed the right of workers to organize for decent wages and safe working conditions. Not surprisingly, labor education services have been meager or non-existent in these states. As recently as 1978, the University of North Carolina was forced to cancel its plans for a labor education center because of opposition from groups opposed to the very existence of unions. Sadly, the rich promise of the Morrill Land Grant College Act of 1862 has remained just that when it comes to the educational needs of workers and their labor organizations.

Almost 200 years ago coal miners, weavers, and the earliest metal workers met in their Sunday schools in England to learn to read and write and count, so they could read the Bible to find their way to God and organize unions to find their way to economic justice. This concept was brought to our country.

Today, we must extend that education concept so we can make science and technology, and our vast industrial structures help us move into a democratic society where all the people, fully informed, with complete access to the entire culture, have equal voices in present political decisions, so that we have an equal opportunity to share in the future, its material benefits, its spiritual rewards, and its educational and cultural richness.

The Federal Government is on record in support of lifelong learning as a concept and as the right of every American. It is time to make this a right as well for those disadvantaged adults who have been prevented from obtaining equal educational opportunities. In the words of Vice President Walter Mondale,

> "... we must now return to the job of providing greater access to learning for all Americans, regardless of age or social and economic position."

Thank you.

RECOMMENDATIONS FOR HIGHER AND CONTINUING EDUCATION

(1) Increased educational opportunities.

(2) Make benefits of education more accessible to all our citizens.

(3) Education today has become the major route to social mobility, this avenue should be greater expanded.

(4) Those who have been unable to follow this route have frequently found themselves denied access to further education and thus are barred from many occupational opportunities.

(5) The nature and pace of economic technological and social change require access to lifelong learning for all our citizens, but especially for those disadvantaged adults who have been historically underserved by our educational system.

(6) Support the concept of paid educational leave provisions.

(7) Colleges and universities must develop new and innovative programs which take into account the special needs and lifestyles of workers.

(8) Recommend curriculums that take a problem-oriented, interdisciplinary approach to issues directly relevant to the lives of working people.

(9) Counselors from the University to work closely with local union officers to hold counseling, orientation and registration sessions right at the locals.

(10) Promote the use of the concept of "study organizer" (on-the-job counselors).

(11) Greatly expanded opportunities in labor education.

(12) The need to provide and expand community and trade union leadership training for women and minority members.

(13) We must extend these education concepts so we can make science and technology, and our vast industrial structures help us move into a democratic society where all the people, fully informed, with complete access to the entire culture, have equal voices in present political decisions.

COMMUNITY EDUCATION, WEST VIRGINIA

Mr. KEE. I am Jim Kee, director of community education for the State of West Virginia. I am very pleased to be here before your committee. We are seeking increased funding for the Community Schools and Community Education Act of 1978, Public Law 95-561.

It's my privilege to speak for the National Council of State Education and Community Educators, and the 45 other State directorates, including Washington, D.C.

COMMUNITY SCHOOLS AND EDUCATION ACT

Community education has expanded greatly in West Virginia over the past 5 years since the enactment of the first law in 1974—30 of our 55 counties are designated as community school systems.

Facility utilizations are increased from 30 counties in 1975—30 schools in 1975—to 350 community schools today. Of our 1,197 schools, 800 of them are using their schools beyond the normal days for citizen participation.

In West Virginia, our schools are opening their doors, serving the total community, and are assisting local citizens in resolving their needs and solving their problems. The result is involvement of more citizens. We had 620,000 involved last year.

We, in West Virginia, have a small State. We have greatly increased public support for our public education, and decreased vandalism in our schools. The dropout rate is beginning to decrease. This is also evident in the other 45 States and the District of Columbia, where a person is charged with community education responsibilities.

With the help of the Community Act of 1974, a tremendous amount of money, millions of dollars, has been generated by a very small grant. At the local level, the U.S. Office of Education had an evaluation conducted in 1978 by the Developmental Associates of Arlington, Va., and the results demonstrated that the community education program had resulted in increased utilization of school facilities, interage coordination and cooperation, and increased support for public schools.

I think the findings of that national evaluation justify a greater involvement by the Federal Government in the development of community education.

The Congress is to be commended for passing the comprehensive Community Education Act in 1978, but it can't be implemented with only the $3.138 million President Carter recommended.

Each section of the bill is important, but the most important component is section 804, the State programs for community education.

COMMUNITY EDUCATION STATE PROGRAM FUNDING

Our group, the National Council of State Educators and the National Community Education Association, is recommending $20 million for the State program. Now, that is only one-third of what Congress originally felt would be necessary to implement the program.

This isn't something you will have to continue indefinitely. We feel that in 2 or 3 years, with the sunset law, community education can become totally self-sufficient, without any Federal support whatsoever.

I think States are in a much better position to determine who should be funded locally than the Federal Government. I think we would all agree. The State can provide more continuous and meaningful guidance, I think, in funding programs.

Consider what can be accomplished, I think, in the future. A major portion of school vandalism can be eliminated. Interage coordination will take place. Taxpayers dollars will be saved. As for the energy situation, we need facilities for localized service, where 85 percent of our people can walk to some school or facility.

I thank you for hearing this request. I think all people would benefit greatly from this situation, if it could be done. I feel like Don Quixote, though, fighting windmills.

[The statement follows:]

STATEMENT OF JAMES R. KEE

I am James Kee, Director of Community Education for the West Virginia State Department of Education, and I am pleased to come before your Subcommittee today seeking increased funding for the Community Schools and Community Education Act of 1978 (PL95-561). It is my privilege to speak for the National Council of State Education Agency Community Educators (NCSEACE) and the forty-five (45) other State Directors of Community Education.

It is indeed a pleasure for me to testify today since my Senator, the Honorable Robert Byrd, is a member of this very important Subcommittee.

Through the efforts of the West Virginia State Department of Education, Community Education has expanded greatly in my State. Thirty (30) school districts out of fifty-five (55) are designated as Community Education School Systems and 350 schools are being utilized fully by their communities.

A recent National Institute of Education Study found that the cost of school vandalism runs about $200 million annually and that more acts of vandalism occur during non-school hours. As a result of Community Education Programs in West Virginia, vandalism to our schools has decreased greatly. We all know that school buildings represent one of the biggest public investments in this country. Today in West Virginia 350 community schools open their doors to serve the total community, preschool through senior citizens, and assist local community members in resolving their own needs. As a result, they dramatically increase the usage of such buildings, and make public tax support of schools a much better investment.

In West Virginia, Community Education has also had an effect on decreasing high school dropouts and juvenile crime rate. This has been accomplished by getting the young people involved in the community school activities and through an increased support for youth and service organizations by the adult community members.

This is not just here in my state but a majority of our states. Presently, forty-five (45) state education agencies (SEAs), including D.C., have a person charged with Community Education responsibilities.

Five (5) state education agencies are considering or in the process of developing State Community Education Legislation, twelve (12) states have passed legislation supporting Community Education, and thirteen (13) state education agencies are providing State funds to local education agencies for Community Education Programs. This progress within the states has been due to the Federal funding for Community Education. These Federal dollars have generated millions of State and local dollars for Community Education. Before the advent of Federal

funding there were only twelve (12) state education agencies involved in Community Education.

Because of the Federal dollars, the state education agency has been responsible for implementing Community Education at the local level. The Federal involvement in Community Education has been very successful. The Community Schools Act of 1974 was evaluated by Developmental Associates of Arlington, Virginia. This independent firm stated that the results of the evaluation were overwhelmingly positive. The study found that:

- At the local level, the project's results included increased use of school facilities, increased inter-agency coordination, increased citizen participation in school and other public agency decision-making, and increased community support for schools.

These conclusions were reached as a result of interviews with randomly selected individuals directly involved in the projects.

A sampling of school principals and teachers resulted in 85% reporting that their buildings were open more for community use. Moreover, 77% stated that there were improvements in the types of cooperation and communication between their school and other agencies because of project activities.

With regard to the impact of Community Education on interagency cooperation, 78% of the staff from community agencies said that the community school project staff had facilitated an interagency network of services and 56% described positive changes in interagency cooperation and coordination which were attributable primarily or entirely to Community Education project staff.

The sentiments of lay citizens were equally positive. For example, 68% of the chairpersons of project advisory councils reported increased community involvement in project schools because of Community Education.

Thus, the findings justify greater involvement by the Federal government in developing Community Education throughout the country.

You are to be commended for passing the Community Schools and Comprehensive Community Education Act in 1978. This excellent legislation can not be implemented with only the $3,138,000 recommended by President Carter for 1981.

Although each section of the bill is important if the legislation is to fully meet its stated objectives, the most important component is Section 804: State Programs for Community Education. The National Council of State Education Community Educators and the National Community Education Association recommend $20,000,000 for the state program. Provided as Appendix A is a breakdown of the amount each state would receive if this section were funded at the level of $20,000,000.

The role of the State Education Agency is critical if Community Education is to continue to expand in the years ahead. The states that have experienced the most successful development are those where the State Education Agency has taken an active role in terms of providing developmental and technical assistance. Eighty percent of the funds received by the State Education Agency under this legislation would flow to local education agencies. There is little question that the states are in a much better position than the Federal government to determine who should be funded. Of equal importance, the State Education Agency can provide more continuous and meaningful assistance to funded projects.

It has been determined that a small amount of Federal seed money is necessary to start Community Education at the local level. With these Federal dollars school buildings can remain open, learning can take place for all ages, a major portion of school vandalism will be eliminated, interagency coordination will take place, increased citizen participation will occur and this will result in increased community support for public education.

Mr. Chairman, it is with a sense of urgency that I have appeared before you today requesting $20,000,000 for Section 804 of the Community Education Act. I thank you for hearing this request. Should it be granted, the beneficiaries will be millions of individuals of all ages involved in their public schools.

Appendix A

BENEFITS TO STATES UNDER THE ALLOCATION FORMULA SECTION 804
"STATE PROGRAMS FOR COMMUNITY SCHOOLS & COMPREHENSIVE
COMMUNITY EDUCATION ACT OF 1978"

Sec. 804 - 1981 Authorization level - $60,000,000
Sec. 804 - 1981 Appropriations level proposed by NCSEACE - $20,000,000
(Dollars in thousands)

	State	Proposed 1981 Appropriation
1.	Alabama	343.500
2.	Alaska	62.500
3.	Arizona	231.000
4.	Arkansas	212.500
5.	California	1,900.000
6.	Colorado	250.000
7.	Connecticut	306.000
8.	Delaware	81.000
9.	District of Columbia	81.000
10.	Florida	756.500
11.	Georgia	456.000
12.	Hawaii	100.000
13.	Idaho	100.000
14.	Illinois	1,000.000
15.	Indiana	493.500
16.	Iowa	268.500
17.	Kansas	231.000
18.	Kentucky	325.000
19.	Louisiana	362.500
20.	Maine	118.500
21.	Maryland	381.000
22.	Massachusetts	531.000
23.	Michigan	812.500
24.	Minnesota	362.500
25.	Mississippi	231.000
26.	Missouri	437.500
27.	Montana	81.000
28.	Nebraska	156.000
29.	Nevada	81.000
30.	New Hampshire	100.000
31.	New Jersey	662.500
32.	New Mexico	118.500
33.	New York	1,600.000
34.	North Carolina	493.500
35.	North Dakota	81.000
36.	Ohio	962.500
37.	Oklahoma	268.500
38.	Oregon	231.000
39.	Pennsylvania	1,056.000
40.	Rhode Island	100.000
41.	South Carolina	268.500
42.	South Dakota	81.000
43.	Tennessee	400.000
44.	Texas	1,112.500
45.	Utah	137.500
46.	Vermont	62.500
47.	Virginia	456.000
48.	Washington	343.500
49.	West Virginia	175.000
50.	Wisconsin	418.500
51.	Wyoming	62.500

Senator WEICKER. I don't know. Again, I consider all the panels here to some extent share that feeling under the limit of the day.

On the other hand, these things are worth fighting for. But they have to be fought for.

I suppose I am in the greatest dichotomy of all. I have a State with the highest per capita funding for defense projects, and probably the highest amount of money spent in terms of the educational institutions of the State of Connecticut.

I think the time has come for the country to understand, and I made this point time and again in the year past, the great strength of this Nation is its people.

You can't buy our security in weapons systems alone. They won't give us the strength we need. If anybody wants a historical example that certainly should stick in everybody's mind being of recent vintage, the Shah of Iran's army was the finest money could buy. It lasted 2 hours.

I am very serious. I am going from this area now to the Defense Subcommittee hearings. All these endeavors you are engaged upon, you should be proud of what you are doing. You are right. But you have to fight for these things. I think that is what hasn't happened in these areas. Not just this year, but for the last several years. Political activism can be exercised for a very positive cause. That should be the case here. But it has to take place.

I thank you all very much. Your statements will be included in entirety in the record.

[CLERK'S NOTE.—Testimony submitted for the record relevant to the programs and issues discussed during the morning hearing on Wednesday, March 12, 1980, follow:]

LETTER FROM CHILD DEVELOPMENT CENTERS

February 29, 1980

Senator Walter Huddleston
2121 Dirkson Senate Office Building
Washington, D. C. 20510

Dear Senator Huddleston:

As a group of citizens deeply committed to meeting the special needs of persons with handicapping conditions, we urge you to support full funding of the proposed FY'81 budget for the Bureau of Education for the Handicapped. While we recognize the need to eliminate unnecessary federal spending, we firmly believe that funds must be appropriated to adequately support educational programs and related services for handicapped children and youth.

We are especially concerned that funds for programs such as arts, leisure education and camping, described as "related services" in P.L. 94-142, be made available. These services are absolutely vital if the handicapped are to be afforded an opportunity for a quality life. The Bureau of Education for the Handicapped is to be commended for its past support of such programs and should be encouraged to continue support of these activities in the future.

A recently completed project funded by the Bureau of Education for the Handicapped at the University of Kentucky has resulted in comprehensive series of materials for training personnel to meet the special needs of handicapped children in organized camping programs. These materials have been endorsed and published by the American Camping Association which is using them to train camp personnel throughout the nation. We commend and support this effort and are convinced that it will result in new opportunities for the handicapped to participate in camping programs with their non-handicapped peers, a right to which all handicapped children are entitled.

During recent years, many camping programs for the handicapped in Kentucky have been cut back or eliminated because of inadequate funding. This is indeed unfortunate because our experience has convinced us that camping is an activity in which the handicapped find great joy and derive untold benefits. We also believe that camping is a learning experience as well as a constructive recreational pursuit.

From the many comments given to me by parents of preschool children in our camping program I am enthusiastically in favor of funding for direct services in recreation and camping as well as in the arts, in addition to the research program which has produced so many excellent materials that are of practical use to those of us working directly with children. Some of these parents and some Board members have joined me in writing this letter.

Finally, we would appreciate this letter being incorporated into the record for the FY'81 appropriation hearings. Thank you very much for your consideration and support.

Sincerely yours,

Rhea A. Taylor

Mrs. Rhea A. Taylor, M.A., A.C.S.W.
Executive Director

cc: Senator Wendell Ford

Mr. & Mrs. Howard R Sullivan
(We sincerely hope that you will help with the needs of handicapped children through the BEH program. We are parents of a handicapped child and this is very important for his future)

Please Support the B.E. It has been my observation that one of the outstanding deficiencies among many of our mountain people is learning how to enjoy recreation of all kinds, from the arts,

& Nature, to camping & Outdoor Programs aimed
at correcting his body will improve his physical
& mental health as the people served.

Mr & Mrs Roy D Durham
As parents of a handicapped child, we would appre-
ciate your help in the BEH program.

Mr & Mrs Earl Carraway - We appreciate your help to support the
BEH Bill. It will be a great opportunity for our Son to
[illegible] camping at the camp of Enchantment

Mr. and Mrs. Ronnie Dale Rose
Your support for BEH program and be greatly appreciated
it will give a handicap child the opportunity to experience
a different environment and atmosphere that broadens their
knowledge, and it will also encourage independence.

Mr & Mrs. Mark Jackson - We would greatly appreciate your
support for the B.E.H. program. As the parents of a handicapped
child you would like him to experience everything that
any other child would have the opportunity to experience.
Mr. & Mrs. Laurence Seccia - Please support the
BEH program. It is an important program for handicap
Children, in order to experience and learn other aspects
of living they are not normally involved in to
become a well rounded person. Our handicap
daughter would enjoy these benefits very much.
Mr & Mrs Thomas Gaud - Please don't cut funding
on our handicapped children. These children are only
now getting the experiences "normal" children have
always had. Our Children learn so much from
camping experiences and it helps them in so many
ways. Please please - let them continue to learn

Statement of the Hispanic Higher Education Coalition

The Hispanic Higher Education Coalition (HHEC) recommends the FY 1980 supplemental appropriations and FY 1981 appropriations summarized in the following table. Justifications for each program follow the table.

	1979	1980	Proposal Supplement	1981 Recommendation	HHEC Recommendation
Census Analysis	-	-	-	1,000	2,500
TRIO	140,000	147,500	3,000	159,500	185,000
(Talent Search of TRIO)	15,300	15,300	3,000	15,300	18,300
GPOP	8,000	8,850	4,100	13,000	18,000
CLEO	1,000	1,000	-	2,500	3,500
Bilingual Education	158,600	166,963	-	192,000	232,000
Biomedical Sciences	-	3,000	-	3,000	4,000

Note: All dollar figures are in thousands

Census Analysis

The HHEC has recommended a $1.5 million increase in the census program aimed at producing data by school district. Such a program is crucial for equitable distributions of ESEA Title I funds, technical assistance activities of states, and educational policy analysis. The president's request of $1 million will not allow for the project to be completed in FY 1981 as originally scheduled; it will not be before FY 1983 before results are available if $2.5 million are not appropriated now.

TRIO (Talent Search)

The HHEC recommends a FY 1980 supplement of $3 million to TRIO to be earmarked for Talent Search. The increasing complexity of the financial aid process, especially for Basic Grants, has made Talent Search a priority. Yet current funds are enough to serve only between two and three percent of the eligible youth. In addition, the HHEC recommends an additional $3 million for FY 1981. The sums would increase the number of youths served in FY 1980 from 76,500 to 91,500 and in FY 1981 to 101,500. Overall under TRIO, the HHEC recommends adding $25.5 million to the President's FY 1981 request. Applications to the Special Services program have increased 15 percent over the previous year in each of the last three years. In view of the favorable evaluation of the Upward Bound program given by the Research Triangle Institute and the announced intention to divert some Upward Bound funds to a Special Emphasis program, increased funding seems appropriate.

Graduate and Professional Opportunities Program (GPOP)

The continution fellowships from the first two years require continuing support, and have only allowed 211 new fellowships for FY 1980-81; this supplement would allow full funding for a total of 1200 fellowships.

CLEO (Grants to increase minority access to legal education)

The statutory ceiling ($1 million) has been removed in both the House and Senate bills. This increase will allow the stipends to rise from $1000, and will allow new summer sites to be developed.

Bilingual Education

Materials Development:

It is strongly urged that the monies currently slotted to be appropriated for the network of Title VII materials development (MDCs) and evaluation dissemination assessment centers be increased by $7 million over and above the Administration's request of $8 million, to meet the projected cost for distribution and development for FY-81. This increase will impact markedly on the numbers and types of materials developed (especially for small language and historically underserved populations) that could be made available to those eligible beneficiaries of Title VII funds. FY-80 grants to the network of centers averaged $570,000 per center, providing services to 42 states, Alaska, Hawaii, Puerto Rico, the Virgin Islands, and the Trust Territories. Similarly, the increase will bolster the capability of the network of centers to provide adequate technical assistance to the increasing service areas.

Part C - Research:

Bilingual Education is currently at a stage where answers to problems concerning rates of second language acquisition, cognitive achievement and cumulative effect data, are currently resting on a weak empirical data base. While the Federal role in remedying this unmet need has been forthcoming, Congressional pressure and mandates to conduct a variety of research efforts have not been followed by comparable appropriation of funds. It is recommended that the amount of funds for Part C research in Bilingual be increased $2 million above the administration's mark of $6 million.

Training Grants:

Increased provisions of funds to the training for its category, ($10 million) will ensure the increased availability and continued quality of a bilingual professional pool, made necessary by the increasing numbers of Title VII eligible populations.

ESAA Bilingual Desegregation Assistance Programs:

The ESAA Bilingual Desegregation Assistance Programs (P.L. 92-318, formerly administered by EEOP) are awards granted to school district (under a court order to desegregate) which have students who require bilingual instruction. Currently funded as non-competing continuation projects, there are 19 projects in 5 states:

3	California	$3.18 million
3	Florida	$1.66 million
2	Los Angeles	$ 400 thousand
1	New York	$ 506 thousand
10	Texas	$2.846 million

Increased funding will encourage an expansion of the program to a greater number of systems and states with large LEP popu-

lations (i.e., Illinois, Michigan, Massachusetts) not currently recipients of ESAA Bilingual Program Assistance.

Basic

It is currently estimated that there are approximately 3.4 million children (ages 4-18) who are of Limited English Proficiency (LEP). Three million dollars requested increase ($130 million as compared to the Administration mark of $127 million) will add to the Basic coffers (calculating at the lowest FY-81 average cost per pupil of $375.00) funds for approximately 90,000 additional students.

Biomedical Sciences Program

Many people suffer from inadequate health care in this country because of few accessible physicians. Studies have shown that the persons most likely to go into practice in disadvantaged areas are those who come from these areas themselves. These are minority and low-income persons, but they are underrepresented in biomedical sciences.

Low high school achievement scores and few bachelor's and master's degrees in the sciences prevent Hispanics from entering the biomedical professions. Hispanic 17-year olds score eleven percentage points below the mean achievement score in sciences and fourteen points below the mean score in mathematics. These scores are lower than those for blacks and whites. On the U.S. Mainland, of the total Hispanic undergraduate enrollment, only 2.2% are enrolled in biological sciences, and of their total bachelor's degrees awarded, only 5% are in these fields. Of the total Hispanic graduate enrollment only 2.4% are in biological sciences, and they take only 1% of their master's degrees in these fields.

These data indicate that Hispanics are not likely to be employed in the health and medical professions; thus, many disadvantaged areas will continue to suffer from inadequate health care. Hispanic students would benefit greatly from this program. An appropriation of $4,000,000 for fiscal year 1981 would allow more projects to be funded and provide better opportunities for these students to enter into the biomedical professions.

STATEMENT OF FREDERICK S. KLINE, DIRECTOR, SOCIETY FOR EXCELLENCE IN EDUCATION

Mr. Chairman and members of the subcommittee, the Society for Excellence in Education (SEE) represents students, effective educators and taxpayers who are concerned with the improvement of educational opportunities without additional inflationary pressures. Our three recommendations are discussed in the SEE Spring 1980 Review as an adjunct of this statement. The recommendations are designed as amendments for FY 1981 Labor-HEW Appropriations eligibility which will prevent unecessary discrimination and expenditures.

(1) School districts must implement ethnic representation for personnel vacancies and promotions for qualified personnel. An ethnic representation amendment will prevent continued discrimination on the

basis of national origin and racial identity. Approximately 20% of Detroit's population is Slavic but none of the top level administrators and only a negligible representation of other administrators employed by the Detroit Board of Education are of Slavic national origin. The Slavic educators have filed a class action suit in Federal District Court against the Detroit Board of Education for discrimination on the basis of national origin. A decision is expected this spring.

(2) School districts must have contract agreements for all personnel units for the school year.

(3) School districts must demonstrate annual average academic achievement progress of at least 150% of 1980 based national norms for all students in regular classes, through the eighth grade. An amendment that requires definite achievement progress will prevent unecessary expense for taxpayers to repair the damage caused by ineffective instructional programs.

SOCIETY FOR EXCELLENCE IN EDUCATION

"The Society for Excellence in Education recommendations challenge all individuals to become more aware of the primary function of our public schools; and their inherent capacity to perform intrinsic needs for American students, in their pursuit of quality education."

Mrs. Mable Cornelia Kline, English Teacher, Cass Technical High School, Detroit Public Schools, Former Supervising Teacher, Michigan State University, Member, Association for Supervision and Curriculum Development, Member, Delta Sigma Theta Sorority, Inc.

"It is essential that administrators, teachers and elected officials respect the potentials of all American students. The implementation of the Society for Excellence in Education recommendations can serve as a catalyst for the correction of past and current discrimination."

The Reverend Horace L. Sheffield III, Chairman, King's Ideals and Dreams for Society, Student, Union Theological Seminary, New York City, Former Member, Detroit Board of Education.

"In view of my forty-four years experience as a classroom teacher, principal, associate superintendent and deputy superintendent in the Boston Public Schools, I fully recognize and subscribe to the outstanding value of the Society for Excellence in Education recommendations. If all schools fully implement these recommendations I am certain that the quality of education in the United States would be significantly improved."

William G. Tobin, Deputy Superintendent Emeritus and Former Legislative Agent, Boston Public Schools, Former Member, American Association of School Administrators, Past President, Boston Elementary Schools Principals Association.

The Society for Excellence in Education (SEE), since its inception in 1966, has proceeded to develop a feasible solution to the problem of increasing the academic achievement of all students. The solution does not require an increase in taxes. The solution does require a process of redirecting educational expenditures that will reduce inflationary pressures. The recommendations summarized in the SEE Spring 1980 Review are drawn from proven principles of motivation and research analysis, and the experience of educators, thousands of students ranging from high school dropouts to university honors graduates, clergymen, civic leaders, community organizers representing a diversity of opinion on controversial issues, concerned citizens and parents.

The recommendations of SEE are based on a philosophy of education. The objectives of our educational system should provide a positive motivational climate and assist students to develop:

1. Mastery of academic, vocational and technical skills which will enable students to become active participants in the American Free Enterprise system and in a rapidly changing society.
2. Creative abilities expressed through language, writing, art, music and physical education which will encourage full participation in the culture of our society and leisure time activities.
3. Self-confidence and self-discipline to enhance the students' ability to participate in various activities as individuals or members of groups.

Realization of these objectives will produce American students capable of developing practical solutions for the critical problems they will encounter in the future.

SEE members may offer additional recommendations for adoption that shall require the approval of 75% of the advisory board and the director and associate directors.

RETAINING EFFECTIVE EDUCATORS

The Society for Excellence in Education has stated in United States Congressional hearings, most recently on March 13, 1980, that valid research would verify that dual educational standards within the same school are not uncommon, regardless of the ethnic composition or economic background of the student body. Students in some classrooms receive an excellent education with effective teachers, while other students attend classes with ineffective teachers and are subjected to educational discrimination.

The important qualities of effective teachers are: the ability to utilize new methods of teaching regardless of the years of teaching experience; obtain firm and fair discipline; communicate and establish excellent rapport with students; and motivate students to achieve goals that correlate with the students' maximum abilities.

The assignment of effective teachers must be made to provide the best education possible for all students. Teachers should be allowed to teach where they can best motivate their students. Teachers who are bilingual, biliterate and bicultural should teach students whose similar home language is other than English. All school personnel should meet specific qualifications for various employment classifications and represent a range between the ethnic composition of the student body and the ethnic composition of the total population of the school district. Individual rights of all school personnel and ethnic groups should be considered to fill vacancies and promotions. Initial employment guidelines for the school district of Detroit should be 1% Arabic, 1% Armenian, 1% Asian, 1% Baltic, 60% Black, 2% Celtic, 1% Flemish, 1% French, 2% German, 1% Greek, 2% Hispanic, 2% Italian, 1% Jewish, 1% Scandinavian, 20% Slavic, 1% West Indian and 2% others. Guidelines revisions, corrected to 1/10 of 1% should be completed after the publication of complete statistics of ethnic heritage recorded for each decennial and mid-decade census. Legislation that mandates ethnic representation for personnel vacancies and promotions for qualified personnel, should become effective July 1, 1980 for the continuation of federal and/or state financial assistance to any school district.

All teachers should be rated periodically utilizing due process procedures which expedite the removal of ineffective teachers and relieve them of their contractual agreements completely. School administrators, who have the responsibility for the evaluation of teacher performance, must also be rated by their superiors. The unsatisfactory evaluation of any administrator by their superior should result in reassignment to teacher status, if eligible, or complete termination. Legislation that requires contract agreements for all school district personnel for the school year should become effective June 30, 1980 for the continuation of federal and/or state financial assistance to any school district.

Despite a well organized educational program, there may be a few students who consistently disrupt the learning process of an entire class. The overly disruptive students should be assigned to an individualized assistance class. The individualized assistance class should contain a maximum of twelve students. The assignment of students to an individualized assistance class must stipulate that a student can return to regular classes after satisfactory adjustment is completed.

Definite academic achievement progress should be expected from students who attend regular classes consistently. Academic achievement tests for students should begin at the kindergarten level. The results of the academic achievement tests should be recorded in the permanent record of each student at the beginning and ending of each school year. The academic achievement tests should be extended through the eighth grade. At that time, the majority of students in all schools would be capable of academic performance at least comparable to the norm achieved by current high school graduates. Effective July 1, 1981, yearly average academic achievement progress of at least 150% of 1980 based national norms for all students in regular classes, through the eighth grade, should be required for the continuation of federal financial assistance to any school district.

Advanced placement courses which give college level credit should be available at all high schools. The courses would provide challenging curricular options for capable students and allow credit for one complete year of college. The savings on college expenses would be substantial for both students and taxpayers.

Techniques such as the quick thinking test, motivational talk on positive thinking and comprehensive tutoring programs detailed in the *War on Ignorance Program of the Society for Excellence in Education* booklet, 1975, have been implemented successfully by some classroom teachers. The academic achievement of the students increased at a rate of over 200% of the national norms.

IMPLEMENTING QUALITY EDUCATION FOR ALL

Citizens, parents and taxpayers must demand that elected and appointed officials pass legislation and implement policies that will prevent educational discrimination. Court orders which remedy school segregation should be reconsidered after a quality education program has been implemented in a school district. A desegregated school should be defined as one that can document the evidence of substantial student academic achievement; effective administrators and teachers; adequate curricula, supplies, books, physical facilities and maintenance; ethnic representation of school personnel and strong parent support.

The initiation of a quality education program which remedies past negligence and the continued misuse of taxpayers' dollars by many school districts would justify reconsideration of court ordered desegregation decisions. Students should be permitted to attend the school where they are best motivated to learn. Free transportation should be provided to a distant school at the parents' request for equal access to quality education.

In the current period of tax limitation, it is mandatory that priority educational programs be adequately funded. The financing of basic programs should not require increased taxes. Placing an effective teacher in every classroom is the first priority. The current shortage of effective administrators and teachers is an unnecessary burden to the taxpayers and a major cause of inflationary pressures. The annual cost of public education exceeds one trillion dollars. This cost includes upgrading basic skills for high school graduates by private industry, private tutoring and various remedial programs developed by local, state and federal governmental agencies. A substantial increase in the minimum retirement benefit for educators and other school personnel is long overdue. Retired educators should be provided simple equity.

The Society for Excellence in Education will coordinate selected issues of mutual interest with other organizations. All members will receive quarterly reviews with additional SEE recommendations. Elected and appointed officials who are sincerely interested in the improvement of education for all students and the curtailment of the waste of taxpayers' money, will publicly support the Society for Excellence in Education recommendations.

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Statement of the American Home Sewing Association

Mr. Chairman, The American Home Sewing Association is pleased to submit the following written statement and recommendation to this distinguished Subcommittee.

The Association is comprised of manufacturers, retailers, users and publications engaged in the pursuit of sewing in the home, the classroom and in various guilds where Americans wish to make wearing apparel, home furnishings and craft items.

Taken along with nutrition, child development, home management and consumer education; home sewing constitutes one of our time honored national resources--now increasingly important to individuals and families as budgets tighten and inflation continues.

Mr. Chairman, our Association wishes to recommend that enhanced funding commitments either within existing levels or by increased appropriations be made to support Department of Education; Quality Improvement categories such as Reform, Demonstration and Dissemination as well as Educational, Personnel Training and Development programs.

This recommendation is based on a preliminary study conducted by the American Home Sewing Association which shows that classroom content and teacher training must be enhanced if these basic personal capabilities which typify America's domestic strength are to be preserved and passed along from generation to generation. As members of this Committee well know, the strength of primary and secondary education is not only based on the solid subjects such as English and math but also on a well-rounded curriculum which enable a person to cope with the complexities of modern day life. When such educational institutions neglect a balanced curriculum, total education suffers.

Local education budgets are often too thin to give proper attention to developing basic skills such as home sewing. Self-help efforts by local school systems are under way in these categories but Federal assistance should not be forgotten. Additionally, industry groups such as the American Home Sewing Association have conducted, at their own expense, assessments and initiatives to improve both classroom curricula and teacher training. Our Association, for one, would be very responsive to any opportunity to act in partnership with the Department of Education to build on and seek more meaningful results from the work which we have already initiated in this regard. We would hope funding could be available for such a partnership activity.

We thank the Subcommittee for the opportunity to submit this statement.

1981 BUDGET
QUALITY IMPROVEMENT INCREASES
(Millions of Dollars)

	1980	1981	CHANGE
✳ *Reform, Demonstration, and Dissemination* (Basic Skills, Vocational Ed. Quality, Cooperative Ed., Postsecondary Improvement, National Diffusion, Special Initiatives)	$213	$274	+$61
Research, Development, and Statistics (Research and Development, Handicapped Research, Statistics and Evaluation)	122	143	+21
Institutional Preservation (Museums, Interlibrary Cooperation, Research Libraries)	22	32	+10
✳ *Educational Personnel Training and Development* (Teacher Corps, Teacher Centers, Administrators Training, Science Teacher Training)	45	57	+12
TOTAL			+$105

Statement of United Cerebral Palsy Associations, Inc.

United Cerebral Palsy Associations, Inc. appreciates the opportunity to submit written testimony to the Senate Subcommittee on Labor-HEW Appropriations. This testimony will discuss appropriations needs in the following areas:

- P.L. 94-142, The Education for All Handicapped Children Act";
- P.L. 95-602, The "Rehabilitation, Comprehensive Services, and Developmental Disabilities Ammendments of 1978", particularly appropriations for the Title VII comprehensive services for independent living program, the National Institute of Handicapped Research, and the Developmental Disabilities program; and
- The National Institutes of Health, with special consideration of appropriations needs for the National Institute of Neurological and Communitive Disorders and Stroke, the National Institute of Allergy and Infectious Diseases; and the National Institute of Child Health and Human Development.

It should be pointed out that the majority of the recommendations in this statement have the endorsement of the Consortium Concerned with the Developmentally Disabled (CCDD), a coalition of 18 national organizations that work together on major issues of concern to persons who are developmentally disabled. The appendix one table highlights our major appropriations recommendations.

P.L. 94-142 The"Education For All Handicapped Children Act"

Basic State Grants

The full implementation of P.L. 94-142, the "Education for All Handicapped Children Act" continues to be a priority for UCPA. For far too long children with cerebral palsy have not received a public education which fully meets their needs. Until the passage of P.L. 94-142, many UCPA affiliates were in the business of providing children with cerebral palsy special education and related services. With the implementation of P.L. 94-142 well under way in most states, many UCPA affiliates are closing their schools and turning their attention to preschool or adult services. Now it is even more important for the Congress to increase its fiscal commitment to this legislation so that school systems across the country can respond to the needs of handicapped children.

It should be emphasized that P.L. 94-142 authorizes forward funding for both the state grant and the preschool incentive programs. Thus, the Congress is considering funding for these programs in FY 82.

The CCDD Task Force on Appropriations has made the following observations and recommendations regarding funding for the basic state grant program.

According to justifications accompanying the President's budget, "the Federal Government will continue (its) 1980 policy of providing approximately 12 percent of the national-per-pupil expenditure." It should be recalled, however, that the original authorizing language of P.L. 94-142 projected that the Federal Government should be providing 40 percent of the national average-per-pupil expenditure at this time. Using a formula of 40 percent of a n.a.p.p. of $2,033 times a minimum of 3.85 million children counted, the fiscal 1982 authority for P.L. 94-142 is in fact a minimum of $3.130 billion.

The President's budget went on to further state that the $922 million will be used during the 1981-82 school year to serve approximately 3.85 million handicapped children. This amount will cause the per-pupil reimbursement received by states under P.L. 94-142 to increase by $9, to $239 per student.

It should be pointed out that the rationale for the Administration's FY 82 recommendation is based upon two very conservative and controversial estimates. First, there are many individuals who would argue that the figure of 3.8 million handicapped children to be served in FY 82 is rather low. Responsible authorities speculate that the number of handicapped children served at this point could be as high as 4 million. Second, there has been considerable debate with regard to the projected rate of future inflation as it affects the national average per pupil expenditure. The Administration used the figure of 7 percent to arrive at its FY 82 projection. Most experts, on the other hand, anticipate that the rate of inflation at this time will be between 10 and 13.5 percent.

In light of these discrepancies, if even moderate projection rates were used, one could very easily justify an FY 82 budget recommendation for state grant programs for the handicapped to exceed $1 billion even using the 12 percent rate. What becomes even more startling, is the fact that if one were to use the higher projection figures for child count and rate of inflation, the $48 million increase proposed by the Administration could, in actuality, be a decrease leading to a reduction in services to the handicapped.

As Co-Chair of the CCDD Task Force on Appropriations, UCPA fully endorses the recommendation of $1 billion plus for the basic state grant program. States are at a critical point in implementing this legislation. Of particular concern to our organization is the provision of related services to handicapped children. This is of importance because many children with cerebral palsy are multiply handicapped and may require speech, physical, and occupational therapies in order to reach their full human potential. However, many school districts are either providing these services with insufficient frequency or are not providing these services at all. We suggest that by providing states with the fiscal support which we have recommended, the Labor-HEW Subcommittee on Appropriations will greatly enhance the availability of these related services.

Beyond our recommendation of $1 billion plus for the state grant program, we would like to briefly highlight our recommendation to the authorizing committees last fall pertaining to related services. We do this simply to make you further aware of our concerns in this area.

The Bureau of Education for the Handicapped has taken a laudable first step in assuring that handicapped children receive the related services promised under P.L. 94-142. BEH has initated several interagency agreements with other federal agencies with the goal of enabling agencies on the federal, state, and local level to coordinate their responsibilities in providing related services to handicapped children. There is no question that such interagency agreements will enhance the provision of related services. However, it appears that state and local human service agencies will need more direction and resources in providing related services. We believe that a possible solution to the problems surrounding the provision of related services may be to specify which agency has first dollar responsibility. Currently human service agencies often feel that because related services are specified as being linked to the child's education, they are somehow relieved of their responsibilities. We submitted that this is not what was intended by the authors of 94-142. In fact, we feel that this legislation calls for increased coordination between all human service agencies so that handicapped children receive the services to which they are entitled. We believe that this stipulation of first dollar responsibility will increase such inter-agency coordination. In this way, handicapped children will receive the full benefits of a free appropriate public education. If human service agnecies receive adequate financial resources theyare more likely to cooperate with school systems in providing related services.

Preschool Incentive Grants

There is no question that providing preschool education and related services to children with cerebral palsy is critical: If such services are given to the child early enough, preschool education can significantly ameliorate and in some cases actually reverse the functional deficits of children with cerebral palsy. As such, preschool education has been a high priority of our agency for several years. In 1971, BEH awarded us with a three year grant which allowed us to develop the Nationally Organized Collaborative Infant Project which enabled us to develop new techniques of working with developmentally delayed children and their families. As a result of the Collaborative Infant Project, many UCPA affiliates are now providing preschool services (Refer to Appendix II for a list of affiliates currently operating preschool programs). It is safe to say that we still have much to learn about serving preschool children with developmental problems. However, if we are to provide such preschool services to children with cerebral palsy and other developmental disabilities, funding of the preschool incentive program must be significantly increased.

The CCDD Task Force on Appropriations has deliniated the need to increase preschool incentive grants:

> "It is conservatively estimated that there are one million handicapped children of preschool age (0-5). Approximately 350,000 are receiving some form of early childhood educational services from either public and/or private sources. This leaves approximately 65 percent of the preschool handicapped children without needed services.

In 1979, states reported providing special education and related services under P.L. 94-142 to 215,637 handicapped children aged 3-5 years. If the states expand their services to only an additional 4,400 children, they will require $66 million under the authorized formula: $300 times the number of children served. From 1978 to 1979, states in fact, increased the number of serviced preschoolers by over 15,000.

In 1979, the national average per pupil expenditure for school-age students was approximately $1750. Thus, the $300 incentive is but a very small portion of the necessary revenue to serve preschool handicapped children. However, at the proposed figure of $25 million, the per pupil "incentive" is less than $100 per child. Few states who are not already mandated to serve the 3-5 age child find the $100 per child grant sufficient to change their policies.

Educational programs for the preschool handicapped child are mandated in only about nineteen states. Where there are voluntary programs, funds are running thin and programs are folding. It is absolutely essential to reinstate the original congressional commitment to the very young handicapped child and to a future which would be greatly enhanced by preschool experiences. We must supply the fiscal resources necessary to maintain the momentum that was obtained by a long, hard battle."

It is for these reasons that we actively support $66 million for the preschool incentive grant program to be forward funded for FY 82. We feel that such an increase in funds must be made now in order for young handicapped children to grow into adulthood with an optimal amount of functional abilities and not disabilities.

P.L. 95-602 TITLE VII COMPREHENSIVE SERVICES FOR INDEPENDENT LIVING

By far, the program within the Rehabilitation Act which offers the most potential for severely disabled adults is Comprehensive Services for Independent Living. It is a dichotomy therefore that the program which espouses to provide services which will enable many handicapped persons to live with dignity in their communities should be so poorly funded. This concerns UCPA and other advocacy organizations to the extent that an Ad Hoc Coalition has been formed to articulate the need for adequate funding.

When it was enacted in 1978, this program was intended to provide disabled persons with such services as attendent care, wheelchair repair, peer counseling, and a variety of other services with the goal of allowing these persons to live as independently as possible. For persons with cerebral palsy the provision of these services may mean living in one's own apartment for the first time as opposed to living in a nursing home or institution.

Further, it must be pointed out that as our affiliates begin to provide adult services, one of the must crying needs remains the ability to provide clients with independent living services.

Perhaps the best argument for increased funding for independent living comes from a client who is currently being served by UCPA of Pittsburgh. Howard was placed in a state institution for the mentally retarded at the age of six. At that time he was severely physically disabled due to polio. When the staff of our Pittsburgh affiliate prepared to open their first community living program they visited several of the state institutions looking for persons who would be able to function in a community setting. Although he was not considered to be eligible for such a placement, Howard sought out the UCPA staff and asked to be considered for community placement. At that time Howard was 63 years old. Howard was one of the first clients in UCPA of Pittsburgh's community living program and has been successfully living outside the institution since 1975. More importantly, after working with Howard for some time the staff does not believe that Howard is retarded. As a footnote, it now appears that Howard is ready to be moved into an apartment building for the elderly and will need only minimal support services from our affiliate.

The President has requested $18 million for FY 1981 to fund Part B of Title VII which authorizes Centers for Independent Living. According to one of the Administration's budget documents, "An increase of $3 millon for independent living will expand the number of model centers to 15. While it is indeed laudable

to increase such centers, both the Ad Hoc Coalition for Independent Living and the Consortium Concerned with the Developmentally Disabled are deeply concerned that the administration has chosen to ignore Parts A and C of the program.

The reason Parts A and C are not implemented is simply lack of appropriated funds. The Council of State Administrators of Vocational Rehabilitation is in the process of completing a survey of their member agencies regarding their ability to match funding for independent living programs in the coming fiscal year. While all of the results of the survey are not in as yet it appears that states will be prepared to match independent living funds at a much higher level than the Administration is currently recommending. Further, an analysis of the preliminary findings of the CSAVR survey indicates that states are now ready to implemtnt Part A. This is contrary to the Administration's argument that States need more time to "gear up" to provide these services. Because we feel that this program is of such great importance to severely disabled persons, we have joined with the Ad Hoc Coalition for Independent Living in requesting $45 million for fiscal year 1981. We have justified this recommendation on the assumption that the following accomplishments could be achieved:

- a reasonable initiation of the Part A Comprehensive Services State Grant Program;
- the continuation of ongoing efforts with Centers for Independent Living (Part B); and
- start-up for the Part C Older Blind Individuals program.

The State Grant program under Title VII is based on the ratio of state population to the population of all the states with a minimum allotment of $200,000 or one third of 1% of the funds available, whichever is greater. If all fifty states received the minimum allotment of $200,000, approximately $10.5 million is necessary. In order to launch equitably the program in the more populous states, an appropriation of approximately $25million is suggested. That level of funds would provide approximately one third of the states with the minimum allotment, with the remaining, more populous states, reviewing a larger, proportional share. This level of funding would allow the Part A program to be implemented with sufficient services available in each state to secure much needed assistance to severely handicapped individuals.

THE DEVELOPMENTAL DISABILITIES ACT

State Grant Program

The Developmental Disabilities State Grant Program provides funds for coordinated and comprehensive services to the developmentally disabled. The primary goal of this program is to focus on the needs of those developmentally disabled persons, including those with cerebral palsy, who will require a multiplicity of services throughout their lifetime. These are the persons who all too often have been unnecessarily placed in institutions. Although much progress has been made toward meeting the needs of these persons within the community, we have only to refer you to our example of Howard in the independent living section of this statement to realize that, for the developmentally disabled, we have only begun to provide adequate services.

Because of the importance of this program to the persons we serve, United Cerebral Palsy Associations and the Consortium Concerned With The Developmentally Disabled are requesting $60 million for the State Grant program. The CCDD Task Force on Appropriations has explained the need for the State Grant Program in this way:

> "The 1978 Amendments (P.L. 95-603, Title V) to the Developmental Disabilities Act made major modifications to the basic Developmental Disabilities State Grant Program. States are now required to spend at least 65% of their state allocations on the new priority service areas:
>
> Case Management;
> Child Development;
> Alternative Community Living Arrangements; and
> Non-Vocational Social - Developmental Service.

The States are presently limited to fund up to two of the four priorities. The limitation stems from a formula in the Act which allows no more than two priority areas to be funded if the annual appropriations is below $60 million.

Recent Developmental Disabilities State Plans have clearly indicated the pressing need to expand the service in each state in all four priority areas. For this reason, the CCDD strongly recommends a $60 million appropriation level for FY 1981. The approximately $17 million increase will provide for 1) continued services to those D.D. persons currently being served; 2) expansion of the current state priorities to serve those individuals not now being served; and 3) the initiation of a third priority service based upon the need as determined in the DD state plan."

Perhaps an additional view of this program from our organization's perspective will provide some further insight as to the need for this increase in funding. The Professional Services Program Department has as one of its national priorities, the development of alternative community living arrangements for persons with cerebral palsy. While some progress has been made in providing these living arrangements, the problem remains substantially unaddressed. As such, an increase in state grant funds would allow these services to be somewhat expanded.

Another more concrete example of the need to increase these funds is the problem faced by UCP of Alabama. Currently UCP of Alabama serves approximately 55 severely disabled adults in three cities: Birmingham, Anniston, and Tuscaloosa.

These adults receive non-vocational developmental skills training. This program is currently funded through a combination of Title XX and Developmental Disability funds. Recently, however, UCP of Alabama was informed that their Title XX funds would be cut off in the near future. If our affiliate did not have these DD funds to turn to, those 55 adults who currently receive their services would have no place to go. Thus, these persons would either remain at home or in an institution, making little or no progress.

Protection And Advocacy

P&A systems are designed to provide legal, personal and systemic advocacy to persons who cannot speak for their own interests. As such, P&A systems provide an invaluable service to many developmentally disabled persons who might otherwise be totally unable to articulate their rights. Among the major systems are involved are the following:

- assisting DD individuals and their parents with their due process rights under the Education for All Handicapped Children Act;
- zoning, barrier removal and other activities geared to provide access to community housing and other facilities;
- Section 504 anti-discrimination protections under the Rehabilitation Act; and
- preventing abuse and upgrading conditions in institutions.

Both UCPA and CCDD agree that the P&A system is critical to the full realization of rights for the developmentally disabled. As such, we are requesting $15 million for P&A systems for FY 81.

Perhaps a look at what one of our affiliates is doing in the area of advocacy, independent of their P&A System, will give the committee some insight into needs which are yet unmet by the P&A systems due to lack of funds. UCPA of Kansas City became involved with a group of handicapped teenagers who are attending the local high school for the handicapped. Some of these young people are ready to move into pre-employment training and are now looking for employment. However, the staff of the Kansas City affiliate began to sense that, while these teens were academically prepared to move on, they were drastically lacking in the personal self-esteem which anyone handicapped or otherwise must have in order to "sell one's self" to an employer. The affiliate is now working with the local community mental health agency in order to obtain some therapeutic services for these young people. UCP of Kansas City will begin a pilot project in the near future with the community mental health staff and begin group therapy with these clients in order to better prepare them for both employment experiences and

adult life. Such systemic advocacy is extremely important to the developmentally disabled individual. If the Congress increases these funds, Protection and Advocacy Systems can work with other agencies such as ours to improve the lives of persons with disabilities.

NATIONAL INSTITUTE OF HANDICAPPED RESEARCH

One of the most promising endeavors in the field of research on the pragmatic problems which face handicapped persons today is the National Institute Of Handicapped Research. Both consumers and professionals alike agree that this new Institute has the potential to make significant breakthroughs in the area of applied technology and thus enable handicapped persons to live much fuller lives.

P.L. 95-602 established the National Institute Of Handicapped Research to develop a comprehensive, coordinated approach to the administration and conduct of research, demonstration projects, and related activities including training. Such a thorough approach is to include dissemination of information, financial support for the distribution of technological devices and equipment, and an increase in scientific and technological information.

In addition to extending federal support for both the Rehabilitation Engineering Centers (REC) and Rehabilitation Research And Training (R&T) Centers, P.L. 95-602 earmarked a number of new research efforts, including joint projects with other federal agencies, a study of the special concerns of rural areas, special needs of persons 60 years of age and older, and support of model training centers to evaluate and develop employment potential.

Many persons within UCPA have been concerned for some time that much of the research which has heretofore been done in the name of "handicapped research" has been funded only to become an academic study to be published and placed on library shelves. Without question there is need for pure research for without it many of the medical advances which our society witnesses today might never have been realized. However, there is a strong need to now convert what has been learned through pure academics into practical solutions to the day-to-day difficulties encountered by handicapped individuals.

Training Alternatives for Living and Learning (TALL), a project of UCP of Greater Kansas City, trains and employs severely handicapped persons, many of whom have been rejected by traditional vocational rehabilitation programs. TALL's Executive Director, Ronald Torner, testified before the Subcommittee on Select Education of the House Education and Labor Committee in 1978 and we believe that his thoughts on rehabilitation research accurately expresses the direction in which this type of research must go. He stated:

> "The technology of habilitation could be greatly enhanced by more reality-oriented research conducted through direct partnership with service programs. Besides contributing to the solution of the problems of translation and implementation, it would ensure evaluation by those whom the research is designed to benefit as well as ensure real world input to the researcher.
>
> Further, there must be emphasis on the dissemination of information emerging from research. Valuable information that demonstrates the capabilities of persons with severe disabilities to perform tasks or exhibit behaviors totally inconsistent with previous expectations has been available for several years, and has yet to find its way into practice in comparatively few programs."

We reiterate Mr. Torner's concern that research must filter down to the people and programs which it purports to study if it is to be effective.

Our concern is further buttressed by the fact that, out of 15 Rehabilitation Engineering Centers which are funded by RSA, only one, Center Industries Corporation in Wichita, Kansas, is a non-medical REC. Center Industries is working to put applied technology to work for handicapped people. Operated by UCP of Kansas and aided by Wichita State University, this Center operates a job shop thus giving support for local Witchita industry in the basic areas of fabrication, machining and assembly. Handicapped persons compromise 75% of the workforce. As a result of the application of sound engineering principles in solving the demands of rehabilitation, severely disabled workers are meeting the demands of industry and becoming productive members of society. Center Industries has proven what can be done when applied technology is directed towards the consumer.

In addition to the responsibility for assuring that research reaches the consumer, the National Institute Of Handicapped Research has been given many other responsibilities, which are all essential to the development of a comprehensive research initative on behalf of disabled persons. These include the following:

From Section 202 (b) of P.L. 95-602:

- Educational materials dissemination on how to improve the lives of handicapped individuals;
- Educational programs to inform the public about ways of rehabilitating handicapped individuals; and
- Statistical reports and studies on employment, health, income and other demographic characteristics of handicapped people.

From Section 204 (b) of P.L. 95-602:

- A new research program in the use of existing telecommunications systems;
- Joint projects with NIH, HSA, AOA, NSF, VR, OE, and NASA;
- Research into the rehabilitation of handicapped children and the rehabilitation of handicapped individuals who are aged 60 or over;
- Attract and retain rehabilitation professionals in rural areas;
- Model research and demonstration programs to develop innovative methods of providing services to preschool age handicapped children; and
- Assist R&T Centers to develop and use more advanced and effective methods of evaluating and developing employment potential of handicapped individuals.

The administration has requested a $5 million increase for NIHR. These monies will allow for NIHR to implement the section 202 (g) requirement for the development of and submission to Congress of a long range plan for rehabilitation research, will ease the inflationary pressures forced on the existing Rehabilitation Engineering Centers and the Research and Training Centers and will target roughly $1 million for technology development. The CCDD and UCPA feel that the administration's request of $37.0 million is not enough given the previous explaination of the importance of the NIHR to the clients whom we represent. Therefore, we urge the Labor-HEW Subcommittee to appropriate $45 million for the NIHR. If this sum is appropriated, we believe that the Institute can begin to address some of the critical issues of which it was created.

UCPA RESEARCH CONCERNES RELATED TO THE NATIONAL INSTITUTES OF HEALTH

UCPA supports several research and training efforts through the United Cerebral Palsy Research and Education Foundation. The Foundation has funded scientific investigations in cerebral palsy as well as the training of personnel in the habilitative sciences. Such training efforts have included professorships, clinical fellowships and student stipends. The Foundation has in the past and will continue to work closely with those Institutes within NIH which are involved in research into the prevention or ameliotation of cerebral palsy. Considering the current state of the economy, it is becoming increasingly more difficult to secure private research funds. We believe that this is all the more reason for the federal government to continue its efforts in both research and training. Further, we are concerned that training programs may suffer as a result of budgetary constraints. While we support the need to decrease federal spending, we are concerned that too many significant reductions in NIH training efforts will result in a drastic shortage of persons to conduct research which will one day lead to prevention of disabling conditions. With these thoughts in mind let us turn to the specific research concerns within NIH.

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National Institute of Allergy and Infectious Disease

The National Institute of Allergy and Infectious Diseases conducts and supports research contributing to a better understanding of the causes of allergic, immunologic, and infectious diseeases and to the development of better means of preventing, diagnosing, and treating these conditions. Viral infections (viruses, bacteria, and other microorganisms) affecting fetal development are etiologically related to the causes of certain developmental disabilities such as cerebral palsy. Other diseases, such as varicella (chicken pox) and cytomegalovirus (CMV), are known causes of neurological disorders occurring early in life. The relationship of infections to neurological disability has only recently begun to be studied; perinatal infections and their effects on the developing nervous system, neonatal bacterial diseases, viral respiratory infections, and bacterial meningitis are all important areas under investigation.

Infectious disease in particularly important with the Infulenza B which is going around right now. This type of infulenza does not respond to the vaccine which is normally given to prevent the flu. This strain of flu is often followed by a disease called Reye's syndrone which affects young children. This disease can cause degeneration of the brain and also has a very high fatality rate. Realizing that this disease can have a drastic effect on the central nervous system, UCP supports all efforts to find-a-cure for this disease.

Because of the importance of preventing such infectious diseases, UCP supports the NIAID "Professional Judgement Budget and recommends $264.936.

Increases in the Institute's budget are required because of the following reasons:

(1) Funds for centers, contracts, and intramural research (except for increases for mandatory pay raises) have levelled off in f.y. 1979 and 1980 because of the Congressionally directed emphasis in budgetary increases for research project grants.

(2) Research training in microbiology, immunology, and the relevant clinical sciences has been reduced so that an already small pool of new researchers will become smaller. Training M.D.'s for clinical investigation is a particular problem and requires new approaches.

(3) New problems, such as Legionnaire's disease, Reye's syndrome, Lyme arthritis, infant botulism, and fatal virus infections such as Morburg, Lassa, and Ebola virus, have not been adequately addressed.

(4) The NIAID has been committed to provide resources to the World Health Organization's tropical disease research program as well as to NIH's risk assessment of recombinant DNA research. Without substantial increases in funding, other research efforts may be undermined.

National Institute of Child Health and Human Development

NICHD has been involved in significant research in areas which pertain to children with cerebral palsy and their families. Of particular concern to UCP is the research which they have done on the assessment and evaluation of low birth weight infants and the follow along of infants who are born prematurely. Prematurity and low birth weight are two primary causes of cerebral palsy. Naturally, the sooner these children are identified the greater the chance there is of alleviating the disability.

Because the NICHD contributes to our understanding of important aspects of child development UCP joins CCDD in recommending $264.936. Funds made available by this increase would be utilized to develop new research initiatives in:

- Genetics such as the new fragile X gene;
- Early intervention with emphasis on the interactions between mothers and their children; and
- Mentally retarded adults, where minimal research and information currently exist.

National Institute of Neurological and Communicative Disorders and Stroke

Research which is being done to prevent disabling conditions is certainly a priority of UCP. However, of equal importance is that research which is being done to reduce the impact of the disability. Such is the research which is being carried out at NINCDS. In the past UCP has supported research projects which are of interest to NINCDS. These projects include the development of surgical techniques to reduce the effects of cerebral palsy on the indivdual, the use of pharmacological agents related to the control of spasticity and athetosis, bioengineering contributions which improve the quality of life for persons with disabilities and prevention activities directed at eliminating the environmental causes of cerebral palsy such as trauma, accidents, chemical reactions and child abuse.

Recently NINCDS has been involved in research relating to the regeneration of the central nervous system. For a very long time researchers believed that such regeneration was a medical impossibility. It now appears that the nervous system can in fact regenerate, much like other cells of the body. Much more research is needed in this area. Further, while such research will directly effect spinal cord injury patients, such breakthroughs in neurology will ultimately effect persons with cerebral palsy. While this research may take a lengthy amount of time before any conclusive results are reached, we strongly believe it must be consistently supported.

UCPA supports the CCDD recommendation of $285 million for NINCDS for f.y. 81. This will allow for a 14.5% inflationary increase plus a modest amount of monies for special projects. Considering the complexities of neurological science and the breakthroughs which may be eminent, we consider this sum a small price to pay.

APPENDIX I

PROPOSED APPROPRIATIONS BY PROGRAM
(in millions)

	1979 Actual	1980 Appropriations	1982 Authorization	1982 President's Budget Request	UCPA Recommendation
1) Education for the Handicapped (forward funded)					
• Grants to States	$804.0	$874.0	$3.130 billion	$922.0	$1.2 billion
• Preschool Incentives Grants	$20.863	$25.0	$66.0	$25.0	$66.0

	1979 Actual	1980 Appropriations	1981 Authorization	1981 President's Budget Request	UCPA Recommendation
2) Comprehensive Services for Independent Living	$2.0	$15.0	$200.0	$18.0	$45.0
3) National Institute of Handicapped Research	$31.5	$32.0	$90.0	$37.0	$45.0
4) Developmental Disabilities					
• State Formula Grants	$35.0	$43.181	$75.0	$43.181	$60.0
• Protection and Advocacy Systems	$3.8	$7.5	$15.0	$7.5	$15.0
5) National Institutes of Health					
• National Institute of Allergy and Infectious Diseases	$191.884	$216.671	such sums	$228.487	$264.936

	1979 Actual	1980 Appropriations	1981 Authorization	1981 President's Budget Request	UCPA Recommendation
5) National Institute of Neurological and Communicative Disorders and Stroke	$212.0	$242.0	such sums	$249.8	$285.0
6) National Institute of Child Health and Human Development	$197.357	$209.800	such sums	$217.546	$239.1

APPENDEX II

LIST OF UCPA AFFILIATES OPERATING PRESCHOOL PROGRAMS

Alabama

UCP of Alabama

Colorado

Denver

Connecticut

Fairfield County

Florida

Broward County
Miami
Polk County
Tampa

Illinois

Greater Chicago

Kentucky

Bluegrass
Greater Louisville

Louisiana

Greater New Orleans

Maine

Northeastern (Bangor)

Maryland

Central Maryland (Baltimore)

Massachusetts

North Shore Area

New Jersey

Monmouth & Ocean Counties

New York State

UCPA of N.Y.S.
Nassau County
New York City
Orange County
Queens County
Suffolk County
Syracuse

Ohio

Akron & Summit Counties
Cincinnati

Pennsylvania

Lackawanna County
Lehigh Valley
Philadelphia
Pittsburgh
Schuylkill, Carbon &
Northumberland Counties

Texas

Dallas County

Wisconsin

Greater Dane County

LETTER FROM JOSEPH D. ROMER, DIRECTOR OF GOVERNMENTAL AFFAIRS, NATIONAL EASTER SEAL SOCIETY

March 13, 1980

Honorable Warren G. Magnuson
Chairman
Subcommittee on Labor, Health,
Education and Welfare
Room 1108 Dirksen Senate
Office Building
Washington, D. C. 20510

Dear Mr. Chairman:

I am writing on behalf of the National Easter Seal Society to urge the Subcommittee to appropriate funds for recreation for the handicapped for fiscal year 1981. I respectfully request that this statement be included in the hearing record with respect to the hearings your Subcommittee has been holding on appropriations for fiscal year 1981. We are proposing that this appropriation be made under Section 316 of the Rehabilitation Act of 1973 which authorizes federal funding for recreation for the disabled. This provision authorizes the Rehabilitation Services Administration to make grants for these programs. The Rehabilitation Services Administration is among those agencies soon to be transferred to the new Department of Education. Section 316 was added to the Rehabilitation Act by the Rehabilitation, Comprehensive Services and Developmental Disabilities Amendments of 1978, Public Law 95-602.

Being the nation's oldest and largest voluntary health agency serving the handicapped, our organization has had a longstanding tradition of advocacy on behalf of the nation's disabled.

During the year 1979, Easter Seal Societies across the country provided a comprehensive spectrum of services to more than 450,000 persons with disabilities. Easter Seal affiliates offer a wide variety of services to handicapped persons disabled from any cause. Our clients include victims of accidents, cerebral palsy, multiple sclerosis, blindness and the whole range of birth defects.

In addition to providing direct services, the Society benefits the entire handicapped population of the nation by its legislative and other governmental activities. The organization is also subtantially involved in public education and research designed to enhance the lives of disabled people.

In our dual role as a provider of rehabilitation services to the disabled and as an advocate for the handicapped, we have a substantial interest in funding for programs under the Rehabilitation Act of 1973. This year, we are particularly interested in funding for recreation for persons with disabilities.

During the 60 years that we have been in existence, Easter Seals has been a leader in the field of camping and recreation for handicapped people. Innumerable Easter Seal programs serve as prototypes in the communities in which they are offered. During fiscal year 1978, the most recent year for which we have figures, Easter Seal Societies provided recreational opportunities to over 56,000 individuals at a cost of about $6 million. These programs are funded primarily through charitable contributions raised in the local communities where they are offered.

From our extensive experience in this field, we can attest to the value of recreation for the disabled. Recreation for our disabled population is important for a number of reasons. First of all, it is intrinsically beneficial. Just as is the case with able-bodied persons, recreation enhances the physical health and psychological well-being of handicapped persons. Simply put, recreation is an indispensable ingredient in any well-balanced life.

In many cases, recreation and leisure activities are even more crucial to disabled persons than they are to the nondisabled. For, many handicapped individuals have an inordinate amount of leisure time because they are unable to work or to find work. Individuals without work need recreation opportunities to experience the sense of satisfaction and socialization that a person usually gets from employment.

It should also be noted that recreation is often an integral part of an individual's overall medical rehabilitation program. Experts in the rehabilitation field will attest to the fact that recreation and other leisure activities play a very important role in expediting the rehabilitation process thereby lessening

the need for extensive medical services frequently paid for by the federal government. For many individuals with employment potential, recreation provides an opportunity to learn the skills that they need to return to work. When these people reenter the work force, there is an increase in tax revenue attributable to their earnings and a decrease in disability benefits otherwise payable to them. This is a result which is benficial not only to the handicapped, but to all taxpayers.

It should be kept in mind that recreation is a relative concept and what might be recreation to one person may be drudgery to another. For some, recreation means activity and action; for others, it may mean more passive pursuits. Recreation includes cultural, literary, nature and social activities, as well as arts and crafts, music, special events, sports and tourism. The possiblities are almost limitless. However, the common goal is enjoyment and personal satisfaction. Leisure activities provide relaxation, renewal and balance in our lives. Recreation should not be conceived of as a limited set of specific activities, but rather as a range of endeavors which meet individual needs.

When discussing the concept of recreation for the handicapped in the context of governmental policy, it should be noted that the subject is much broader than it might seem at first glance. Obviously, it includes the question of direct federal support for traditional recreational programming. But beyond that, the subject raises a myriad of issues which should be mentioned: (1) Will the federal government enforce the legal obligation under Section 504 of community recreation departments, national and state parks and educational institutions to make physical adaptions and program modifications to allow equal recreational access for handicapped persons? (2) Will the federal government maintain or expand its role in the training of recreational specialists? (3) Will the government assume a significant role in conducting or funding research in recreation for the handicapped? and, (4) Will the government enforce the requirement that recreation be incorporated as an integral part of education for handicapped children under Public Law 94-142? These are only a few of the many questions that remain unanswered under existing policy. However, they are indicative of the parameters of the subject.

Although a number of federal programs have an impact on recreation for the handicapped, it is funding for basic recreational programming that is the focus of our statement.

Based on our experience as the largest provider of services to handicapped people in the United States we believe that the lack of adequate recreational programming for disabled persons is one of the most glaring gaps in our existing social service system. Simply put, most handicapped people do not have the degree of access to recreational opportunities that they need for a well-balanced life. During the 1950's, it was estimated that only 3 percent of the disabled population living in the United States participated in community recreation. Recently, the estimate has risen to 10 percent but that means that 90 percent of the handicapped population remain outside the mainstream of America's recreation lifestyle. Handicapped people have been denied participation in recreation by public, private and commercial agencies. The barriers blocking participation in recreation are many of the same that prevent equal opportunity in employment, housing and education. These include: (1) lack of transportation; (2) architectural barriers; (3) community attitudinal barriers; (4) lack of adequately trained personnel; and, (5) inadequate funding.

The National Easter Seal Society believes that the quickest and most cost-effective way for the Congress to address this problem would be to appropriate a modest amount of money, specifically $2 million, under Section 316 of the Rehabilitation Act.

Enacted in 1978, Section 316 authorizes the Rehabilitation Services Administration to make grants to states and other public and nonprofit agencies for recreation programs for the handicapped. The stated purpose of this provision is to "aid in the mobility and socialization" of persons with disabilities. It specifies that existing resources should be used whenever possible, thereby discouraging the development of new facilities and encouraging the integration of handicapped persons into existing community recreation programs. Activities funded under this section may include indoor and outdoor recreation; competitive, active and quiet recreational activities; social activities; and, activities related to the fine arts. Under the proposed regulations implementing this provision, projects may be approved for a maximum of five years. This is consistent with Congressional intent in that Congress intended that funds appropriated under this provision be used as seed money to initiate programs which eventually could be taken over by local public and private agencies and operated exclusively with nonfederal funds.

In 1978, the Senate Committee on Human Resources reported to the full Senate S.2600, the bill which contained Section 316. In that report, the Committee justified Section 316 as follows:

"Recreation programs for handicapped individuals are greatly needed in order to assist them in developing their capacity for mobility and socialization. Unfortunately, existing programming for this purpose is limited; therefore, it is the committee's intent that this authority stimulate the development of and utilization of more community-based recreation programs.

It is the committee's intent that handicapped individuals participate in existing regularly scheduled recreation programs to the maximum extent feasible; the committee realizes, however, that the specialized needs of handicapped individuals may necessitate adaptive equipment and programming and specially trained personnel. The committee, therefore, expects that such adaptive equipment and programming as well as specialized personnel attuned to the needs of handicapped persons will be an integral part of any recreation program initiated under this authority. It is further expected that such recreation programs should be coordinated with other recreational activities offered in the community."

Presently, there is no federal funding for special recreation in that Congress to date has not appropriated any money under Section 316. Thus, Congress has recognized the problem but has failed to do anything about it.

In urging Congress to appropriate a small amount of funds for recreation for the handicapped, we are not proposing the creation of a major new government program. We are, however, suggesting that these monies be used as seed money to fund a small number of programs. A substantial part of these funds could be given to local public and nonprofit agencies to facilitate the integration of handicapped persons into existing recreation programs. This seed money could be used for training the staffs of community recreation departments in developing programs and making program modifications for persons with disabilities. In addition to providing direct benefits for those who participate in these federally funded programs, these prototypes would undoubtedly serve as a catalyst for the hundreds of public and private agencies across the country which could replicate these demonstration projects in their own communities.

This approach is a cost-effective one. It would not involve the construction of any new facilities but rather would maximize the use of existing resources.

Presently, voluntary organizations such as the National Easter Seal Society are the primary providers of recreational opportunities for our disabled population. We are proud of our contribution and intend to continue our efforts. In proposing this appropriation, we are not suggesting a major departure from the status quo. We are not proposing that the federal government assume primary responsibility in this area. For, if it is demonstrated that the innovative programs funded under Section 316 are workable, they will be replicated largely by voluntary nonprofit and local public agencies without the use of federal funds. The point is that we need assistance from Congress if we are to fulfill our mission to bring the disabled into the mainstream of this aspect of American life.

The Congress should recognize that, altruistic reasons aside, it is in the best interests of the federal government to encourage the activities of the voluntary sector. Voluntary organizations provide innumerable services to the American people, many of which would fall within the responsibility of the federal government. If one were to compute the cost to the federal government to fund the programs which are now provided by these agencies, the amount would be staggering.

Recreation is an integral component of a well-balanced life in our culture. Social psychologists can attest to the fact that recreation is essential not only to an individual's health and well-being but that it also has a direct influence on the health and vitality of our society as a whole. Governments at the national, state and local levels have recognized this and have made an unequivocal commitment in this area, as evidenced by billions of dollars that they expend each year for recreation. Thus, the public responsibility for recreation is clear. It is the fundamental premise of our proposal that this responsibility should be extended to include our disabled population.

We hope that the Subcommittee will find our arguments persuasive and will appropriate $2 million for fiscal year 1981 for recreation for the handicapped.

Sincerely,

Joseph D. Romer

Joseph D. Romer
Director of Governmental Affairs

STATEMENT OF COMPREHENSIVE SERVICES FOR INDEPENDENT LIVING

Title VII, Parts A, B and C - P.L. 95-602

(in millions)

Fiscal Year 1979	Authorization		Appropriation
	80		2
Fiscal Year 1980	Authorization		Appropriation
	150		15
Fiscal Year 1981	Authorization	President's Request	Recommendation
	200	18	45

Rationale For $45 Million Recommendation

Programs authorized by Parts A, B and C of Title VII (Comprehensive Services for Independent Living) of the Rehabilitation Act of 1973 as amended promise better, fuller lives for our nation's severely handicapped citizens who cannot qualify for basic vocational rehabilitation services. However, the Administration's budget for fiscal year 1981 requests $18 million to fund Part B (Centers for Independent Living) and does not request funding for Part A (Grants to States for Independent Living Rehabilitation) and Part C (Independent Living Services for Older Blind Individuals), which is dependent upon Part A funding for its own financing.

An Ad Hoc Coalition of eighteen major national organizations committed to the implementation of Title VII of the Rehabilitation Act recommends an appropriation of $45 million to fund Parts A, B and C in Fiscal year 1981.

When the Congress enacted Title VII as part of the Rehabilitation Act amendments of 1978, it, along with handicapped citizens and their advocates, envisioned a substantial new service program with sufficient funds to develop effective long range plans and services. The appropriations' history since the program's passage in 1978 clearly indicates that the mission of the program has not been fully met due to the serious lack of funds to implement Part A, the basic State Grants, which is the heart of the program.

It is important to note that the only reason Part A is not implemented is the lack of appropriated funds. The time is ripe for full implementation in fiscal year 1981. The State Rehabilitation agencies, which have the responsibility for program planning and implementation at the State level, have indicated a strong desire to initiate the program through their planning efforts to secure the fiscal year 1980 funds for Part B. Numerous demonstration projects of various sorts in recent years have indicated the viability of the Independent Living concept.

To implement this vital program now makes inordinate sense. The State agencies and public and private service providers are prepared to deliver the services. Handicapped citizens are clamoring for the services. Without such services, severely handicapped citizens who, because of the severity of their disabilities, cannot qualify for vocational rehabilitation services, will frequently be subjected to unwanted, undesirable and very costly institutionalization. Many who are willing to work, will be unable to do so due to the lack of training and support services which would be provided

by the Independent Living program. Handicapped citizens want to participate in our society. Independent Living services would provide the mechanism to achieve this goal.

The Ad Hoc Coalition recommendation for $45 million for fiscal year 1981 is justified on the basis of:

- a reasonable initiation of the Part A Comprehensive Services State Grant program;
- the continuation of ongoing efforts with Centers for Independent Living (Part B); and
- start-up for the Part C Older Blind Individuals program.

Part A - Grants to States for Independent Living Rehabilitation

The Part A portion of the Independent Living program has never been launched due to the unavailability of appropriated funds. The State Grant program under Title VII is based on the ratio of state population to the population of all the states with a minimum allotment of $200,000 or one-third of 1% of the funds available, whichever is greater. If all fifty states received the minimum allotment of $200,000, approximately $10.5 million is necessary. In order to equitably launch the program in the more populous states, an appropriation of approximately $25 million is suggested. Attachment A shows the state by state breakdown of the formula grant at the $25 million level as an example. Such a level of funds would provide approximately one-third of the states with the minimum allotment, with the remaining, more populous states receiving a larger, proportional share.

This level of funding would allow the Part A program to be implemented with sufficient services available in each state to secure much needed assistance to severely handicapped individuals.

Part B - Centers for Independent Living

The Coalition generally concurs with the Administration's proposal to continue to slightly expand the Centers for Independent Living portion of Title VII. Again, states are eager to implement this program and put services in place. The need of the program is well documented. Such Centers should exist in every community of our country. An appropriation of approximately $18 million will allow for the continuation of the approximately seventy-five projects currently funded and allow for some additional Centers to be newly funded in fiscal year 1981.

Part C - Independent Living Services for Older Blind Individuals

This Part allows the Commissioner of the Rehabilitation Services Administration to allocate up to 10% of the Part A funds to provide independent living services to older blind individuals. Again, there have been clear demonstrations that such services can prevent more costly long term care, including institutionalization, for older blind persons. Services under Part C would enable such persons to remain in their homes at a cost of almost half of the cost of appropriation levels or nursing home care. This is cost-effective and highly desirable from a humanitarian perspective as well.

ATTACHMENT A

PART A - TITLE VII
DISTRIBUTION SCHEDULE
OF $25 MILLION

If $25 million were made available in FY '81 for "Part A" Independent Living Services by State Agencies (apart from separate resources for Parts B and C) the federal allocations by States and territories would be approximately[1] as follows[2]:

STATE	FINAL ALLOTMENT		FINAL ALLOTMENT
TOTAL			$25,000,000
ALAB	$ 387,217	OHIO	$1,112,292
ALAS	200,000	OKLA	298,018
ARIZ	243,589	ORE*	252,902
ARK	226,204	PA*	1,215,874
CAL	2,306,955	RI*	200,000
COLO	276,288	SC*	301,951
CON*	320,580	SD	200,000
DEL*	200,000	TEN*	450,856
DC	200,000	TEX*	1,346,671
FLA*	889,295	UTA*	200,000
GA	526,085	VT*	200,000
HAW	200,000	VA*	532,708
IDA*	200,000	WAS*	390,528
ILL	1,163,410	WVA	200,000
IKN	556,094	WISC	484,177
IOW*	299,674	WYO	200,000
KAN*	242,968	AMER	31,250
KY*	361,968	GUAM	31,250
LA	410,396	NMAR	31,250
ME	200,000	PR	331,649
MD	428,712	TTER	31,250
MAS*	597,486	V.IS	31,250
MIC*	950,865		
MIN*	414,742		
MIS*	248,763		
MO*	502,906		
MON*	200,000		
NEB*	200,000		
NEV	200,000		
NH	200,000		
NJ*	758,188		
NM	200,000		
NY*	1,836,539		
NC*	577,100		
ND	200,000		

* States that have two agencies, general and blind

1 Population data by states as of December 1976 used for this distribution calculation. The most recent population data would be used when distribution actually occurs.

2 The source is a computer print out of 02/01/80 from RSA, prepared in response to a formal public request.

February 12, 1980

Independent Living: Coalition

The coalition is currently composed of representatives of the following organizations:

1. Association for Retarded Citizens
2. National Rehabilitation Association
3. National Mental Health Association
4. National Association of Private Residential Facilities for Mentally Retarded
5. United Cerebral Palsy Association
6. American Association of Workers for the Blind
7. American Coalition of Citizens with Disabilities
8. National Federation of the Blind
9. American Foundation for the Blind
10. National Association for the Deaf
11. Council of State Administrators-Vocational Rehabilitation
12. National Easter Seal Society
13. Epilepsy Foundation of America
14. National Multiple Sclerosis Society
15. National Society for Autistic Children
16. Goodwill Industries of America
17. National Association of Rehabilitation Facilities
18. American Association of Homes for the Aged.

STATEMENT OF JOHN CHARLES HOUSTON, DIRECTOR, CONGRESSIONAL AFFAIRS, PUBLIC SERVICE RESEARCH COUNCIL, VIENNA, VA.

I would like to thank the committee for the opportunity to appear before it today. My name is John Charles Houston, Director of Congressional Affairs for the Public Service Research Council, located in Vienna, Virginia.

Public Service Research Council is the largest independent citizen's lobby in the United States, with over one million members, devoted solely to the influence of government unions on government, whether at the state, local or federal level. It is our concern with the role unions play in Teacher Centers, that prompts our testimony today.

The Higher Education Act as amended in 1976 created a grant program to establish local teacher centers around the United States. These teacher centers were designed to be run by teachers to serve their needs as professional employees.

These centers have had broad latitude in how they spend their money, what programs and goals they pursue and the overall direction in which the center moves.

There are at present about 100 Teacher Centers around the country, an increase of 40 since last year. The growth of Teacher Centers has caused some debate in recent hearings held by the Education and Labor Committee in the House of Representatives as to the role of collective bargaining agents in controlling Teacher Centers. In testimony given at a Committee hearing held in Detroit in 1979, Mr. Willard McGuire, President of the National Education Association, asked that the present regulations, which have attempted to balance the competing interest of who should select policy board members for Teacher Centers, be radically altered.

The NEA proposed that "if teachers have a collective bargaining agent, that agent will appoint the teacher representatives, or if there is no collective bargaining agent, then the teacher organization with the greatest membership will appoint the teacher representative. Or, if there is no collective bargaining agent or teacher organization, then the teacher representatives will be chosen in an election by the teachers."

It should be noted that only in the third case, where there is no collective bargaining agent or teacher organization, will the teachers themselves be allowed to have any voice in who controls their own centers.

The present regulations provide for a variety of ways, which may be mixed in their application, to select members of the board for Teacher Centers.

a. One would be an agreement between the local school board and the teacher collective bargaining agent as to who the specific teacher representatives are.

b. Second, appointment of the teacher representatives by the teacher collective bargaining agent.

c. Third, appointment of the teacher representative by a teacher organization with the largest number of members.

d. Fourth, voting in which all teachers in the area to be served by the center have an opportunity to participate either through a general or a school-by-school election.

e. Fifth, permits teachers generally, either directly or through their teacher organization to nominate or to select the teacher representative on the board.

This procedure which was created by regulation, would be changed to a mandatory one in which the prevailing union, such as the National Education Association, or the American Federation of Teachers, would dictate to teachers who they would choose to be their representative. In essence this circumvents the purpose for which Teacher Centers were created.

The Carter Administration does not favor repealing the present regulations by statute. The feeling in the Committee itself is not favorable to granting special status to the unions through changes this year.

However, it highlights the press for legislation to create special powers which the unions continually make, to control and dictate to teachers what they may do in their professional lives.

The representatives from NEA went on to ask in these hearings, that local Teacher Centers be guaranteed the power to intervene in state educational policy by federal requirement that they do so. This is an unprecedented demand for control of educational policy making activities by unions. Moreover, it is a use of Teacher Centers entirely unenvisioned by Congress when they were created -- a use designed not to better education, but to further the power of those who control Teacher Centers.

The primary concern that the Public Service Research Council has with Teacher Centers is their potential for enlarging the hand of unions in education. The model for private sector unions is often distorted when it is used for public sector employees. None of the motivation to oppress workers, minimize their salaries, oppose job security as argued as reasons for unionizing the private sector exists in government labor relations. All of the benefits conferred on public sector employees including job tenure, salary levels, civil service protection, etc. have been given to these employees gratis by state and local legislative bodies, or by Congress.

The argument for the need for unions in such professions as teaching has not been resolved. But, to the degree that unions are used to deal with employers in bargaining for increased salaries and benefits, they represent teachers in an adversarial setting. If teachers need the protection of collective bargaining in this setting, this is something which they are able to do in light of the state law on the subject.

But, the issue of the role of a collective bargaining agent in running a Teacher Center which is controlled by teachers and run solely for their benefit hardly seems a matter of concern for a collective bargaining agent. Teachers do not need to be protected from themselves. Attempts to do so will insulate them from the clear intent of Congress -- that is to involve them in the selection of their own board members for the Teacher Centers. The unions who represent teachers sound completely condenscending when they insist that only they know enough to select board members.

The Public Service Research Council has undertaken a complete study of the Policy Boards of all the Teacher Centers funded under this program. We have received this information from the Teacher Centers themselves and the Department of Health, Education and Welfare. In evaluating this information, it is essential to remember that Congress envisioned a program being run by teachers. This, in fact, has not been the result, in light of the way unions have exploited this situation.

We found that thirty-two of the Teacher Center's Policy Boards had a majority of members appointed by the union. In some cases, the union created the Teacher Centers from the beginning, and they function as a tool of the particular union local. Such a result was never foreseen by Congress.

Thirty-one of the Teacher Centers had a majority appointed by the teacher organization which has a majority of teachers as members. Non-member teachers are not represented or consulted, nor do members exercise any real voice in the selection of their boards. Once again this is an unforeseen result which Congress did not intend or desire.

Twenty of the Teacher Centers were actually elected by teachers themselves. The relatively small number of such Teacher Centers is additionally due to the fact that unions have been extremely active in promoting Teacher Centers as they, more than any other group, have the most to gain from their creation. The disproportionately high number of union-run centers, or teacher organization controlled centers reflect the incentives to control the federal dollars which may be used to whatever use the parent union or organization desires. Five Teacher Centers used some combination of appointment or election.

To underline the lack of control by either the local education authorities who are elected by the public, or by federal bureaucrats who dispense these federal dollars, one need look only at the first example of a Teacher Center which is totally pursuing its own whims. The Connecticut Teacher Center for Humanistic Education has aroused the concern of local citizens, who are concerned that their local Teacher Center is teaching a particular brand of secular religion called "Humanism," in fact, dedicating the organization to this end. They requested Senator Weicker to ask HEW, what could be done to prevent this from continuing, or perhaps worse programs from being pursued in the future. They

were told by the director of the Teacher Center program, Dr. Bruce Gaarder, in an attached letter dated January 9, 1980:

> "Furthermore, in view of the prohibition against federal control of education, it would be unseemly for our staff member to monitor and question the substantive content of their curriculum."

This is a perfect illustration that what Congress intended has been circumvented by the way the regulations have been written. And, the practical application of the law has been to set up autonomous "education" related organizations which are free of local control by local education officials, free to pursue their own interests at the public expense. As HEW has relinquished all control of the "substantive content," no one but the unions can control the use of the public's money.

It should as well be noted that West Virginia has established seven state funded Teacher Centers which are run by the elected education establishment. They, in fact, serve the function which Congress desired when it created the Teacher Center program.

According to the newsletter Education USA, February 25, 1980:

> The strength in West Virginia's teacher education centers lies in the make-up of its advisory councils, participants said. In Harrison County, for example, the council includes a representative of six colleges, the state department of education and the local schools. The school representatives include four principals (two elementary and two secondary), two teachers, and the superintendent. Students and the community are included.

Education USA went on to suggest that the future of Teacher Centers lay in state funding and state and local control. West Virginia has seven Teacher Centers programs, West Virginia would seem to be better able to serve their teacher's in-service training needs.

NEA and AFT have suggested increasing the annual cost of Teacher Centers to $100 million dollars. When such services can be provided by West Virginia at a cost to the state of $100,000 as seed money for seven centers, one may wonder that a recent grant for one center in Idaho was for $97,000 for one year. This has brought in local money where it was felt that Teacher Centers served local needs, all without the expense of vast amounts of federal tax dollars.

Teacher Centers would seem to be a prime item to be cut in the federal budget, if not entirely eliminated. By returning this function to the local education, the Congress would be doing more for education than this program will do under the most optimistic appraisal of its effects.

Teachers represent one of the best educated segments of our society. Although they may or may not lack the recognition afforded teachers in other societies, they are a fiercely individualistic group who have educated opinions about the things that concern them. After all, they are hardly coal miners or steel workers, too tired physically from a days work to contemplate the meaning of a candidate or policy. They are professionals who must teach our youth how to understand current issues and act intelligently upon their own judgment.

Congress intended that Teacher Centers be the province of teachers themselves, not the arm of whatever labor relations organization which teachers employ. By keeping this political activity open, it is more likely to encourage the entrance into the programs of teachers of all shades of views and opinions rather than those which are only acceptable to union shop stewards. Moreover, where there are teachers from private schools, they would be largely excluded from influencing the selection and policy of board members. This would be completely contrary to the intent of Congress, and the current regulations of the Office of Education which seeks to balance the respective interests, no matter how diverse.

What is good for a union is not necessarily good for teachers themselves, much less the education of the young people who are to ultimately benefit from the results of these centers. It is the experience of bureaucracies that the farther removed from the recipient the actual decision making is, the less likely that the recipient's needs will be met. And, as Supreme Court

Justice Powell noted recently in the Aboud case, when a union is campaigning for something in the public sector, it is indistinguishable from a political party.

The special interests which are asking for special favors here will only serve to further politicize Teacher Centers. Politicizing Teacher Centers and education in general, is not synonymous with improving education. Allowing the unions an increased role in determining the function of Teacher Centers will serve only to enhance their power in the control of education at the expense of teachers and the public.

Where teachers are heavily unionized, the unions already play a large role in the operations of Teacher Centers. This was an unforeseen effect of Teacher Centers. To keep the centers from becoming little more than union halls, bought and maintained out of the public purse, it is necessary to draw clear lines between the role of unions as private organizations based upon the right, of association, and the public interest in improving education. The union interest in education is basically staying in control of a particular school district and collecting its dues. All else in education is subordinate to these concerns. Hence, the public interest in maintaining an academic, as well as professional atmosphere in Teacher Centers must, to a large extent, exclude unions from their control and operations. New regulations should be written which would specifically preclude unions from propagandizing teachers with tax financed printing, use of facilities for union business or meetings, or in any other way aggrandizing and diverting these public resources for these budding political parties.

The selection of board members, whether teachers belong to a union or not, should be solely in the hands of the teachers themselves. Any other procedure is demeaning to the teachers' ability to run centers for themselves, which was the intent of Congress. Congress did not ask unions to provide these services, or tell teachers what they may or may not do. Hence, their cloying request to control them must be firmly relegated to special interest politics.

January 9, 1980

Honorable Lowell P. Weicker, Jr.
102 U.S. Court House
Federal Building
915 Lafayette Blvd.
Bridgeport, Connecticut 06604

Dear Senator Weicker:

This is in response to your request for findings and views pertinent to the letter sent to you on November 29, 1979 by the Reverend Mr. Dane A. Curri of Branford. Reverend Curri has found reason to object to the training which is provided in the Connecticut Center for Humanistic Education, a teacher center supported by a grant made to the Stratford, Connecticut public schools.

I am enclosing a brief statement about the teacher center, which addresses the issue raised by Mr. Curri. The statement is based on the information available to us and gives our best assessment of the matter. We are, of course, unable to attend all of the training sessions sponsored by the Stratford project (it is in fact State-wide, with six small regional centers). Furthermore, in view of the prohibition against Federal control of education it would be unseemly for our staff members to monitor and question the substantive content of their curriculum.

We are grateful for your interest in the Teacher Centers Program.

Sincerely,

A Bruce Gaarder

A. Bruce Gaarder
Acting Director, Division of
Educational Systems Development
Teacher Centers Program

64-129 O - 80 - 47

STATEMENT OF THE PUBLIC SERVICE RESEARCH COUNCIL

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These centers have had broad latitude in how they spend their money, what programs and goals they pursue and the overall direction in which the center moves.

There are at present, 100 teachers's centers around the country, an increase of 40 since last year. The growth of teacher's centers has caused some debate in recent hearing held by the Education and Labor Committee in the House of Representatives as to the role of collective bargaining agents in controlling teacher's centers. In testimony given at a Committee hearing held in Detroit this spring, Mr. Willard McGuire, new President of the National Education Association, asked that the present regulations, which have carefully balanced the competing interest of who should select policy board members for teacher's centers, be radically altered.

The NEA proposed that "if teachers have a collective bargaining agent, that agent will appoint the teacher respresentatives, or if there is no collective bargaining agent, then the teacher organization with the greatest membership will appoint the teacher representative. Or, if there is no collective bargaining agent or teacher organization, then the teacher representatives will be chosen in an election by the teachers."

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The representatives from NEA went on to ask in these hearings, that local teacher's centers be guaranteed the power to intervene in state educational policy by federal requirement that they do so. This is an unprecedented demand for control of educational policy making activities by unions. Moreover, it is a use of teacher's centers entirely unenvisioned by Congress when they were created -- a use designed not to better education, but to further the power of those who control teacher's centers.

The primary concern that the Public Service Research Council has with teacher centers is their potential for enlarging the hand of unions in education. The model for private sector unions is often distorted when it is used for public sector employees. None of the motivation to oppress workers, minimize their salaries, oppose job security as argued as reasons for unionizing the private sector exists in government labor relations. All of the benefits conferred on public sector employees including job tenure, salary levels,

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But the issue of the role of a collective bargaining agent in running a teacher's center which is controlled by teachers and run solely for their benefit hardly seems a matter of concern for a collective bargaining agent. Teachers do not need to be protected from themselves. Attempts to do so will insulate them from the clear intent of Congress -- that is to involve them in the selection of their own board members for the teacher centers. The unions who represent teachers sound completely condescending when they insist that only they know enough to select board members.

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NEA and AFT have suggested increasing the annual cost of Teacher Centers to 100 million dollars. When such services can be provided by West Virginia at a cost to the state of $100,000 as seed money for seven centers, one may wonder that a recent grant for one center in Idaho was for $97,000 for one year. This has brought in local money where it was felt that Teacher Centers served local needs, all without the expense of vast amounts of federal tax dollars.

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What is good for a union is not necessarily good for teachers themselves, much less the education of the young people who are to ultimately benefit from the results of these centers. It is the experience of bureaucracies that the further removed from the recipient the actual decision making is, the less likely that the recipients needs will be met. And as Supreme Court Justice Powell noted recently in the Aboud case, when a union is campaigning for something in the publi sector, it is indistinguishable from a political party.

The special interest which are asking for special favors here will only serve to further politicize teacher centers. Politicizing teacher centers and education in general, is not synonymous with improving education. Allowing the unions an increased role indetermining the function of teachrs centers will serve only to enhance their power in the control of education at the expense of teachers and the public.

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unions from propaganizing teachers with tax financed printing, use of facilities for union business or meetings, or in any other way aggrandizing and diverting these public resources for these budding political parties.

The selection of board members, whether teachers belong to a union or not, should be soley in the hands of the teachers themselves. Any other procedure is demeaning to the teachers' ability to run centers for themselves, which was the intent of Congress. Congress did not ask unions to provide these services, or tell teachers what they may or may not do. Hence, their cloying request to control them now must be firmly relegated to special interest politics.

JOINT STATEMENT PREPARED BY THE DIVISON OF GOVERNMENTAL RELATIONS, AMERICAN COUNCIL ON EDUCATION

American Association of Colleges for Teacher Education
American Association of Community and Junior Colleges
American Association of State Colleges and Universities
American Council on Education
Association of American Colleges
Association of American Universities
Association of Catholic Colleges and Universities
Association of Jesuit Colleges and Universities
Coalition of Independent College and University Students
Council for the Advancement of Small Colleges
Council of Graduate Schools in the United States
National Association of College and University Business Officers
National Association for Equal Opportunity in Higher Education
National Association of Independent Colleges and Universities
National Association of Schools and Colleges of the United Methodist Church
National Association of State Universities and Land-Grant Colleges
National Association of Student Financial Aid Administrators
National University Extension Association
United States Student Association

Thank you for this opportunity to testify on the Administration's FY 81 budget request for the Department of Education, on behalf of 19 higher education associations listed on this statement.

Education and Inflation

Our testimony is presented against a background of national concern with the need to control inflation, and the search for appropriate cuts in the federal budget to achieve this objective. We share this concern, which we have taken into consideration in developing our recommendations. We emphasize two points to be considered with respect to federal program for higher education:

1. Education is a principal victim, not a cause, of inflationary pressures. Rising costs make it all the more difficult for the schools, colleges and universities to provide the educational opportunities that are essential for the nation's future social and economic health.

2. Spending for education is not inflationary; it is anti-inflationary in the long term because investment in education is a major contributor to increased productivity.

Consider, for example, the tradeoff between student aid and unemployment compensation: students who do not go to college, or drop out because they are unable to afford it, are less likely to find work when economic activity is slowing

down. The federal cost of supporting an unemployed person is many times greater than the federal share of supporting a needy student who also receives help from private and state sources.

Because education is one of the most labor-intensive sectors of the economy, and because the federal dollar is so highly leveraged with funds from other sources, spending for higher education has a greater positive impact on employment than spending in almost any other sector--without in any way creating pressures on supply that help to fuel inflation. As The Budget of the U.S. Government, FY 81 notes (p. 36), "Federal employment, training, and education programs, equal opportunity programs, and programs...that contribute indirectly to labor mobility all help increase productivity, reduce structural unemployment, and make it possible to achieve employment goals with less inflationary pressures."

* * *

The following recommendations are based entirely on existing authorizing statutes. They do not include requests which would require new authorizations. Upon completion of the current reauthorization cycle, we expect to request funds needed to finance changes in existing programs, notably student aid, and to begin new programs (such as the Urban Grant University program) which are strongly supported by the community)

Student Assistance

Basic Grants

We strongly support the Administration's request to maintain the full payment schedule for Basic Grants. We are pleased that the Administration also recognizes that, unless an increase in the maximum is provided, some 170,000 presently eligible students will be dropped from the program because a minimal increase in their family incomes--insufficient to keep pace with inflation--will increase their expected family contribution and thereby make them ineligible for the program. We understand that any increase from the current $1,800 maximum would require a change in the reauthorization, which is under study by the Senate Committee on Labor and Human Resources. We would support an increase in the Basic Grant maximum as soon as the authority becomes available.

Supplemental Grants

The Administration is requesting level funding of $370 million for this program, which provides an essential supplement to Basic Grants, particularly for low- and middle-income students attending higher-priced institutions. Level funding would result in a reduction of benefits to these students, to the extent that inflation erodes the purchasing power of these funds. We recommend a $50 million increase, to $420 million.

College Work Study

The Administration's request of level funding for CWS at $550 million also represents an effective reduction in the operating level of this unique program which provides a self-help mechanism for low- and middle-income students to help meet their educational costs. The program is also particularly important for graduate students now that federal fellowships are no longer widely available. We recommend an appropriation of $575 million to provide jobs for some 1,035,000 students.

State Student Incentive Grants

We recommend $100 million for this program, which the Administration would continue to fund at the FY 80 level of $77 million. An increase would provide further stimulus for the expansion of state student aid programs, since dollar-for-dollar matching is required.

Direct Loans

The Administration would replace NDSL with a new program of need-based loans which is currently unauthorized. Therefore it is essential to maintain the existing program at the current level ($286 million in capital contributions) while the congressional authorizing committees consider possible changes.

Student Information Allowances

Current law authorizes an institutional allowance of $10 for each student receiving a Basic Grant or Guaranteed Loan, to help cover the costs of student information and program administration. An appropriation of $45 million would fund this authority and make a major contribution to strengthening the administration of student assistance.

Total Requests for Need-based Student Assistance

These recommendations call for increases of $429 million, which could be met for $61 million less than the Administration's total request for need-based student aid programs since the budget calls for $490 million for new (unauthorized) need-based loans.

Guaranteed Loans

The Administration proposes to replace the Guaranteed Loan program with a new, more restrictive program to provide loans of convenience. While the current program is in need of restructuring, and changes are being considered by the authorizing committees, the new authorization is not expected to be completed before the appropriations cycle. Therefore the GSL must be funded according to the need for the current program, and for this purpose the Administration's budget

request is approximately $278 million short of the program's FY 81 cost as estimated by the Congressional Budget Office.

Facilities

Barrier Removal

In FY 80 the Congress appropriated $25 million for Title VII HEA to begin meeting the needs for barrier removal to provide access to higher education for the handicapped. A 1978 HEW study estimated these needs to be in excess of $560 million. We recommend $50 million for FY 81 to provide further progress.

The Administration has asked that the FY 80 appropriation be deferred to FY 81 rather than asking for additional funds, since regulations for the program have not yet been published. We are still hopeful that regulations may be issued in time for funding this summer, and that further steps to meet this priority may be taken in FY 81.

College Housing

The Administration is not requesting that the approximately $97 million available in the College Housing Loan Fund from repayments of prior loans be made available as in past years for new loans for energy conservation and to alleviate housing shortages. Releasing these funds would not require new obligational authority, and they are urgently needed: last year 321 colleges and universities submitted applications, but only 51 projects could be funded out of the $82 million available.

Categorical Programs

We fully support the Administration's requests for a number of programs which are important to the higher education community. These include: Developing Institutions ($120 million), Cooperative Education ($23 million), Fulbright-Hays ($7 million), Graduate and Professional Opportunities ($13 million), CLEO ($1 million), the National Institute of Education ($88 million), the National Center for Education Statistics ($11.8 million), the Women's Educational Equity Act ($20 million), Teacher Corps ($37.5 million), Minority Institutions Science Improvement ($5 million), and Biomedical Sciences ($3 million).

Programs for Which No Funds are Requested

We oppose the Administration's effort to eliminate several categorical programs which are targeted to important priorities:

University Community Services: This is the only federal program which addresses one of the central challenges for higher education in the 1980s: to meet the needs of older citizens, women re-entering the job market, and persons seeking retraining for new careers. This priority has been given additional emphasis in the reauthorization legislation now being considered in the Senate Committee on

Labor and Human Resources. Therefore we urge an increase from the current level of $10 million to $20 million to stimulate further progress on this priority.

Graduate Fellowships: Public Service Fellowships and Mining Fellowships serve clear national needs to improve public sector management and to make more effective use of mineral resources for energy needs. These programs should be maintained at their current levels of $4 million and $4.5 million, respectively, to admit a new entering class and to maintain second- and third-year continuing awards.

Education Information Centers: This program needs expansion from the FY 80 level of $3 million to $5 million to stimulate further efforts by the states to provide networks of information on educational opportunities, available financial assistance, and job placement. The states provide two-thirds of the cost of this program.

Current funding should also be maintained for Law School Clinical Experience ($4 million). For State Postsecondary Commissions, we recommend an increase to $3.5 million to help states administer the new funds for barrier removal under Title VII HEA.

The programs listed above, which the Administration would zero out, currently total only $28.5 million. They can be funded without significantly increasing the budget, since the Administration is requesting $20 million for a new but unauthorized program of challenge grants for Title III institutions.

Other Categorical Programs

College Libraries

Libraries are the backbone of higher education, yet most college libraries today cannot even keep up with the pressures of inflation and rapid social and technological change, must less improve the quality of their collections. Although grants under the College Library Resources program (II-A) are modest, they have a significant impact on the quality of library holdings throughout the country, especially in small colleges where the grants may stretch library budgets by as much as 40 percent. In FY 80, Part A funds were cut in half to $5 million--only 20 percent of the FY 68 appropriation of $25 million. Yet since 1968, the average cost of a book has increased 239 percent, a periodical subscription 318 percent. Instead of level funding for II-A, as the Administration requests, we recommend $15 million to fund basic grants at the authorized $5,000 maximum for the 2,600 eligible institutions, and to provide $2 million for supplemental grants for institutions with special needs.

For II-B, Library Training and Demonstration, we recommend $6 million: $4 million for career training and $2 million for research and demonstrations,

instead of the $500,000 requested for each by the Administration. Training funds are needed to provide priority assistance for minority students; the research authority is the only source of support to advance library and information services technology.

For II-C, Research Libraries, the Administration is requesting a $1 million increase to $7 million. We recommend a $10 million appropriation to provide more adequate help in maintaining the unique collections of major research libraries and making them more available to users of other libraries. Last year research libraries increased their spending for periodicals by 16 percent, but this increase purchased one percent fewer subscriptions than the year before.

International Education

The Administration is requesting an increase in foreign studies and language development (NDEA VI) from $17 million to $23 million, and an increase from $3 million to $7 million for Fulbright-Hays programs. We support the Fulbright-Hays increase, but we urge a further increase to $38 million for NDEA VI as the minimum necessary to begin carrying out the recommendations of the President's Commission on Foreign Language and International Studies.

The Commission report calls for a substantially greater increase in federal funds to reverse the "dangerous trend" toward erosion of foreign language and international studies and to diversify the types of activities presently supported. Yet the Administration request would eliminate support for graduate international studies programs, phase out support for undergraduate programs, and reduce the number of undergraduate language and area centers receiving federal support. These programs have been important and successful, and should be an essential part of any national strategy to build our knowledge base for international issues.

A $38 million appropriation would restore the basic Title VI programs in real dollar terms to the funding level attained over a decade ago. This would make a small but significant step toward stemming the erosion of language and area centers, sustain important undergraduate and graduate program activities and networks now in place, and expand slightly the international education efforts now underway at the elementary-secondary and adult and continuing education levels. It would provide 95 Language and Area and International Centers, at roughly $100,000 per center--an increase of 10 over the number of centers supported by FY 80, but 12 less than the number supported in FY 72. It would provide 1,200 fellowships at an estimated per scholar cost of $6,000; $1 million for intensive summer language fellowships, $7 million for graduate and undergraduate programs at junior and community colleges, state colleges and universities, $4 million for assessment and evaluation studies

to follow up the work of the President's Commission, and $5 million for citizen education activity to extend international knowledge.

Special Programs for Disadvantaged (TRIO)

The provision of supportive services is necessary at both the pre-college and college levels if a larger number of low-income students are to be provided an opportunity to achieve the upward mobility afforded by higher education. Today only 22.4 percent of students from low-income dependent families attend college, compared to 58.2 percent of dependent students from families with incomes above $25,575. The Administration is requesting a modest increase of $12 million for these programs; we recommend an increase to $170 million to provide services to an additional 85,000 students.

Veterans Cost of Instruction

Instead of a further reduction to $12 million as the Administration has requested for this program which provides out reach and counselling services to Vietnam-era veterans who are educationally disadvantaged, we recommend restoration of the FY 79 level of $19 million. Otherwise several hundred institutions will be forced to drop out of the program because grants would be insufficient to maintain viable programs. Over 400 of the institutions currently receiving grants obtain less than $9,000, which is barely the minimum to provide the needed services.

Fund for the Improvement of Postsecondary Education

The Administration budget requests $17 million for FIPSE, a $3 million increase over FY 80. This program has earned high marks in recent evaluations for its support of effective projects designed to improve many aspects of postsecondary education. The demand for funds is so great that only 5 percent of proposals are funded. We recommend a further increase to $20 million.

Teacher Centers

We support an increase to $52 million to assure funding of at least one Center in every state, and to permit 275 grants (245 local districts and 30 college and university projects) to serve 300,000 teachers.

* * *

The attached chart lists our recommendations for FY 81 appropriations for Education Department programs of importance to the higher education community. Also attached is our letter of March 4 to the Subcommittee requesting FY 80 supplemental appropriations totalling $7.1 million for the Graduate and Professional Opportunities Program and the Veterans Cost of Instruction Program.

3/14/80

FY 81 Budget
Postsecondary Programs of the Education Department
($ Millions)

	FY 80	Administration FY 81 Budget	Higher Education Community's Recommendation*
Need-Based Student Assistance (HEA IV)			
Basic Opportunity Grants	$2,262	$2,309*	$2,309
Supplemental Opportunity Grants	370	370	420
College Work Study Grants	550	550	575
State Student Incentive Grants	76.8	76.8	100
National Direct Student Loans (FCC)	286	0*	286
Basic Loans		492*	0
Student Information Allowance-BEOG	0	0	30
Student Information Allowance-GSL	0	0	15
Facilities Renovation (HEA VII-Barrier Removal)	25	0	50
College Housing Loans			97**
Categorical Programs			
Special Programs for Disadvantaged (HEA IV)	147.5	159.5	170
Education Info Centers (statewide)	3	0	5
Developing Institutions (HEA III)	110	120	120
Challenge Grants		20*	
Foreign Studies & Lang Dev (NDEA VI)	17	23	38
Fulbright-Hays Training Grants	3	7	7
Community Service & Continuing Ed (HEA I-Part A)	10	0	20
State Postsecondary Ed Commissions	3	0	3.5
Veterans Cost-of-Instruction (HEA IV)	14.4	12	19
Cooperative Education (HEA VIII)	15	23	23
Graduate Education (HEA IX):			
Part B-Fellowships	8.9	13	13
Part C-Public Service Fellowships	4	0	4
Part D-CLEO	1	1	1
Mining Fellowships	4.5	0	4.5
College Libraries (HEA II):			
Part A-Grants	5	5	15
Part B-Training & Research	1	1	6
Part C-Research Libraries	6	7	10
Law School Clinical Experience (HEA XI)	4	0	4
Fund for Improvement of Postsecondary Ed	13.5	17	20
Other Education Department Programs			
National Institute of Education	77.1	88	88
National Center for Education Statistics	9.9	11.8	11.8
Women's Educational Equity Act	10	20	20
Biomedical Sciences	3	3	3
Minority Institutions Science Improvement (NSF)	5	5	5
Teacher Centers (HEA V)	13	14.3	52
Teacher Corps (HEA V)	30	37.5	37.5

* Assumes passage of Administration reauthorization proposals.

** Release of current loan fund; no new obligational authority.

***These recommendations are based entirely on existing authorizing statutes, and do not include funds which the community will request be appropriated upon completion of the current reauthorization cycle. Such additional funds include those needed to finance changes in existing programs, notably student financial assistance, and to begin new programs, such as the Urban Grant University program, which are strongly supported by the community.

March 4, 1980

The Honorable Warren G. Magnuson
Chairman, Subcommittee on Labor-HEW Appropriations
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

The higher education associations listed below urge supplemental appropriations totalling $7.1 million in FY 80 to avoid serious disruption of two small but important programs:

Graduate and Professional Opportunities (GPOP): $2,500,000

We recommend a supplemental to permit funding of a full new class of students for these fellowships, which are designed to increase the number of women and minorities in graduate disciplines in which they are underrepresented. This would raise the program from the current $9 million level to $11.375 million, and make it possible to award 500 new fellowships, the same number as awarded to students now in the second year of the program. Without a supplemental only 200 new awards could be made, and many institutions which made promising beginnings in support of this Administration initiative would not be able to admit new students. Not only would the continuity of the program be lost at these institutions; the program would be unable to maintain a balanced geographical distribution of awards.

Veterans Cost of Instruction (VCIP): $4,620,000

We recommend a supplemental to raise the current appropriation of $14,380,000 to the previous year's level of $19 million, in order to avoid forcing several hundred institutions to drop out of this program in support of veteran students. As the attached list shows, 417 participating institutions received $9,000 or less in 1979-80 when the appropriation was $19 million. Any further reduction would make it necessary for most of these institutions to drop out because funding would be too minimal to support a viable program. The $19 million level is necessary to maintain present efforts to help veterans take advantage of their educational benefits.

This request is submitted on behalf of: American Association of Community and Junior Colleges, American Association of State Colleges and Universities, American Council on Education, Association of American Universities, Association of Catholic Colleges and Universities, Council of Graduate Schools in the United States, National Association of Independent Colleges and Universities, and National Association of State Universities and Land-Grant Colleges.

Sincerely,

Charles B. Saunders Jr.

Charles B. Saunders, Jr.
Vice President for Governmental Relations

1979-80 VETERANS' COST-OF-INSTRUCTION PAYMENTS PROGRAM:

Institutions Receiving Awards Ranging from $879-$8,999

STATE	# of Awards	STATE	# of Awards
Alaska	1	Mississippi	8
Alabama	19	Montana	6
American Samoa	1	North Carolina	26
Arkansas	5	North Dakota	3
Arizona	2	Nebraska	1
California	13	New Hampshire	2
Colorado	6	New Jersey	5
Connecticut	12	New Mexico	
District of Columbia		Nevada	1
Delaware	5	New York	21
Florida	4	Ohio	10
Georgia	28	Oklahoma	11
Gaum		Oregon	2
Hawaii	4	Pennsylvania	24
Iowa	8	Puerto Rico	3
Idaho	1	Rhode Island	1
Illinois	22	South Carolina	6
Indiana	8	South Dakota	3
Kansas	6	Tennessee	8
Kentucky	10	Texas	17
Louisiana	3	Utah	1
Massachusetts	7	Virginia	13
Maryland	11	Vermont	3
Maine	3	Washington	6
Michigan	18	Wisconsin	8
Minnesota	10	West Virginia	3
Missouri	14	Wyoming	3

STATEMENT OF ROBERT C. SCHLEIGER, PRESIDENT, CHESAPEAKE COLLEGE, WYE MILLS, MD.

The Council of Developing Institutions is an organization of 315 community and junior colleges which are participants in the Title III Strengthening Developing Institutions Program. On behalf of these 315 institutions I am grateful for the opportunity to express our concerns regarding the administration of Title III grants.

The Council is aware of the rightful concerns of the GAO and the Congress regarding the abuses by assisting agencies. We believe the situation was abetted by a previous requirement that a grantee obtain an assisting agency for every funded activity. The current limitation to one assisting agency is sound. It enables the grantees to use external assistance only where needed, and to the extent needed, rather than using such assistance simply because it was required. The colleges need, and appreciate, the ability to more carefully tailor external assistance to their specific needs.

The issue which we wish to testify before this distinguished Subcommittee is the reduction of the FY 81 appropriation by $10 million and the requirement that the reduction be obtained by curtailing the use of assisting agencies. We recognize the National mood regarding austerity, and have mixed feelings regarding restoration of the $10 million. First, however, we urge that this Subcommittee consider the following points of concern.

Applications for FY 81 grants contain, as required by law provisions for using assisting agencies, which, per the GAO definition, we understand to be institutions of higher education or agencies, organizations, or business entities.

The specific performance objectives to which each applicant commits itself in its grant application is therefore dependent upon the external assistance the applicant was required to include in the program design. This is an extremely important point. The funds awarded under Title III are targeted for the attainment of specific objectives and not for discretionary use by the grantee. The FY 81 applications have been or are currently being evaluated. If, because the ground rules are changed after the applications were submitted, the Office of Education, or the Department of Education, is then required to disallow the external assistance, the integrity of the applications selected for funding will be jeopardized. The outside readers used by the Government to evaluate the applications will have made their judgements on the basis of the specific objectives and methods of achieving them proposed by the colleges, but then Federal grant administrators with no understanding or responsibility of programs will simply disallow certain expenditures for external assistance. The systematic and objective selection process carried out by experts in higher education will in effect be voided. It is, incidentally, interesting to note that the Government turns to

external assistance for this sensitive and complex process of developing recommendations. Especially harmed will be the institutions which have applied for non-competitive continuation grants. Many of the long-term activities which were previously initiated with continuing external assistnace as an integral part will be disrupted.

The intent of Congress regarding Title III is becoming more sharply focused, which we strongly support. We believe this focus addresses fundamental issues which must be addressed at and by the highest levels of an institution's management if the college is to develop and, in fact, survive, and will in turn determine the most valid requirements for other activities, rather than initially dealing with faculty development, academic programs, student services, equipment acquisition, etc., those needs should be a sequel to truly comprehensive strategic planning, improving the management processes and implementing effective fiscal controls. And we believe that in addressing those fundamental issues the grantees must have the opportunity, and freedom, to determine if external assistance is needed. It is our understanding that this is the intent of the Education Subcommittee. And we believe that in some cases external assistance may not be required and in some cases external assistance will be needed, just as it is by the Fortune 500 Companies who frequently use qualified management consultants. Although we are talking here about future legislation, we believe that the intent of Congress during FY 80 is that the grantees also emphasize the improvement of institutional management processes. As a consequence, we believe that a one-time constraint, in FY 81, on the use of external assistance is a serious impediment to the intended development of Title III institutions.

Based on these points, the revision of ground rules after FY 81 applications were prepared and the inherent need for grantees to have the freedom to obtain external assistance to meet the purposes of Title III as expressed by the Congress, The Council of Developing Institutions recommends that restrictions on the use of assisting agencies be modified for the FY 81 appropriations.

As stated previously, the Council has mixed feelings regarding restoration of the $10 million. We believe, on the one hand, that the National mood is such that the reduction should stand. We also believe that the adverse publicity regarding assisting agencies, and the requirement that only one such agency be engaged by a grantee, means that the total FY 81 Title III funds required by the grantees for external assistance will be significantly less than in FY 80, which is consistent with the intent of the $10 million reduction. Rest assured the grantees prefer to use the funds internally, and now that we are not required to have external assistance for every activity, we will indeed request fewer funds for that purpose. Further, because of that expected reduction in funds for external assistance, the balance of the $110 million appropriation, which is to be expended by the colleges themselves, may be very close

to the FY 80 level. It is for those reasons -- austerity, the inherent reduction in funds for external assistance, and the perhaps slight impact on on-campus expenditures, that we feel the $10 million reduction should stand. However, even though the $110 million in FY 81 will provide approximately the same on-campus funding level as in FY 80, the impact of that funding will be less because of inflation. And because Title III is an outcome-oriented program, with targeted performance measures, those colleges with continuation grants will be especially hampered by the effect of inflation. As a consequence, the Congress may wish, because of the unique performance-oriented nature of Title III, to restore the $10 million to accommodate inflation. This would provide consistency with the increasing authorizations proposed for future years, and would ensure that the benefits from prior expenditures are not diminished by a one-time cut back in FY 81.

Mr. Chairman, on behalf of our 315 members of the Council of Developing Institutions, I greatly appreciate the opportunity to present this statement.

Joint Statement of Concerned Faculty and Staff From Several Graduate Schools

We wish to offer written testimony concerning FY 1981 appropriations for Title IX, parts A and B, of the Higher Education Act of 1965, as amended, specifically, the Graduate and Professional Opportunities Program (G*POP).

This statement reflects the views of concerned faculty and staff from several graduate schools deeply committed to and involved in expanding educational opportunities for women and minority persons. Time constraints have prevented many others from the graduate school community who have expressed similar concerns from joining in this letter to you.

A brief outline of the present status of women and minorities in advanced study will emphasize the importance of the G*POP Program.* The situation of non-minority women must be distinguished from that of minority persons. Non-minority women comprised 28% of the doctorates awarded in 1978. Their participation varies sharply according to field of study. They represent 40% of education doctorates, but only 11% of physical science PhDs.

Minority persons comprise an estimated 20% of young adults in this country, but they received only 7.5% of doctorates conferred in 1977-78. In addition to their low numbers, field distribution is a problem; almost one half of minority doctorates are in education. In contrast, black, Hispanic, and Native American persons earned only 3.4% of natural science PhDs.**

As presently funded, G*POP provides support for only 1,002 fellows enrolled in masters, selected professional and doctoral level programs of study. Since approximately 32,000 doctorate, 300,000 masters and 100,000 law degrees are awarded annually, it is clear that only a small proportion of potential students will receive support through the Program. In FY 1980 only 214 new fellowships were awarded, representing less than 0.05% of degrees earned in the eligible disciplines. At this level, G*POP can be expected to have only a minimal impact on expanding the participation of underrepresented groups in graduate and professional study.

A second concern is the impact of inadequate and uneven funding on institutional efforts in this area. Applications for funding have far

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* We have focused on doctoral education since it is at this level that minorities and women have experienced the most severe educational disadvantage.

** Figures cited are from special analysis of data from National Research Council Doctorate Records File, September 1979.

exceeded appropriations each year of the Program. Requests for FY 1980 awards totalled $21.5 million, despite the fact that funding was increased by only $850,000 over the previous year to a total of $8.85 million. Sixty-four institutions that were funded in the first two years of the Program (representing 60% of all institutions previously funded) did not receive new fellowship awards. If G*POP is to serve as an effective catalyst to institutional efforts, then there must be a realistic prospect of obtaining federal funds. Successful recruitment of talented students, development of appropriate support services, and organization of academic administration require extensive lead time and financial commitment; effective institutional activities may be severely weakened or terminated if G*POP funding is erratic and inadequate. G*POP can assist institutions with demonstrated commitment and substantial accomplishments in educating women and minorities to improve or expand their overall efforts. However, unless funding is increased to a significant level, G*POP will be regarded as little more than a token federal commitment relative to the extent and seriousness of the problem.

For these reasons, we urge that funding be increased to $15.0 million for FY 1981, a level that will permit award of approximately 650 new fellowships, or a modest 0.1% of degrees awarded annually in the eligible graduate and professional fields.

We appreciate this opportunity to present our views to you. We are in the process of developing a more extensive commentary on the status of women and minorities in graduate and professional education, national priorities in advanced study, and the role of G*POP in addressing these issues. We will forward it to you shortly.

If you have any questions or wish further information, please do not hesitate to contact us.

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Statement of Ronald W. Hampton, President, Chesterfield-Marlboro Technical College

As your Appropriations Subcommittee begins work on the 1981 appropriation, I would like to share a few of my thoughts and concerns about Title III (The Strengthening Developing Institutions Program) of the Higher Education Act.

Chesterfield-Marlboro Technical College is one of 143 two-year colleges in 40 states (10 of them in South Carolina) which have derived substantial benefits from participating in the ACCTion Consortium, which receives funding from Title III. Participation in ACCTion's instructional component has made it possible for our faculty and staff to keep up with the rapidly changing educational techniques which are so vital in meeting the needs of our service area. In addition, our participation several years ago in the resource development component of ACCTion made it possible for Chesterfield-Marlboro Technical College to increase its effectiveness in providing the financial and material resources necessary for a first-rate technical education program. In short, Title III has meant a great deal to us and to the people we serve.

For this reason I was especially concerned when I read of recent GAO reports and Senate hearings which have uncovered certain abuses of Title III, particularly concerning the use of assisting agencies and consultants. Permit me to emphasize the fact that ACCTion is not an assisting agency. Rather, ACCTion is a consortium of colleges working together for their common benefit. ACCTion's motto, "Colleges Helping Colleges," is descriptive of the organization's purpose, which embodies in both spirit and practice the original intent of Title III.

I would like to point out that because ACCTion has a coordinating office in the Washington, DC area, the consortium has been labeled an assisting agency. However, this is a total misinterpretation. Our Washington coordinating office is part of the grant awarded to Kirkwood Community College and is in no way similar to the outside consulting firms accused of making thousands of dollars at the expense of Title III.

As you know, efforts have already been made to tighten the administration of Title III and prevent recurrence of past abuses. Furthermore, the record shows that the bulk of all Title III funds awarded have, in fact, been used responsibly. The "questionable administrative practices" which were reported have been eliminated, and the management of the program improved, with new built-in safeguards to ensure more responsible decisions about grant awards.

herefore, I believe your subcommittee is justified in returning Title III to ts full authorization level of $120 million, as in FY78 and 79.

I respectfully request that this letter be made a part of the subcommittee earing records.

Statement of Harry Robinson, Vice President, National Conference of Christians and Jews

The problems confronting America are enormous. Inflation, energy, poverty, unemployment—irrational acts in Iran and Soviet aggression in Afghanistan.

The international situation has resulted in calls for a renewed cold war and increased military spending.

We understand the need for a strong defense posture.

Nevertheless, we are concerned that important domestic problems may be ignored in the process.

We see the nation's energies focused on inflation, energy and defense to the neglect of racial equality, full employment and urban revitalization.

The result can easily be further deterioration in race relations and the quality of life, not only for black and poor people, but for all our citizens.

Significantly, education is considered the primary vehicle for improving the quality of life for all.

Since the Brown decision in 1954, many cities have recognized the justice of desegregation and made good faith efforts to prevent turmoil; using careful planning, fair and workable procedures and community programs to keep teachers, parents and children informed.

In every city where courts have ordered action to desegregate the schools, non-profit organizations, churches, service clubs, civic organizations and civil rights groups have been mobilized to work for the good of the community, in fact, the NPO's often are the only vehicle with which the concerned and affected groups have a mode of expression.

Desegregation of schools is moving ahead and it must not be allowed to be relegated to the back burner.

Hopefully, the budget cuts are not an indication of a Congress that has decided to retard the process of desegregation.

Quality education is the right of every child.

Where it entails desegregation efforts, we are committed and united in the need for real inter-action and cooperation among students, parents, school authorities and community groups.

The National Conference of Christians and Jews and hundreds of other NPO's have thought to make inter-ethnic and inter-racial experiences positive and meaningful.

In Charlotte, N. C. for example, the courageous decision by a federal judge in the Charlotte-Mecklenberg school district served to hasten the "with all deliberate speed" decision.

An NCCJ ESAA funded program there has directly reached more than 200,000 students, teachers and parents during the past five years.

74,000 people were involved in the 1979 program.

Students from 21 junior high schools and 10 senior high schools are given training in human relations throughout the school year. With our help, the students design and conduct activities in their own schools to facilitate and promote the desegregation goal of the program--developing mutual understanding and respect among the races.

It is the only human relations program conducted in the Charlotte-Mecklenberg schools. There are no other programs conducted by the school system or any other organization to overcome racial problems.

Our NCCJ director in Charlotte reports:

"Although the schools in Charlotte-Mecklenberg are thoroughly desegregated, there has been very little interaction among students of different races except through this program.
"If this program were discontinued, there would be no sustained efforts to bring the races together in a meaningful interaction".

Gentlemen, it is your responsibility and ours to fully implement the Brown decision, now more than 25 years old.

Thank you for your consideration, patience and understanding.

STATEMENT OF ASSOCIATION OF MEDIA PRODUCERS

Secretary of Education Shirley M. Hufstedler has publicly proclaimed libraries as this Nation's treasure chests. If libraries truly constitute a national treasure, why is the Administration proposing level funding for a program with demonstrated effectiveness and a documented need for additional funds? Where else but in our libraries can one find the riches of past and present generations working so hard to fulfill the promise of future generations! Yet, the fact remains that our school libraries and learning resource centers are still woefully inadequate. It is our strong belief that this national treasure chest should be replenished by increasing the appropriation for ESEA Title IV-B from $171 million to $205 million in the FY 1981 Budget.

Instructional materials and library resources play a central role in the educational development of both teachers and students. Whether or not it pleases us, our children are, indeed, the television generation; they learn differently from those of us who attended grade school thirty, twenty or even ten years ago. As a result, teachers are discovering that they must employ new methods and techniques which recognize that not only have educational needs changed, but each student responds differently to different approaches. Thus, a variety of learning resources becomes imperative, not only as resources for the student, but as essential occupational tools for the teacher. No one expects a carpenter to build a house or a surgeon to perform an operation without the necessary equipment -- why should teachers?

With the diversity of student populations to be served -- gifted, handicapped, functionally illiterate -- teachers need every possible resource to assist them in serving their students. The IV-B program makes learning materials and information available on a one-to-one basis, as well as providing instructional support for the teachers in the classroom.

Experience has shown that schools are turning increasingly to IV-B to meet instructional materials needs associated with programs targeted towards specific populations such as handicapped, gifted, students deficient in English, among others. Because of competing demands upon funds for such programs as bilingual and special education, for example, dollars allocated under these programs often go toward personnel and training, leaving schools to rely on IV-B for the acquisition of essential learning materials.

Two polls conducted recently, one by the Gallup organization (of the public in general) and one by Instructor magazine (of 10,000 teachers) demonstrate the need for a substantial learning resources program, which cannot be implemented without significant increases in Title IV-B -- the one program which is designed to put these resources directly into the hands of the students and teachers who need them.

First, the Gallup Poll: Asked what 7 steps a school must take to earn an "A" grade, citizens included two which have direct bearing on the quality and quantity of learning resources available: give students more individual attention and provide more emphasis on basics. In order to accomplish this, schools must provide their teachers and libraries with the materials which enable them to assist each child in addressing his or her unique problems to assure that each emerges from school with functional life skills. Title IV-B provides these resources.

Another question asked by Gallup was "What do you like most about your schools?" One of the top four answers was "special programs -- for gifted, learning disabled, college-oriented and vocational students." To serve these equally important but very diverse needs, schools must be equipped with adequate resources. Again, it is Title IV-B upon which schools depend.

Finally, when queried about elements in an "ideal school," Gallup respondents emphasized "much more attention to careers." Though visits and lectures by representatives of various occupations are valuable, the daily schedule of a school does not permit much of this kind of activity. Multi-media materials on this topic, of which there are many, can bring the entire world of work into a student's view, and assure that non-traditional career roles are examined.

Answers to the Instructor poll of 10,000 teachers again emphasized the importance of learning resources in the instructional process: (1) in describing an ideal teaching situation, teachers listed a choice of multiple texts and having every class a resource center as top priorities; (2) to the question, what makes a good elementary school, only teachers, the community and the principal were listed ahead of instructional materials; (3) in a list of five situations considered the biggest handicap to teaching, respondents included large class size and children with low skills (hence, the priority placed on learning resources).

Another high priority effort emphasized by both President Carter and Secretary Hufstedler is to teach basic skills in conjunction with occupational skills -- especially to young adults who cannot enter the job market because their skills are either insufficient or non-existent. According to a survey of New York City employers, the major obstacle they face in hiring the un-employed is not the absence of specific occupational skills, but the lack of basic educational skills. Many of these people, who were not served well by the system in their early years, require new approaches, new techniques, to bring them to a functionally literate level.

Equally tragic -- and with more dangerous consequences -- is the effect that the decline in basic skills is having on the U.S. armed forces. Only 64% of 1979 enlistments were high school graduates -- a 10% drop from just a year ago. More to the point, the Army has had to simplify its training publications to the 7th grade level, and still 19% of its new recruits read below that level.

It is irresponsible to ignore this problem, but it is absurd to propose spending billions of dollars in remedial training while spending almost nothing for the instructional materials needed to teach basic skills in the first place. There is nothing brilliant about the conclusion that Johnny can't read unless he has materials appropriate to his needs. In the case of the military, Private Johnny not only needs to learn how to load a gun; many times he needs to be taught first to read the instructions. Certainly, it does not make sense to wait until Johnny enters the military, or the job market, to teach him those skills he should have learned early in school. (Ironically, it was the armed services during World War II who first demonstrated the effectiveness of audiovisual instruction by using it to teach new skills to large numbers of people quickly.)

That the American public is demanding some set standards for basic skills achievement at the elementary and secondary level is evident from the fact that, in response to public demand, thirty-six states now have instituted some form of competency testing -- and seventeen use competency testing as a basis for graduation. Teachers and students simply cannot be expected to meet the standards being set for them without the support of the instructional materials they need.

It is not only the quality of education which is being questioned, but, as in all parts of the nation's economy, the cost-effectiveness of the programs is under examination. As stated in a study published by D.T. Jamison in 1978, The Costs of Educational Media; Guidelines for Planning and Evaluation, "The key to productivity improvement in every economic sector has been through the augmentation of human efforts by technology, and we see no reason to expect a different pattern in education. We use the term augmentation deliberately here to set aside the notion of technology's replacing teachers; the purpose of the technology must be to make teachers more productive, not to replace them ... The problem is not that of replacing teachers but of successfully using the technology to improve production."

The IV-B program has consistently demonstrated its effectiveness in helping all schools, including non-public, address the issues raised above. (According to the U.S. Office of Education, over 96% of the Nation's non-public schools participate in the IV-B program -- the highest degree of participation by non-public schools in any Federal education program.) Examples of the variety of ways in which IV-B funds are used to achieve the objectives of Federal top priority concerns (serving the handicapped, disadvantaged, etc.) are described in Appendix A.

Need for Increased Federal Appropriations: Soaring Silver Costs Boost Instructional Materials Prices

The inflation all sectors of the economy are confronting has recently taken on an even more pernicious form for the educational film materials industry with the staggering increases in the silver market. Silver is an essential ingredient of raw film stock. Producers of filmstrips and films had managed, over the last five years, to raise the average price of a 15

minute, 16mm film only 24%, while abosrbing a cost increase of almost 54%; average filmstrip prices rose approximately 30% while costs to the producers increased 38%. Now, the impact of the rampant escalation in silver prices and petrochemicals has meant that the leading manufacturer of film stock has increased the price of color film 59%; black and white film has soared 92% -- causing upheaval in the educational media industry. Producers and distributors, knowing the inelasticity of school budgets, will again absorb a significant portion of their increased costs. However, merely to remain in existence, companies have already had to raise film prices from 13-20% in the first two months of 1980.

The National Commission on Libraries and Information Science's most recent report on "National Inventory of Library Needs" stated that at that time public school library/media centers needed at least $4.5 billion in additional funds "for acquisition of nonprint materials, additional print materials, and equipment needed for effective use of A-V materials." The study also revealed that school library/media centers had only 50% of the print materials needed for the pupil populations served and only 5-20% of the nonprint materials needed. Further, only 22% of the library/media centers reached or exceeded 10% of the needed level of operating expenditures; and those served less than 1/5 of the pupil population.

Today, 16.5% of our public schools still have no library/media center at all -- these schools serve approximately one million elementary and secondary school children.

More recent statistics (1978) indicate that in our urban schools, many of them serving the disadvantaged populations targeted by the Administration for special attention and services, 12% of the elementary schools lack library/media centers; 8% of the secondary schools lack these vital facilities.

Students in rural schools, also identified by the Administration as needing significant support from the Federal government, have even less access to library/media center services. A shocking 25% of rural elementary schools have no library/media center; neither do a full 16% of the secondary schools.

Even our suburban schools are sadly inadequate, with 15% of the elementary schools and 10% of the secondary schools unable to provide these resources to their students.

Since the 1975 NCLIS report, IV-B appropriations have increased by only $35 million -- just over 20% -- and nowhere near the amount NCLIS said was needed. To compound the problem, during the period since NCLIS conducted the needs assessment the combined cumulative increase in the consumer price index rose by more than 39%. Thus, not only have this Nation's school libraries moved no closer to narrowing the gap between what exists on library shelves and what is needed, but they have actually fallen away from the goal as a result of the decline in real dollars available to meet the needs.

The National Center for Educational Statistics just completed a study of a schools' needs for financial assistance to purchase books, periodicals, audiovisual materials and audiovisual equipment for their school library/media

center program. More than 75% indicated a need for assistance to purchase audiovisual materials; close to 50% expressed this need as "strong" to "very strong." Over 70% need assistance to purchase adequate books and audiovisual equipment.

The inflation factor alone makes level funding for Title IV-B unrealistic; with the added factor of price increases caused by the silver market, it is imperative that Congress increase the IV-B appropriation to at least $205 million, to relieve local school districts of a part of this burden and assist them in providing quality learning materials for their students.

We have all heard the critics of our educational system; they point to irrefutable declines in basic skills achievement during the past ten years. We do not think it inappropriate to point out that during the space race of the 1960's, and after enactment of the National Defense Education Act and the Elementary and Secondary Education Act, there was a heavy emphasis on libraries and new technology. All of the studies conducted during this period showed not only improvement in skills, but renewed interest in learning. This seems to be missing now. We believe that the excitement of learning can be restored if we pay close attention to the needs of those who are being served. This means we must find the best teachers and provide them with the best resources available and permit them to do their jobs properly. To this end, we ask Congress to renew its financial commitment to school libraries and to demonstrate this commitment by increasing funds for the Title IV-B program to at least the level of $205 million.

STATEMENT OF E. JOSEPH SCHNEIDER, EXECUTIVE DIRECTOR, COUNCIL FOR EDUCATIONAL DEVELOPMENT AND RESEARCH

The Council for Educational Development and Research (CEDaR) is pleased to submit testimony in support of the FY81 budget request of the National Institute of Education (NIE).

We understand the Secretary of Education seeks $88.1 million for the agency as part of the Department of Education's "research and related activities" request.

The Council is a professional education association with the regional educational laboratories and university-based research and development centers as its charter members. The NIE provides these labs and centers with the bulk of their funding. Currently, they receive about $30.6 million in contracts and

grants from the Institute. For FY81, NIE estimates it will spend approximately $31 million with them.

The labs and centers, in other words, anticipate receiving 35 percent of NIE's FY81 budget request. Because they receive a significant percentage of NIE's total appropriation, the labs and centers wish to supplement the agency's FY81 budget justification with one of their own. Our testimony, in other words, will concentrate on the NIE-funded programs and projects being conducted within the eight regional educational laboratories and eight university-based research and development centers. (NIE also supports the National Center for Higher Education Management Systems out of laboratory and center funds.)

HISTORY OF SUPPORT

The centers and laboratories were created with congressional approval in the early 1960s. Originally, the U.S. Office of Education provided them with their funding. However, with NIE's creation in 1972, HEW transferred the lab and center programs from USOE to the new research agency. Since then, the existing 17 labs and centers have received the following funding:

Year	NIE Appropriation* (in millions)	Lab Funding (in millions)	Lab/Center Percent Of NIE Funding
1973	$142.671	$44.764	31.4%
1974	75.700	32.302	44.7
1976	70.000	26.798	38.3
1977	70.385	25.680	36.5
1978	90.100	27.615	30.6
1979	96.614	29.200	30.2
1980	91.171	30.600	33.5
1981	103.050**	31.000**	30.0

*NIE figures include salaries and expenses
**Budget estimate to Congress

The Institute's current funding of the labs and centers is responsive to congressional intent. Last year the Senate Appropriations Subcommittee on Labor; Health, Education, and Welfare, included report language that stated:

> Three years ago, Congress created a Panel for Review of Laboratory and Center Operations. This panel of 14 scholars and school practitioners spent over a year examining the labs and centers, and recommended that NIE establish long-term relationships with 15 of the 17 institutions. Within the year, the remaining two institutions are also expected to have such a relationships. In light of this highly positive review of the labs and center program, the Committee directs that at least $29.8 million be used to continue and strengthen the program. (Emphasis added.)

The report of the House Appropriations Subcommittee on Labor; Health, Education, and Welfare contained similar instructions, as did the two committees' conference report.

NATURE OF LAB/CENTER PROGRAMS

The Institute's authorizing legislation instructs NIE to treat the labs and centers differently from its other contractors. That is, Congress directed NIE to request from the labs and centers long-range plans. The Institute, then, was told to review them and to request proposals for funding from those labs and centers having submitted high-quality, acceptable plans.

This process resulted last year in the Institute's decision to invite 15 of the 17 labs and centers to enter into a special, long-term relationship. Following an extensive review of each institution's three-year funding proposals, NIE proceeded to contract for the support of agreed-upon work.

What makes the relationship between the labs and centers and NIE unique is the fact that the institutions, not the government, determine their research and development agendas.

In most instances, NIE assumes the authority to determine the federal research agenda. And it then turns around and selects researchers and r&d institutions to work on this agenda.

However, this agenda-setting process does not apply to the labs and centers. Instead, these institutions initiate their own programs and submit them to NIE for review, approval, and eventual funding.

Stated another way, about 35 percent of NIE's resources are going to address significant research problems identified by the scholarly community within centers and to meet critical needs surfaced regionally by state departments of education, school administrators, and classroom teachers.

Each university-based r&d center, in other words, concentrates its effort around a critical problem area. Their entire staff of scholars then devotes its energy to seeking knowledge, exploring solutions, and disseminating findings. These eight institutions delve heavily into research, both basic and applied.

The laboratories, on the other hand, concentrate more on the applied side of the r&d spectrum. Their programs result from needs sensing activities conducted within their region. That is, the labs by and large work on problems identified by educators within the region. The resulting work takes on more of a complete r&d mix than normally seen within a center. For example, the labs can be depicted as "full-service" r&d institutions; they conduct research, undertake development, and initiate dissemination or technical assistance as necessary. The laboratory's role, simply stated, is to be responsive to the needs of its regional clientele.

Summarizing, then, we believe the labs and centers qualify as unique r&d institutions because they are responsive to the scholarly and school-based communities rather than to the federal government.

COOPERATION ENHANCES IMPACT

The centers, with their basic research focus, seldom impact directly on schools. Research results, in other words, are best utilized by other reseachers and eventually developers who produce tangible products and processes or school and classroom use. Conversely, the laboratories, with their school focus, need a constant diet of new research outcomes to respond effectively to the challenges facing America's educators.

Consequently, the cooperative relationship among the institutions within the network of labs and centers greatly enhances their individual contribution while maximizing the taxpayers' investment.

One example comes immediately to mind. About six years ago Far West Laboratory in San Francisco, using NIE funds, began investigating ways to increase learning of basic skills among elementary school children. This massive effort was labeled the "Beginning Teacher Evaluation Study." The laboratory's researchers developed a model of learning that greatly increased student achievement. The notion, simply stated, is that achievement soars when a student increases the amount of time spent engaged in a particular academic task with a high success rate. That's somewhat logical; what's difficult, the researchers discovered, is putting the notion into practice.

Consequently, today two other laboratories besides Far West are working to translate the findings of this study into procedures and materials teachers can use to improve their own classroom practices. These two laboratories, Research for Better Schools in Philadelphia and Mid-continent Regional Educational Laboratory in Kansas City are working in classrooms helping teachers adapt the study's findings to their local situation.

Another large teacher-related study, this one done by the University of Texas' Research and Development Center for Teacher Education, has influenced numerous laboratories in their dealings with educators. This NIE-financed work at the Texas Center identified effective classroom management strategies and staff development techniques. These processes are being used by the Southwest Educational Development Laboratory in Austin in working with teachers using its bilingual education materials. Other institutions applying the Texas Center's research outcomes are the Philadelphia, Kansas City, and St. Louis laboratories.

At the Wisconsin Research and Development Center for Individualized Schooling, researchers are developing a comprehensive design for the renewal of secondary education. Cooperating in their efforts to develop this design for eventual school use are Northwest Regional Educational Laboratory in Portland, Oregon, and the labs in St. Louis and Philadelphia.

Other examples abound: major study to identify positive classroom activities, conducted by the University of Pittsburgh r&d center, greatly influenced a three-state school improvement effort of the Philadelphia laboratory. And the Student-Team-Learning program from the Johns Hopkins University research center is being used in over 500 school districts, thanks in part to the dissemination assistance provided by the Appalachia Educational Laboratory in Charleston, West Virginia, and those in St. Louis and Portlant. The Hopkins Center's research-based program enhances basic-skills acquisition and improves race relations among students.

NATIONAL NETWORK NEEDS

The current institutions work individually and collectively to apply a critical mass of r&d talent toward the problems facing school practitioners.

Right now, though, this collective expertise does not extend to the entire country. That is, educators in the Northeastern, Upper Midwest, and Southeastern states currently are without regional educational laboratories of their own. The NIE has a planning group addressing this unmet need. And we support its efforts. But we believe the Institute must move faster, with more resources, to establish a minimum of three new laboratories in these three regions. To do less, we believe, would be to deny the benefits of sustained r&d expertise to all schools equally.

LETTER FROM GEORGE B. BRAIN, DEAN, COLLEGE OF EDUCATION, WASHINGTON STATE UNIVERSITY

March 6, 1980

The Honorable Warren G. Magnuson
The United Stated Senate
Washington, D. C. 20510

Dear Senator Magnuson:

The purpose of this letter is to urge that $6 million be appropriated for the National Assessment of Educational Progress for FY-81. This level of funding would be approximately $2.2 million over the amount requested for the assessment by the National Institute of Education. This is a request for an earmark at the expense of programs included in the Administration's $88 million NIE request for FY-81.

The additional funding would be for the following purposes: 1) collection of data on performance information for out-of-school seventeen-year-olds (present funding levels only allow the assessment to reach in-school seventeen-year-olds); 2) provide the same level of data for Hispanic/Chicano students as is provided for other racial/ethnic groups; 3) offset a proposed reduction of the comprehensive scope of the assessment (areas such as science, social studies, and citizenship will have to be dropped); and 4) restore the young adult (ages 26-35) assessment as an integral part of the program. Each of these purposes is directly related to current critical state and local educational policy issues. The level of funding proposed for

National Assessment in the Administration's budget is not adequate to support these essential purposes.

I fully understand the need for the Appropriations Committee to take a hard look at the effectiveness of federal programs in making funding judgements responsive to the necessity of controlling governmental spending and the concomitant impact on inflation. I have no doubt, however, that National Assessment can meet this test. The assessment is fundamentally a service to states and local education agencies to assist development of policy and programs designed to improve the educational achievement of the children and young adults. That the assessment has been, and continues to be, effective in carrying out this mission is reflected in the overwhelming support provided by all educational constituencies to the assessment program. This support was expressed last year as the Congress considered and passed legislation providing a similar authorization for the program and transferring responsibility for the program from the National Center for Educational Statistics to the National Institute of Education.

Despite the demonstrated effectiveness of the program, the Administration has consistently proposed funding inadequate to carry out its basic mission. Since 1973, the budget for the assessment has been reduced from $6 million to $3.9 million per year. It was this lesser amount which was transferred from NCES to NIE in March, 1979. This erosion of the budget has constrained efforts to achieve the four major objectives which the program was designed to provide; technical assistance to state and local agencies also has been negatively affected.

It is requested that this letter be made a part of the hearings record for FY-81 Appropriations. Thank you for

your continuing support of the National Assessment of Educational progress.

Sincerely yours,

George B. Brain

George B. Brain, Dean
College of Education
Washington State University

STATEMENT OF ROBERT G. SCANLON, SECRETARY OF EDUCATION, COMMONWEALTH OF PENNSYLVANIA

Chairman Magnuson, distinguished members of the Subcommittee and ladies and gentlemen.

I am pleased to have this opportunity to share with you the Commonwealth's concerns about appropriations for the Education of All Handicapped Children Act, P.L. 94-142. Before I begin, however, I would like to take this opportunity to thank you for your support in the past for education programs. Through the efforts of this committee, we have been able to reach and serve many more children with effective programs. I am very glad that you believe in improving and enchancing the individual through education.

I am before you today to ask for your continued support of P.L. 94-142. The Act is a commendable recognition at the federal level of the need to support state efforts in special education. The Act exhibits strong federal leadership and recognizes a child's right to a free appropriate education with procedural safeguards. It also recognizes the importance of involving parents in their children's educational programs.

This recognition resulted in very specific mandates to administer education programs to all handicapped children. The implementation of these mandates depends on full federal appropriation of funds. Today I wish to emphasize the need for full funding and to describe the difficulties states and school districts will continue to encounter if the law is

inadequately funded. The following is a brief background and description of the program in Pennsylvania, the current fiscal support of that program, the funding needs, the problems of inadequate funding, and the need for re-examination of the formula.

Background

Over the past several years, we have made great strides in providing handicapped children quality special education programs appropriate to their needs. The major thrust of P.L. 94-142, namely the appropriate placement of handicapped children with procedural protections, has been mandated by Pennsylvania law for several years. It was in this context that the decision was made to participate in the P.L. 94-142 program. The following facts illustrate the Commonwealth's commitment to full implementation of the law.

- Pennsylvania has been spending its funds ($36.7 M this year) the same year it receives them while other states continue to carry-over substantial portions of their funds.
- Our 1980 State Plan was approved in July 1979 and was the first of the major states to be approved. Consequently, we have already allocated dollars to local education agencies, which are spending the money.

While this fact indicates a strong commitment, it appears that Pennsylvania will be penalized for these efforts as I will describe later.

Program Description

Since 1975, we have served almost a million children, ranging from the educable, trainable and severely mentally retarded to the gifted. In 1978-79 school year alone we served 237,908 children in 14 categories of exceptionality. The following chart is a breakdown of Pennsylvania students served by special education programs.

PENNSYLVANIA STUDENTS SERVED BY SPECIAL ED PROGRAMS

Exceptionally	1975-76	1976-77	1977-78	1978-79
Educable Mentally Retarded	38,823	37,046	35,436	33,005
Trainable Mentally Retarded	8,343	8,484	8,054	7,671
Severely and Profoundly Mentally Retarded	3,708	3,492	3,583	3,502
Socially and Emotionally Disturbed	7,763	8,377	8,863	8,947
Physically Handicapped	3,011	3,174	3,007	2,746
Brain Injured	5,913	6,211	5,132	4,245
Learning Disabled	15,458	19,879	23,671	25,557
Hearing Impaired	4,766	4,798	4,710	5,122
Visually Impaired	3,320	3,211	3,016	2,867
Speech and Language Impaired	93,450	93,412	80,698	82,008
Gifted/Talented	20,332	27,526	42,637	50,762
Multihandicapped	2,119	1,919	1,587	372
Mixed Categories	2,239	1,799	4,964	8,379
Detention	3,262	4,240	3,544	2,725
TOTAL	212,507	223,568	228,902	237,908

Current Fiscal Support

For the 1979-80 school year we are spending $359.4 million for handicapped children--$45.3 million in federal funds, $260.5 million in state funds, and $53.6 million in revenue-sharing monies. The following chart illustrates Pennsylvania's use of the Part B portion of the P.L. 94-142 funds.

PENNSYLVANIA'S USE OF P. L. 94-142 FUNDS
($ In millions)

PROGRAMS AND SERVICES	1977-78	1978-79	1979-80
Preschool Programs	5.802	6.318	7.368
Maintain and Expand Programs and Services for LD and SED students		12.652	16.329
Other Activities (To meet priority services detailed in State and LEA Plans for Federal Programs and Services, including Child Find, In-Service Training, IEP Planning, Personnel Development)	7.308	5.024	6.850
SEA Administrative Operations	.690	.915	1.836
Carryover	—	1.391	4.332
TOTAL ALLOCATION	13.800	26.300	36.715

The revenue-sharing monies going to special education comprise 48 percent of the total revenue-sharing funds received by Pennsylvania -- $100,844,000. It should be noted that the state's portion of the revenue-sharing funds is in jeopardy. Under the federal budget the Commonwealth stands to lose 50 percent of its state share for next year and 100 percent of its share for the next year. This last will result in a serious financial burden for school districts and the Commonwealth.

Funding Needs

As you know, the statute provides a formula for allocating funds to the states on the basis of an escalating percentage of the average per pupil expenditure for elementary and secondary schools in the states. The following chart translates those percentages into money and compares the authorization and appropriation levels for all states and Pennsylvania.

P. L. 94-142
AUTHORIZATION V. APPROPRIATIONS

($ in millions)

	Percentage of the APPE*	National $ Amount National	Pennsylvania $ Share
1977-78			
Authorization	5%	$ 315	$ 13.8
Appropriation	same	same	same
1978-79			
Authorization	10%	$ 564	$ 26.3
Appropriation	same	same	same
1979-80			
Authorization	20%	$1,200	$ 54.0
Appropriation	12%	$ 804	$ 36.7
Difference	8%	$ 396	$ 17.3
1980-81			
Authorization	30%	$2,320	$104.0 (est.)
Appropriation	12%	$ 874	$ 40.0 (est.)
Difference	18%	$1,446	$ 64.4
1981-82			
Authorization	40%	$3,000	$140
Appropriation	12%	$ 922	$ 42
Difference	28%	$2,078	$ 98

*Average per pupil expenditure in public elementary and secondary schools in the United States.

When the law was enacted, we were encouraged. It was the first time the Congress has exhibited such a strong interest in supporting the states' efforts to provide education to handicapped children. We were likewise encouraged when the law was fully funded in the first two years. The Congress was willing to support the strict mandates with increasing amounts of money. Accordingly, we have encouraged local education agencies to cooperate with the P.L. 94-142 mandates by pointing to the full funding in the first two years as proof that Congress was serious about serving handicapped children. Our optimism has begun to fade.

As the chart on page 4 indicates, last year the federal appropriation was only 12 percent whereas the authorization level was 30 percent of the national average per pupil expenditure. Under the proposed FY 1981 budget the Act will be underfunded again. The proposed funds are $922 million or only 12 percent whereas the authorization level is 40 percent.

With inflation, this appropriation level will barely allow us to maintain the programs we have established and will make it difficult to expand programs. In addition, the inadequacy of funding has created several problems. As will be described in the next section, those problems will become more severe and new problems will be created.

Problems Resulting from Inadequate Funding

I want to emphasize that there are two sets of problems you should consider when considering the level of appropriations: existing and potential. The following is a brief description of these problems.

Existing Problems

1. The inadequacy of funds specifically has made the tasks of expanding programs for the underserved and of identifying unserved children very difficult. We are currently serving 10,891 socially and emotionally disturbed children, whereas we estimate there may be as many as 39,000 such children in

Pennsylvania. We are also serving about 38,000 learning disabled children whereas we estimate there may be as many as 59,000 such children. We are also uncovering difficulties in our "Child Find" efforts since school districts will be reluctant to identify children who need services if funds to provide those services are inadequate or non-existent.

2. School personnel, children and their parents have misunderstood the level of services available under P.L. 94-142. Expectations have been raised, and needs identified, but the anticipated federal support is not forthcoming. This has put state agencies in the position of explaining the uncertainties of federal funding.
3. Personnel development efforts have been hampered. This issue is of particular importance in preparing regular and that P.L. 94-142 requires the public schools to guarantee that students will not regress in learning or behavior during periods of noninstruction regardless of home environment, nature of a student's past program, or the health of the child. For seriously disturbed and severely retarded children, this means that the public schools will have to provide year-round residential placements for certain children. The Armstrong Court ordered three such placements. The Court reasoned that since P.L. 94-142 does not specifically recognize the conventional school year as the framework in which special education shall be provided, the state education agency must make year-round and weekend programs available. It should be noted that the Court's unique reasoning could likewise be applied to the traditional school day, teacher-student ratios, and any limiting factor on the length or quantity of instructional program.

We are appealing this case because the decision appears to be beyond the intent of P.L. 94-142 and places the unprecedented responsibility on the public schools to provide year-round services and, indeed, to guarantee the success of these services. Armstrong vs. Kline, if upheld,

has the potential for radically expanding the school year for all handicapped school children and the responsibilities of the public school system. This expansion will drastically affect the costs of serving the children. As you know states are currently straining to generate enough money from federal, state and local sources to provide education and related services during the conventional school year. This is why I am offering this testimony. Requiring local education agencies to operate year-round programs will only exacerbate an already serious situation.

If the Congress, by enacting P.L. 94-142, intended the public schools to become a total care system for the handicapped, to prevent regression while a child is out of school, and to guarantee each child's behavioral progress under all circumstances, then the Congress must provide the funding necessary to reach these goals. Our own estimates indicate that the Armstrong decision may cost the Commonwealth more than $131 million. The following chart shows the potential cost impact.

EXCEPTIONALITY	ANNUAL PUPIL COST[b]	DAILY RATE	ADDED COST[c]	EFT PUPILS[d]	TOTAL COST
Severely and Profoundly Mentally Retarded[a]	$ 6,152	$34	$1,870	3,537	$ 6,614,190
Trainable Mentally Retarded[a]	5,386	30	1,650	7,779	12,835,350
Socially and Emotionally Disturbed[a]	6,533	36	1,980	7,335	14,523,300
Brain Damaged[a]	4,012	22	1,210	4,064	4,917,440
Educable Mentally Retarded	3,470	19	1,045	29,968	31,316,560
Physically Handicapped	7,200	40	2,200	2,234	4,914,800
Learning Disabled	5,474	30	1,650	12,116	19,991,400
Visually Impaired	9,646	54	2,970	1,328	3,944,160
Hearing Impaired	8,390	47	2,585	2,552	6,596,920
Speech and Language Impaired	11,407	63	3,465	3,221	11,160,765
Gifted/Talented	4,991	28	1,540	8,632	13,293,280
Detention	4,242	24	1,320	1,098	1,449,360
Total/Average	$ 6,409	$36	$1,569	83,864	$131,557,525

a - exceptionalities with highest potential for extended school year eligibility (potential cost $39 million)
b - BASED upon 9 Month (180 Day School Year)
c - BASED upon 55 Additional Days X Daily Rate
d - EFT means Equivalent Full-Time Students

I should point out that several other Armstrong-like suits have been filed across the states so this is not a problem that can be ignored. You should also know that since the Armstrong ruling we have received many requests from

parents of other non-handicapped and minimally handicapped students for year-round and summer education.

If the decision is upheld, the first program to be eliminated to meet Armstrong costs will be the preschool program. There is also the possibility that services within the 9 month programs for the handicapped will have to be curtailed to meet the Armstrong 12 month mandate. When I testified before the Senate Subcommittee on the Handicapped last fall, I recommended that the Act be amended to (A) limit P.L. 94-142 programs to the regular school year and (B) to clarify the fact the P.L. 94-142 does not require the maximumization of potential or prevention of regression for the children.

2. Provisions for related services and expansion of services to the public and non-public schools are also potential problems. They have not reached crisis proportions because the requirements are vague. Once the requirements of these provisions are clarified the responsibilities of schools will increase and costs will increase accordingly. We are already having considerable difficulty in administering the related services provision since many of the services which are being requested are not only fiscally prohibitive but are also beyond the expertise of educational personnel. In my testimony last fall I suggested these alternatives: recognize and fund agencies which are authorized under state law to provide such services or grant the local agency the authority to decide what services are needed.
3. Inflation coupled with inadequacy of funds is a potential problem and may cause reductions in services.

Need for Formula Re-examination

We believe the statutory formula should be re-examined to assure equitable treatment of all the states in the allocation of funds. A new formula should include the following factors:

Carry Over Funds

Earlier in my testimony I alluded to Pennsylvania being penalized for its whole-hearted efforts to implement the Act. This is because of the rationale that additional funds are not needed because most states carryover substantial portions of their allocations. This rationale does not consider a state like Pennsylvania which typically spends money the same year it is received. We believe P.L. 94-142 means that if needs are identified and funds are available, those needs should be served in a timely fashion.

State and Local Efforts

The degree of fiscal commitment of states and local agencies should be recognized in the formula. Therefore, incentives should be given states such as Pennsylvania which dedicate large amounts of both state and/or federal revenue-sharing dollars to special education.

Standard Child Count Procedures

The statute should prescribe a standard method of counting part-time and full-time equivalent students so that the child count reflects actual need and is compatible across states.

Thank you for the opportunity to present the Commonwealth's rationale for requesting increased funds for P.L. 94-142 and for supporting amendments to the authorizing legislation to clarify certain provisions. My staff and I are willing to assist you in your deliberations on funding for services for handicapped children. Please let me know whether we can be of assistance.

Statement of the National Association of State Directors of Special Education

This statement represents a request on behalf of the Executive Board and membership of the National Association of State Directors of Special Education (NASDSE) urging the support of the Senate Committee on Appropriations for an increased level of appropriations for the State Grants Program of P.L. 94-142, The Education for All Handicapped Children Act.

NASDSE is comprised of personnel within state education agencies having statewide responsibilities for the education of exceptional children in the fifty states and outlying areas. Since 1938, NASDSE has addressed critical issues involving the education of exceptional children, and has maintained close liaison with governmental, professional and private agencies, and organizations which work with and for exceptional individuals.

We wish to identify and discuss three major issues:

(1) The established federal/state partnership must not be eroded if (a) the National public policy and federal mandate of a free, appropriate, public education (FAPE) for all handicapped children is to be achieved, and if (b) the increased state and local levels are to continue;

(2) The figures for the annual per pupil expenditure (APPE) on which the Administration's budget request is made are erroneous.

(3) An increase in the federal share of P.L. 94-142 is essential and an appropriation level of at least 18 percent is recommended.

FEDERAL/STATE/LOCAL PARTNERSHIP

The Education for All Handicapped Children Act, P.L. 94-142, has been widely acclaimed as an historic effort by the Congress to insure the educational rights of all handicapped children. It is a generally shared view that no other piece of educational legislation has had a greater positive impact on statewide educational services.

Inherent in P.L. 94-142 is the promise of a full partnership between the federal government, the states, and local school districts to fund the implementation of the law. These levels of government must cooperatively undertake this major endeavor if the full services goal of P.L. 94-142 is to be achieved and all handicapped children are to receive an appropriate education.

Fiscal Commitment

The states have confirmed their fiscal commitment to the goal and to the partnership. State funding of special education programs is now the largest and most rapidly growing element of state categorical financial assistance to local schools. A generation ago, aid for special education totaled less than $200 million and accounted for no more than 3 percent of all state aid to local schools; it was nonexistent in many states. By 1975, aid for special education was common to every state and totaled over $2.1 billion, or more than 8 percent of all state aid received by schools. Since 1975, the increase in state funding for special education among all states has averaged 14.3 percent annually; during the period FY 78-79 the increase in state funding was 16 percent (see Appendix A). Even with these large increases, a 1979 DHEW report on State Financing of Special Education states that "in many cases the state special education funds, as reported, underestimate state support because of accounting procedures which 'hide' some of the support services provided the handicapped (by the state)."[1]

The federal share of the established partnership for state grant programs, while welcomed and vital to states and local school districts, has not kept pace with state and local appropriations; it has reached a plateau, and has even seen a reduction. Federal dollars as a percentage of total state and federal special education funds averaged only 4.6 percent in 1975, 6.2 percent in FY 77, and 4.9 percent in FY 78 (see Appendix B).

A federal pattern exists and is being reinforced for establishing mandated programs but not appropriating the federal funds necessary to be used in combination with state and local funds to implement these

[1] State Financing of Special Education, Office of the Assistant Secretary for Planning and Evaluation, Department of Health, Education and Welfare, Washington, D. C., August 30, 1979, p. 1.

programs. The proposed federal appropriation for the FY 1981 budget cycle of approximately only 30 percent of what was authorized and anticipated by the state and local school districts for P.L. 94-142 will have a severe negative impact (see Appendix C). It is critical that the federal appropriations for FY 81 reflect a substantive increase in order to assist state and local districts to achieve a free appropriate education for each handicapped child in the nation.

ACCURACY OF BUDGET FIGURES

To assess the impact of the federal share in educating handicapped children adequately, the figures on which that share is based must be examined: (1) Average Per Pupil Expenditure and (2) Child Count.

Average Per Pupil Expenditure

The table which follows, based on the Administration Budget Justification Figures for FY 1981, illustrates the national average per pupil expenditure (NAPPE) and the percent increase in NAPPE calculated by the administration each year.

TABLE 1

Average Per Pupil Expenditure

School Year	NAPPE	Percent Annual Increase	Federal Share/ Child
1977-78	$1430		$ 72
1978-79	$1560	9%	$159
1979-80	$1736	11%	$217
1980-81	$1900 *	10%	$230
1981-82	$2033 *	7%	$239

*Projected figures

With an average increase by percent in the average per pupil cost from 1977-1981 of 10 percent, the Administration's projected 7 percent for NAPPE for 1981-82 must be considered highly questionable and targeted as a very low estimate.

School officials estimate at least a 10 percent increase in the NAPPE for FY 1981. If this is the case, the actual NAPPE would be at least $2090. If the administration maintains its previous policy of funding P.L. 94-142 state grant programs at a 12 percent of NAPPE level, its use as a base cost would result in an appropriation reflecting less than the administration's own policy.

The National School Boards Association (NSBA) indicates that the average cost of educating a handicapped child is approximately twice the cost of educating a child not receiving special education.[2] Using the administration's figure ($2033), a conservative estimate of the average cost of educating a handicapped child would be $4066. Therefore, according to Table 1, the projected Federal Share Per Child of the excess costs is $239, an increase of only $9 from the last year. An 18 percent appropriation would make available an additional increase of $66 per child.

Child Count

Another figure on which the appropriation level depends is child count. Studies show that the number of children actually served in the Nation's schools is far greater (10-20%) than the December 1 child count reports indicate. For example, NASDSE recently completed a specially conducted child count survey involving a sample of 295 school districts in six midwestern states. The survey includes a May 1 count of children being served and a cumulative count of children served throughout the year.

The data collected in the survey for May 1 showed a 1.76 percent increase over the December 1 count mandated in the law. The cumulative count for the six state sample, on the other hand, shows an increase of 12.36 percent over the December 1 figures. Thus many more children are served during the year than the one time official count indicates.

INCREASED COMMITMENT

There is no question that P.L. 94-142 is underfunded. For the past years, state and local education agencies have increased their commitment to funding and developing programs for the handicapped. The state

[2] A Survey of Special Education Costs in Local School Districts, National School Boards Association, Washington, D. C., 1979.

commitments and appropriations are far surpassing the federal share. States are at the breaking point financially in support of this program, and costs continue to escalate for providing salaries, transportation for children, books and materials, and building upkeep and utilities. Officials in the Maryland State Department of Education indicate that local education programs "would be dead" without increased appropriations. Most of the smaller states are in similar circumstances.

Not taking an increased child count into consideration, the Administra- x tion's budget request would spread a lessened buying power over more children. Therefore, state and local education agencies are required under federal law to provide more services to more clients with fewer and inflated dollars.

NASDSE recommends that the appropriations level for P.L. 94-142 be increased. If the federal share for the state grants program of P.L. 94-142 were increased to a minimum of 18 percent of NAPPE, at ($1.4 billion dollars), many additional strides would be made by the states in the areas of identifying and assessing underserved children and providing them with appropriate special education programs.

In Louisiana additional federal dollars generated from 18 percent of NAPPE would have the significant impact: (1) a list of approximately 12-1500 youngsters waiting to be evaluated or reevaluated would be eliminated; (2) the number of children who are unnecessarily referred for special education placement would be reduced by approximately 50 percent through improvements in the child find/early intervention process; and (3) approximately $1 million in federal dollars would be matched by $1 million in state dollars to provide inservice training to regular education personnel.

In the area of educating seriously emotionally disturbed children, an additional $900 million is needed to insure a free appropriate education. This estimate is based on a conservative 2 percent incidence figure as opposed to the larger figures cited by the President's Commission on Mental Health.[3]

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[3] National Needs Analysis in Behavior Disorders, Department of Special Education, University of Missouri, Columbia, Missouri, 1979.

Commitment to a strong federal/state/local partnership in educating the handicapped is crucial. An appropriation level which does not reflect a substantial increase at the federal level would serve to erode the federal share in this partnership; it would dissuade state legislatures from continuing to increase state appropriations; and it would impede the provision of a free appropriate public education for all handicapped children.

State and local education agencies are being mandated by the Congress, the administration, and the courts to provide better and more comprehensive services to all children, and to handicapped children in particular.

With that charge in mind, NASDSE respectfully but strongly urges the Committee to continue the federal commitment and partnership in the education of handicapped children by appropriating a federal share of a minimum of 18 percent. This commitment will help assure that teachers are teaching, children are learning, and parents are involved.

APPENDIX A
TABLE 1 *

STATE SPECIAL EDUCATION FUNDS — FY 1975 - FY 1979
($ in Thousands)

States	FY 1975	FY 1978	FY 1979**	Annual % Change FY75-FY78	% Change FY78-FY79	Annual % Chang FY75-F
Alabama	$ 28,350	$ 70,000	$ 80,000	35.2	14.3	29.6
Alaska	9,390	17,049	20,000	21.9	17.3	20.2
Arizona	16,635	24,200	25,200	13.3	4.1	14.8
Arkansas	6,743	14,000	23,800	27.6	70.0	52.3
California 1/	—	—	—	—	—	—
Colorado	22,665	31,698	34,282	11.8	8.2	14.8
Connecticut	51,119	53,751	53,741	1.7	- .02	1.7
Delaware	—	—	—	—	—	—
Dist. of Col.	—	—	—	—	—	—
Florida	113,515	117,156	122,239	1.1	4.3	2.5
Georgia	43,139	66,603	80,636	15.6	21.1	15.6
Hawaii	8,534	14,482	17,122	19.3	18.2	19.3
Idaho	9,311	12,436	13,892	10.1	11.7	14.3
Illinois	115,066	167,012	186,882	13.2	11.9	17.5
Indiana	16,500	32,999	40,000	26.0	21.2	34.3
Iowa 2/	10,765	72,469	82,309	88.8	13.6	97.0
Kansas	9,476	28,007	33,600	43.5	20.0	52.5
Kentucky	20,427	50,539	62,975	35.3	24.6	45.5
Louisiana	31,450	65,161	70,000	27.5	7.4	30.6
Maine	4,350	5,923	7,326	10.8	23.7	54.9
Maryland	40,977	56,799	62,456	11.5	10.0	15.1
Massachusetts 1/	—	—	—	—	—	—
Michigan	90,050	108,840	177,815	6.5	63.4	25.5
Minnesota	28,500	66,225	78,000	32.5	17.8	39.9
Mississippi	8,199	15,822	33,610	24.5	112.4	60.0
Missouri	28,229	42,047	50,216	14.2	19.4	21.2
Montana	13,457	24,337	28,410	21.8	16.7	40.4
Nebraska	10,326	13,733	14,936	10.0	8.8	13.1
Nevada	6,293	10,560	11,088	18.8	5.0	20.8
New Hampshire	1,305	2,079	5,612	16.8	170.0	62.6
New Jersey	61,541	93,000	101,000	14.8	86.0	18.0
New Mexico	12,661	24,896	30,151	25.3	21.1	33.5
New York	196,600	166,467	204,937	- 5.4	23.1	1.4
North Carolina	40,821	67,819	82,166	18.4	21.2	26.3
North Dakota	1,592	5,375	6,300	50.0	17.2	58.2
Ohio	103,047	164,000	180,000	16.8	9.8	20.4
Oklahoma	7,625	18,612	21,412	34.6	15.0	41.1
Oregon	5,273	11,964	13,600	31.4	13.7	37.1
Pennsylvania	168,000	258,743	269,764	15.5	4.3	17.1
Rhode Island 3/	—	—	—	—	—	—
South Carolina	$ 19,029	$ 28,371	$ 37,463	14.2	32.0	25.
South Dakota	350	3,329	3,684	111.9	10.7	119.
Tennessee	33,514	47,500	49,000	12.3	3.2	13.
Texas	190,805	237,000	250,000	7.5	5.5	9.
Utah	13,573	21,851	24,103	17.2	10.3	21.
Vermont	3,173	8,240	11,484	37.5	39.3	53.
Virginia	21,239	31,437	37,200	14.0	18.3	20.
Washington	33,283	43,891	50,657	9.7	15.4	15.
West Virginia	—	—	—	—	—	—
Wisconsin	37,752	71,305	83,449	23.6	17.0	30.
Wyoming	5,000	9,864	11,364	25.4	15.2	31.
TOTAL.....	$1,699,649	$2,497,591	$2,899,351	13.7	16.1	14.

* Progress Toward a Free Appropriate Public Education: Report to Congress on the Implementation of Public Law 94-142: The Education for All Handicapped Children Act, USOE/DHEW, Washington, D. C., 1979.

* All agencies
** Estimated by SEAs
1/ Data for 1977-1978 and 1978-1979 not available.
2/ State Special Education Revenues do not include support services.
3/ Data for 1975 is not comparable to 1977 and 1978 data.

APPENDIX B

TABLE 4

FEDERAL PART B FUNDS RELATIVE TO COMBINED STATE AND FEDERAL SPECIAL EDUCATION FUNDS*
($ in Thousands)

States	Fed. Alloc. FY 1975 (1)	Fed. As A % of Comb. (2)	Fed. Alloc. FY 1977 (3)	Fed. As A % of Comb. (4)	Fed. Alloc. FY 1978 (5)	Fed. As % of C (6)
Alabama	$ 1,695	4.7	$ 3,366	4.6	$ 3,776	4.5
Alaska	180	.5	491	2.5	491	2.4
Arizona	953	4.4	1,921	7.4	2,537	9.1
Arkansas	918	9.3	1,829	11.6	1,829	7.1
California	9,312	3.9	—	—	—	—
Colorado	1,149	4.5	2,335	6.9	2,846	7.7
Connecticut	1,399	2.3	2,763	4.9	3,922	6.8
Delaware	278	1.4	—	—	—	—
Dist. of Col.	320	—	—	—	—	—
Florida	3,079	2.2	6,381	5.2	7,979	6.1
Georgia	2,298	3.6	4,618	6.5	5,927	6.8
Hawaii	403	4.2	836	5.5	836	4.7
Idaho	373	3.1	782	5.9	896	6.1
Illinois	5,209	3.7	10,222	5.8	14,912	7.4
Indiana	2,533	10.3	5,011	13.2	5,840	12.7
Iowa	1,353	3.4	2,635	3.5	3,293	3.8
Kansas	1,044	7.9	2,061	6.9	2,561	7.1
Kentucky	1,566	4.6	3,099	5.8	3,891	5.8
Louisiana	1,919	4.1	3,775	5.5	5,860	7.7
Maine	482	8.1	960	13.9	1,430	16.3
Maryland	1,939	3.5	3,835	6.3	5,108	7.6
Massachusetts	2,645	3.4	—	—	—	—
Michigan	4,446	3.5	8,818	7.5	10,075	5.4
Minnesota	1,905	4.7	3,758	5.4	4,935	6.0
Mississippi	1,147	9.4	2,317	12.8	2,317	6.4
Missouri	2,157	6.3	4,268	9.2	6,398	11.3
Montana	350	1.8	735	2.9	735	2.5
Nebraska	718	5.5	1,398	9.2	1,770	10.6
Nevada	248	3.0	599	5.4	599	5.1
New Hampshire	361	18.7	760	26.8	760	11.9
New Jersey	3,293	5.1	6,458	6.5	9,837	8.9
New Mexico	570	3.6	1,129	4.3	1,129	3.6
New York	8,023	3.4	15,738	8.6	15,782	7.2
North Carolina	2,497	5.0	4,993	6.9	6,519	7.4
North Dakota	316	8.3	672	11.1	672	9.6
Ohio	5,075	4.0	10,058	5.8	11,053	5.8
Oklahoma	1,180	11.2	2,354	11.2	2,849	11.7
Oregon	991	13.7	1,976	14.2	2,343	14.7
Pennsylvania	5,287	2.9	10,379	3.9	13,807	—
Rhode Island	434	2.4	—	—	—	

*Progress Toward a Free Appropriate Public Education: Report to Congress on the Implementation of Public Law 94-142: The Education for All Handicapped Children Act, USOE/DHEW, Washington, D. C., 1979.

States	Fed. Alloc. FY 1975 (1)	Fed. As A % of Comb. (2)	Fed. Alloc. FY 1977 (3)	Fed. As A % of Comb. (4)	Fed. Alloc. FY 1978 (5)	Fed. % of (6)
South Carolina	$ 1,361	2.7	$ 2,711	8.7	$ 4,968	11.
South Dakota	335	28.3	699	17.4	699	15.
Tennessee	1,874	4.6	3,707	7.2	5,813	10.
Texas	5,601	2.6	11.265	4.5	15,522	5
Utah	602	3.0	1,213	5.3	2,057	7
Vermont	222	5.9	539	6.1	539	4
Virginia	2,268	8.0	4,562	12.7	5,297	12
Washington	1,599	4.0	3,201	6.8	4,867	8
West Virginia	806	16.2	----	----	----	- -
Wisconsin	2,208	4.3	4,348	5.7	4,348	5
Wyoming	167	3.2	471	4.6	471	4
TOTALS.....	94,174	4.60	158,397	6.2	150,970	4

* Federal funds are forward funded. For example, Part B funds allocated for FY 1975 were available to States during school year 1975-1976.

Federal data for FY 1975 from DHEW:OE:NCES:RET. Federal data for FY 1977 and 1978 from Progress Toward a Free Appropriate Public Education, HEW, OE, January, 1979

1975 State data from W. Wilken and D. Porter, State Aid for Special Education, Who Benefits? National Foundation for the Improvement of Education: Washington, D.C., 1977.

APPENDIX C

P.L. 94-142 AUTHORIZATION/APPROPRIATION LEVELS

School Year	Level of Authorization	Level of Appropriation
1977-78	5%	5%
1978-79	10%	10%
1979-80	20%	12%
1980-81	30%	12%
1981-82	40%	12% *

* Projected figure

STATEMENT OF THE ASSOCIATION OF REHABILITATION RESEARCH AND TRAINING CENTERS

Mr. Chairman, distinguished members of this Committee. You are to be congratulated for your patience. You have invited a number of interested groups to testify before you. Some might label us "special interest groups."

Since none of us are likely to recommend a decrease in appropriations affecting our groups, this distinguished Committee will, and probably should, entertain an attitude of healthy skepticism about the position we advance.

May I respectfully request this Committee to disregard the source of the comments that follow and rather evaluate them on the intrinsic merits or demerits of the propositions as they are put forth.

Inflation

A penny saved is a penny earned! Or is it?

If saving the penny from this cookie jar makes me spend a penny or maybe two from a different cookie jar, have I saved a penny? Or have I simply displaced its expenditure and changed the account it's charged to?

In the economic crisis atmosphere of these times--with inflation skyrocketing, government programs running out of control--it is understandable that simplistic lines of reasoning will gain ascendance. For example:

1. Government spending causes inflation.
2. Cut government spending and you cut inflation.
3. Rehabilitation is a government program.
4. So cut rehabilitation and you cut inflation!

Such a line of reasoning is flawed. We don't pretend to be economists. We don't pretend that adequate techniques exist to gauge precisely what the effects of cutting rehabilitation funds would be. Nor do we pretend that our rehabilitation programs of service and research are perfect. Nonetheless, we respectfully submit:

Fact 1: The distinguished economist, Dr. Monroe Berkowitz, computed the cost* of disability in 1973 to be 51.6 billion dollars (constant). In 1990 this will escalate to 222.8 billion in constant dollars, 348 billion in actual dollars.

*Cost includes government and industry expenditures and wage losses. From Monroe Berkowitz, Cost Burden of Disability and Effects of Federal Program Expenditures. New Brunswick, N.J.: Disability and Health Economics Research, Bureau of Economic Research, Rutgers University, 1974.

Fact 2: Virtually all of government disability funds go for cash (e.g., Social Security Disability Benefits, Veterans service-connected disability) and in-kind (e.g., food stamps, subsidized housing, government paid health insurance) benefits. Many, if not most of these programs are CPI-indexed. So when inflation goes up, the cost of the programs go up and may in turn fuel the next upward inflationary spiral.

Fact 3: Less than 1/40th of federal expenditures goes to vocational rehabilitation where the goal is to enable people to be tax contributors.

Fact 4: Less than one tenth of one percent of federal government payout (if the administration's original budget request for FY 81 holds) is going to the National Institute of Handicapped Research. This Institute has been charged by Congress with becoming the central place in government devoted to improved techniques and increasing knowledge so that we can do a better job rehabilitating our disabled citizens. Also, in comparison with other national institutes, NIHR is at the bottom. The funding level for its activities have declined (in constant dollars) over the last years.

Fact 5: Research shows rehabilitation programs often pay for themselves because of increased taxes paid by rehabilitants and decreased use of tax-supported programs.

From these facts we derive the following inferences:

Inference 1: In this period of concern about government programs running out of control, it should be recognized that rehabilitation programs are very much under control. In the last 15 years government assistance kinds of programs have increased 14 fold after correcting for inflation. Rehabilitation has struggled to stay even and in real dollars has declined since 1972.

Inference 2: As a society we seem much more willing to hand out cash and commodities to the disabled than to invest in programs that will assist them gain control over their own lives and achieve independence.

Inference 3: Cutting rehabilitation dollars on service and research to improve service may not save money but only transfer costs to different government cookie jars (welfare). Or worse, lead to greater expenditures from those jars.

Inference 4: The interplay of such factors as unemployment rate, aggregate demand, productivity, inflation, fiscal and monetary policy, are complex. Nonetheless, it appears from data produced by Berkowitz that it is urgent that we as a country devise better ways of dealing with disability rather than just through income transfer.

Inference 5: The proper analytical context for evaluating rehabilitation expenditures is the NET COST TO TAXPAYER. This way, true economy can be distinguished from economy that is illusory.

A penny saved is a penny earned?

OR:

A stitch in time saves nine?

R & T Center Program

When Congress created the NIHR in the Rehabilitation Act of 1976, it was clear that the R & T Center network was a centerpiece concept for the Institute.

- Where are they? There are 21 Research and Training Centers located in the following states:

Alabama	New York
Arkansas	North Carolina
California	Oregon
Colorado	Pennsylvania
District of Columbia	Texas
Georgia	Washington
Illinois	Wisconsin
Massachusetts	West Virginia
Minnesota	

- Are the Centers worthwhile? An extensive, independent year-long evaluation of the R & T Center Program conducted by ABT Associates of Cambridge, Massachusetts was most favorable. I have appended an abstract of ABT's summary. Are the Centers worthwhile? Yes, says this independent evaluation.

- Center Concept: Research Integration. While recommending increased funding for Centers, of equal significance was the evaluation's resounding endorsement of the Center concept, with it's emphasis on research being embedded in a context of patient care/client services, professional education, training, as well as outreach to the host academic institution and through it to the community at large.

- Programmatic Character. Thus in funding R & T Centers, what is being supported is not a collection of dilletante research projects, but a network of centers of excellence, each of which constitutes an integrated program of research, service, and advanced education and technical assistance. This way the problems that get identified for research often derive from the Center's program of patient care. When research results are completed they are often fed immediately into the Center's education program--and that can be anything from post-graduate medical residency programs, undergraduate programs, pre-service or in-service programs for rehabilitation professionals,

and, increasingly, educational programs for consumers and persons with disabilities.

Multiplier Effect. The ABT evaluation shows that a dollar in R & T Center program funding generates almost an additional dollar from other sources. So it seems that Centers are good investments. It also speaks to the positive regard other funding sources have for the Centers' competency.

Modeling Effect. Health care in this country remains pathology oriented. The health care system gets triggered only after pathology has erupted and tends to disengage after the pathology has been arrested, stabilized, cured, or when "that's as much as we can do" has been done. Happily, there's a growing trend to emphasize primary (i.e., pathology) prevention. Witness anti-smoking, nutritional education, obesity control, highway and occupational safety programs. The payoff of primary prevention is evident in the decreased incidence of such pathologies as stroke, highway fatalaties and injuries, etc. An ounce of primary prevention has been shown to be worth a pound of cure. What has not been recognized is that this addage is equally true for secondary prevention. This has to do with minimizing or reducing the disabling consequences of pathology. For example, after the acute treatment of heart attack (pathology) many patients can--with comprehensive rehabilitation of the type being developed at our Colorado and Minnesota Research and Training Centers--regain and even exceed their pre-morbid level of functioning. The March 1980 issue of Runner's World reports that a program has taken heart patients and turned them into marathoners.

Yet, most heart patients in this country, after the acute care phase, get very little in the way of comprehensive (i.e., medical and vocational) rehabilitation. The health care system (other than follow up) pretty much disengages, feeling its job done. "We saved his life, didn't we? What more do you want?" Result? Many are drawing

disability benefits who don't need to, and worse, don't want to! Many go home and retire from life who could once again become vibrant, productive members of the community.

Other examples abound. Unless one is fortunate, after acute care stabilization, the health care system tends to disengage from those who suffer spinal cord injury. If involvement does continue, it tends to focus on pathology alone and not on broader concerns such as minimizing the functional limitations that flow from the pathology, the physical and psychological adaptation, vocational readjustment to the disability that may be required, and the like. These models and the research support they require, are being refined at such Centers as the University of Washington, Baylor, Tufts, and Northwestern University, as well as in the network of Spinal Cord Injury Centers funded by NIHR.

Turning to mental retardation, it has to be emphasized that 70-80 percent of mental retardation is cultural/familial in nature and not attributable to known organic pathology, thus, is largely preventible. Three R & T Centers (Wisconsin, Texas Tech, Oregon) are concentrating in this area with programs of both primary and secondary prevention.

Our Centers represent a network of health care models where the economic and human advantages of secondary prevention and rehabilitation can continue to be developed and demonstrated.

Funding Needs

1. Maintenance of effort. Approximately 15% over FY 80 funding is required for Centers to keep pace with inflation. This translates into a figure of 2.17 million.
2. Capacity building. If the capacity of Centers as a network is to be enhanced, an additional 10% would be required.
3. Geographic maldistribution. Certain regions of the country are

without any Centers. To correct this, a minimum of $350,000 should be budgeted for each Center the Congress may wish to establish.

4. Special efforts. In the Rehabilitation Act of 1978 (P.L. 95-602) Congress called for the "Conduct of a program of research related to the rehabilitation of handicapped children and of handicapped individuals who are aged sixty or older Sec. 204 (b) (8)."

- Pre-school: Many children born with impairments suffer needlessly from secondary disabilities arising from these conditions. The celebrated play, The Miracle Worker, dramatizes how Helen Keller, born deaf and blind, was changed from animal-like in her behavior to a well-functioning child as a result of specialized training and rehabilitation efforts. With the development of more effective pre-school programs of prevention and rehabilitation, the subsequent mainstreaming into regular schooling could be made much easier. As developmental psychologists are quick to point out, the earlier years are critical to cognitive, language and personality development such that deficits occuring in these earlier years may not be easy to reverse. For example, for children who are born deaf, early detection and parental training can prevent or minimize secondary effects of deafness such as learning disability, cognitive underdevelopment, and the like.

- Rehabilitation of the elderly: Between now and the end of this century, there will be important demographic and cultural changes affecting the elderly. In addition to increasing life expectancy, an important demographic shift will be the increasing percentage of the population in the 60 and older age category. While there will be an increase in life expectancy, there will regrettably be no guarantee of comparable increases in the quality of that life. By that I mean, simply because there will be an increase in life expectancy, there's no reason to expect a comparable delay in the onset of disabling conditions typically associated with the aging process, e.g., sensory loss including vision and hearing, impaired mobility due to orthopedic and/or

neurological pathology. The sheer magnitude of the demographic shift makes it imperative that we as a society develop effective secondary prevention and rehabilitative techniques. Just as one of our newer Centers at Boston University in the rehabilitation of the mentally ill has been established as a joint grant between NIHR and NIMH, so too such an approach might also prove fruitful for the establishment of a new Center jointly funded between NIHR and other funding sources such as the Administration on Aging.

National Institute of Handicapped Research

The administration's request of 37 million dollars for FY 81 is well below the authorized level and is most conservative. Funding below this level would be disastrous because of the fragile, embryonic stage of development. NIHR is currently in. In establishing NIHR Congress did something pragmatic and symbolic. Prgmatic in that Congress instituted a rational, administrative framework for focusing and coordinating disability research on a national scale. Symbolic in that Congress signalled some new initiatives were about to be taken in this country regarding disability.

The communication was that this country was going to begin to really harness some of its creativity and fashion a more imaginative social policy toward what is becoming a frightengly expensive national problem. To scholars and scientists in a number of disciplines this symbol no doubt prompted second thoughts in those contemplating leaving the field. And from my personal experience, I can vouch that the creation of NIHR also served to stimulate career interest in disability research on the part of many scientists and professionals who would otherwise not have done so.

Thus a sense of momentum has been created which will be difficult to recapture if funds are further cut, even if the intent is to restore them in subsequent fiscal years. Getting a good start is a key component in any organization. A false start for NIHR at this point would be especially hard to recover from.

The Congressional mandate to NIHR is ambitious and challenging.

1. Rehabilitation is now dwarfed by income transfer as this nation's social policy toward disability, thus making NIHR's mission even more challenging.
2. The charge to NIHR is not only to do research, but to see to it

that this research gets used. Thus, key components of NIHR's mission aside from research are:

- public information
- education and training
- technology transfer
- research utilization

3. The implementation of special Congressionally-mandated initiatives for pre-school and over-60 promises to be a cost-beneficial effort and deserves support. NIHR working to complement, not compete with other agencies (e.g., Bureau for Education of the Handicapped and Administration on Aging) could cooperatively formulate significant new service delivery models in these neglected areas.
4. In technology transfer, NIHR cooperative efforts with National Academy of Sciences and NSF could provide that "extra mile" that makes the difference between technology remaining on the shelf unapplied versus getting down to the business of serving the needs of handicapped persons. For example, recently we have seen the application of NASA-developed microprocessor technology to sensory deficits with computers "translating" print into audible words for persons with blindness. This is but one example of a long list of technologies waiting to be applied. The particular economic advantage here is that the government has already born the heavy costs of technology development leaving only the process of technology application. The Institute's network of Rehabilitation Engineering Centers supplemented by R & T Centers is a ready-made vehicle to pursue this work.
5. The International Foreign Currency Program is also worthy of invigorated support. This program is not supported with our dollars. This program can also serve as a positive instrument in foreign affiars. For example, in building more effective relations with Islamic states it is difficult to think of a better way than the people-to-people approach uniquely represented by cooperative efforts to find better ways of dealing with disability.
6. Back on the domestic side, there is a significant need for trained rehabilitation professionals to work in the black and Hispanic com-

munities. In these communities there is a higher incidence of disability due to poor nutrition, inadequate housing and medical care, illiteracy and the usual litany of problems that go along with poverty. We have a Catch 22 situation here in that while the manpower need is greater, these minority groups tend to be underrepresented in the ranks of rehabilitation manpower. The Institute is in a uniquely favorable position to rapidly respond to this need.

7. Also on the manpower issue, there is a need for new professionals, super-specialists, or perhaps professional hybrids to deal with disability. The magnitude of the disability problem (witness Dr. Berkowitz's data) has caught the nation by surprise as well as many disciplines who could be contributing. For example, we don't have--that I know of--many health economists who are skilled in or knowledgeable about disability. The same goes for manpower economists. There is also a dearth of adequate biomedical engineers. In the past we have emphasized an on-the-job training approach taking engineers and teaching them medically related skills. Perhaps we need to come at the need from a complementary standpoint, taking those trained in medicine and related fields and supplementing their skills with engineering. Perhaps, too, the field is too important to leave only to on-the-job training. There is also a dearth of adequately trained experts to deal with spinal-cord injury. Maybe what we need here is a breed of super-specialists skilled in the comprehensive approach to the management of this disability.

In NIHR and its programs, one being the R & T Centers, Congress has created a structure in which the issue of disability can be dealt with from a comprehensive rehabilitation rather than from an income transfer approach. Admittedly, the rehabilitation voice is hardly audible when compared with the size of the cash and in-kind transfer approach. We think Congress was well-advised to authorize 90 million dollars for FY 81. We regret the administration has seen fit to request only 40% of this amount. We plead that to cut into this amount even further in the name of economy will mute even further the whisper of rehabilitation as a policy alternative.

STATEMENT OF PAUL TREMPER, EXECUTIVE DIRECTOR, NATIONAL COMMUNITY EDUCATION ASSOCIATION

On behalf of the Board of Directors and Members of the National Community Education Association, I want to thank you for this opportunity to present written testimony in support of increased funding for community education.

A part of the Education Amendments of 1978 (PL 95-561), Title VIII - The Community Schools and Comprehensive Community Education Act authorizes the expenditure of $123 million for fiscal year 1981. The total authorization over the five-year period of the legislation is $478 million.

The growing concern on the part of the American people over inflation and the level of Federal funding is understandable. The Congress is demonstrating its leadership in this area by carefully reviewing the level of Federal funding with the intent of reducing the Federal deficit. And as a part of this review funding requests for specific programs will be judged in part on their proven effectiveness.

The Federal community education program has been effective in meeting its Congressionally mandated goals and objectives. In 1977-78, Developmental Associates, Inc., Arlington, Virginia under contract with the U.S. Office of Education, evaluated projects funded under the Community Schools Act of 1974 (PL 93-381). In their final report the evaluators stated in part:

> "The data and analysis lead inescapably to the overall conclusion that the legislation mandate of the Community Schools Act was met and that the Federally supported community education projects were quite successful, at least within the framework investigated here. Such compelling and positive findings are unusual. More typically, the results of Federal program evaluations are mixed and, if anything, tend toward the negative, especially at the beginning of a new program."

The positive findings of the above-mentioned evaluation led Congress to pass PL 95-561 and thereby dramatically increase the potential Federal role in community education. The legislation emphasizes those components of community education that can result in the saving of local tax dollars and the more efficient utilization of human and social services. For example, the Statement of Findings and Policy Section of PL 95-561 says in part, "Congress finds that the school is a primary institution for

the delivery of social services and may be the best instrument for the coordination of frequently fragmented services." Indeed, there is overwhelming support for this position. Some seven thousand community schools throughout the country are being used to coordinate the delivery of social services to meet the needs of the people in the communities which they serve.

Community education programs throughout the country are helping to conserve resources in a variety of ways. Among those approaches are the following more noteworthy examples:

1) Community schools are reducing costly school violence and vandalism in many different parts of the country. This cost-saving potential of community education has been recognized by a number of groups and organizations.

   Last week, U.S. Senate Judiciary Committee Counsel Mary Jolly told a conference on school crime that using schools at night for community activities can be a deterrent to school vandalism and save tax dollars. Jolly was a speaker at the Peter Rodino Institute on Criminal Justice Symposium on violence and vandalism in the nation's schools.

   In its final report on school violence and vandalism, the 1977 Senate Subcommittee to Investigate Juvenile Delinquency, chaired by Senator Bayh, named community education as an approach that has the potential for reducing school violence and vandalism. By extending the operation of the school into late evenings, weekends, and during the summer months, the hours during which such destruction usually takes place is dramatically reduced. And a report by the House Committee on Education and Labor concerning the Education Amendments of 1978 concurred with the Senate Subcommittee. The House report stated:

   > "Some recent trends have converged to make community education a particularly attractive approach... a recent NIE (National Institute for Education) study of school violence found that the cost of school vandalism runs about $200 million annually and that more acts of vandalism occur during non-school hours. Since community education extends the use of school facilities beyond normal school hours, incidents of vandalism are likely to decrease in these facilities."

2. Thousands of school buildings are being closed annually due to declining school enrollments. Vacant buildings are a costly burden to financially strapped school systems. Subject to frequent attacks of vandalism, those unused facilities must continue to be heated and maintained. Community education presents creative alternatives for reopening these facilities to serve the total community with little or no expense to the school district.

3. Older Americans, far too often neglected by our society, must be in close proximity to centers that can provide for their essential needs. In addition, they need to have opportunities to volunteer their skills and experiences both so that they will feel they are worthwhile and needed citizens and so that the community can benefit from their abilities. It is estimated that close to one-half million older Americans have been served by community schools throughout the country during the past two years. Providing social services, including hot meals, at community schools is not only more convenient but can also cut down on the delivery costs of these services, as well as eliminate the need to construct or rent space for this purpose.

4. Community education stresses greater utilization of schools as centers to serve the total community at minimum increase in energy consumption. Simultaneously, studies have shown that when schools are used as community centers energy consumption of local residents is drastically reduced. And as the availability of gasoline decreases, individuals will be looking for learning and recreational opportunities closer to home such as at community schools. Thus, community education can help to conserve as well as reduce energy consumption.

The National Community Education Association, after careful analysis, recommends an appropriation of $32,500,000 for fiscal year 1981. This request, if funded, would allow for successful implementation of PL 95-561. At the same time, it should be noted that the request represents less than one third of the authorization level and shows restraint during this period of financial concern.

Rationale

Although each section of the bill is important if the legislation is to fully meet its stated objectives, the most important component is Section 804: State Programs for Community Education. The National Community Education Association recommends $20,000,000 of a possible $60,000,000 for the state program. Provided as Appendix A is a breakdown of the amount each state would receive if this section were funded at the level of $20,000,000.

The role of the State Education Agency (SEA), is critical if community education is to continue to expand in the years ahead. The states that have experienced the most successful development generally have been those where the SEA has taken an active role in terms of providing developmental and technical assistance. Eighty percent of the funds received by the SEA under this legislation would flow to local education agencies. And, it is estimated that approximately five-hundred community schools would be funded under this section, meeting the educational, recreational and cultural needs of one million citizens. There is little question that the states are in a much better position than the Federal government to determine who should be funded. Of equal importance, the SEA can provide more continuous and meaningful assistance to funded projects.

The other key components of the legislation are as follows:

Section 809 - Local Education Agencies.

The Association recommends a funding level of $5,000,000 for grants to local education agencies out of a possible $30,000,000.

Numerous Federal laws have attempted to mandate the more efficient and effective delivery of social services in local communities, but few have met with success. Section 1006 - "Use of Community Education Programs for Non-Federal Contribution in Certain Federal Programs," of PL 95-561 has more potential for achieving this goal than perhaps any other Federal law. A local education agency may use a grant from PL 95-561 as the non-Federal contribution required under a number of other Federal programs. The only requirement is that the other Federal program must be

delivered through community education. Such a provision has the potential of encouraging numerous Federal programs to use the community school as a delivery vehicle, thereby cutting down on costly duplication of effort. An appropriation of $5,000,000 would allow the funding of 125 communities to test the viability of this unique approach. If they were successful, the potential implications for Federal policy in the area of coordination of social services would be far-reaching.

Section 810 - Public Agencies and Non-Profit Organizations.

The Association recommends a funding level of $7,000,000 out of a possible $10,000,000 for grants to public agencies and non-profit organizations.

A major goal of PL 95-561 is to encourage public and non-profit organizations to use community education for the efficient and coordinated delivery of community services. Based upon the achievements in this area, as noted in the evaluation conducted by Developmental Associates, a significant increase in funding is justified.

Section 812 - Training.

The Association recommends a funding level of $3,000,000 out of a possible funding level of $15,000,000. Currently, there is a critical shortage of trained community education leaders. If Federal funding for community education is increased, the shortage would be even more acute. An appropriation of $3,000,000 would allow 100 institutions of higher education to receive grants to provide short-term training programs in community education.

Section 814A - Clearinghouse.

Federal support for the Community Education Clearinghouse began in 1975 and continued through February, 1979. During the four years of its operation, the Federal government financially supported a feasibility study, a design study, and the establishment of the Clearinghouse, including a sophisticated data base system. The Association is acutely aware that since its beginning in 1976, the Clearinghouse has responded to thousands of requests. The Association believes that it is ill-advised to terminate Federal support for a

service that has a demonstrably strong record of service and, therefore, requests $200,000 to continue operation of the Clearinghouse.

Mr. Chairman, our Association feels that increased funding for community education is warranted and will result in the savings of tax dollars throughout the country. On behalf of the members of our Association, I appreciate the opportunity to present for the record our written testimony.

STATEMENT OF LLOYD H. DAVIS, EXECUTIVE DIRECTOR, NATIONAL UNIVERSITY EXTENSION ASSOCIATION

The National University Extension Association strongly supports appropriations for FY 1981 for two programs which help serve the needs of adult, part-time students: Title IA of the Higher Education Act, Community Service and Continuing Education; and Education Information Centers. These programs help meet the educational needs of those people who have traditionally been left out of the educational mainstream, among them the underemployed, the handicapped, the aging, and women returning to the workforce, often unskilled and with major family responsibilities.

In addition, Title IA is the only federal program which encourages colleges and universities to direct their knowledge to help solve local problems according to local priorities.

Education Information Centers perform the extremely important service of informing nontraditional students of educational options and support services available to them.

Both of these programs use small amounts of money to stimulate and encourage institutional and state activities that far surpass the ability of the federal programs alone to accomplish. They form a cohesive partnership in addressing the needs. The National University Extension Association therefore recommends appropriations for fiscal year 1981 as follows:

	Recommended Appropriations FY 1981
TITLE I, PART A OF THE HIGHER EDUCATION ACT	
Community Service, Continuing Education and Educational Resources Materials Sharing	$ 20,000,000
EDUCATION INFORMATION CENTERS	$ 5,000,000

Today over 30 million adults are currently involved in some form of continuing education. The number of adults studying on a part-time basis at colleges and universities exceeds the number of students whose primary activity is enrollment in a full-time education process. Often the needs of these adult, part-time students have been neglected. These students include those with limited incomes who have traditionally been left out of the educational mainstream, among them the underemployed, the handicapped, the aging, and divorced women who now have the primary responsibility for raising their children.

We strongly believe that our nation's higher education system can and should serve a broader segment of our people and that our priorities in higher education must be directed toward meeting the needs of our adult population as well as our youth. Title IA of the Higher Education Act, Community Service and Continuing Education, was expanded in the Higher Education Amendments of 1976 to help meet the educational needs of adult part-time students who have been neglected heretofore.

The National University Extension Association, an organization of 280 colleges and universities that conducted extension and continuing education programs serving over six million people last year, strongly supports an appropriation of at least $20,000,000 for Title IA of the Higher Education Act for FY 1981 to help meet the needs of these underserved people and the needs of the communities in which they live and work.

The following will elaborate further the reasons this program is of such priority as to justify this level of appropriation when Congress has a strong mandate to reduce spending.

Community service and continuing education programs are conducted to serve the needs of people for lifelong education. None of us learns all we will need to know in the formal education process of our youth. As situations change, we need new knowledge for the new situations. People need new knowledge for new jobs. New knowledge must be applied if we are to reap the benefits of research. The application of knowledge in business, public agencies, and the work and lives of people is basic to progress. Almost any kind of progress in the public sphere is dependent on knowledgeable citizens.

Colleges and universities serve many of these needs for knowledge. They have staff experts in a very wide range of fields. Their research is the source of much of the new knowledge. They have staff skilled in serving the educational

needs of adults. Colleges and universities are highly regarded as places to obtain reliable facts.

Colleges and universities do serve many of these needs for knowledge. They conduct courses for adults at times and places convenient to them. They conduct conferences, short courses and seminars. They conduct educational programs by correspondence, television, radio and newspaper. These programs serve people seeking training and credentials for employment, who want to update or broaden their skills, who want knowledge and skills for dealing with public issues and community problems, who want to improve their family living, or to pursue intellectual or cultural interests.

Most of the programs of community service and continuing education conducted by higher education institutions are not financed with public funds, but are paid by the people served through tuition or fees. While some public higher education institutions have state or local appropriations for costs of some continuing education programs, these funds are limited to a few institutions.

This necessity to pay program costs out of user fees imposes limitations on the needs colleges and universities serve. It requires that for each activity the university must ask "Will it pay?" If the answer is "No," the educational opportunity probably will not be provided. If the answer is "Maybe," the institution may provide the program if it is able to take the risk. This system helps to assure that continuing education programs are satisfying needs of paying clientele, a strength of the system.

There are problems with this system. The problems are that programs that cannot pay their way are frequently not provided and the needs of people who cannot pay are not well served. Programs more fully serve needs of people who have the greater ability to pay and the greater motivation to acquire knowledge and people in the areas of higher population density.

Programs to help people acquire knowledge and skill for use in attacking community problems suffer especially. Community service programs frequently cannot obtain participation by enough people so that a reasonable fee will cover the costs. This is because some programs of this type are most effective if targeted to relatively small groups. They frequently demand large staff inputs. The requirement that recipients pay the costs may stand in the way of reaching the people who must be reached to achieve the program goals. Also, such programs frequently are most effective if they utilize a combination of methods

and media -- meetings, conferences, radio, television, newspapers, publications, etc...and many of these produce no program revenue.

Title I grants help in several ways to greatly increase the quantity and quality of community service and continuing education programs.

Title I, Part A provides a means of financing projects or programs to serve community needs that can be served in a short period of time with a relatively small grant to supplement the resources of the institution. For example, the University of Connecticut, with Title I funds, responded to a need of the Red Cross for trained people to help in its bloodmobile programs. In cooperation with the Red Cross, the University is training young people from low income and minority families to serve as "Blood Programs Assistants," thus preparing these young people for employment, serving an important need of hospitals, and helping these young people get started with health careers.

Another example is the University of Washington's use of Title I funds to create "Energy Forum Northwest," a community-oriented, self-help, energy-conservation program designed to affect local energy use. The project has stimulated community recycling projects, a television documentary and publication of an Energy Resource Guide, as well as a series of workshops on energy conservation strategies.

Title I provides programs for needy people who cannot pay the program costs. For example, Virginia State University is conducting a program on "Consumer Education for the Socio-Economically Disadvantaged" and one on "Parent Education on Discipline" for low income minority parents. Through a Title I grant, Mars Hill and Brevard Colleges are offering learning opportunities to older adults in four mountainous North Carolina counties who would otherwise be unable to participate because of transportation restrictions, physical disabilities and limited incomes.

An institution with very limited funds for continuing education programs frequently does not have the money to develop a new program that will pay its way or be financed from other sources, once established. Title I grants provide needed "front money," and in this way make possible programs that otherwise would not exist.

Title I grants provide "risk capital" to test and try needed programs. An institution short on funds for continuing education frequently cannot afford to risk its resources on a program that may not generate enough participatnt fees to pay its costs. In this situation, small amounts of money through Title I

grants have large and continuing impacts on programs. Such financing of creativity, innovation and vitality in programs through front money and risk capital is an important function of government. Through this kind of help more of the needy people inadequately served are provided the education and training they need.

A program called "Elderhostel" is a fine example of this principle. Several years ago the University of New Hampshire, with a Title I grant, established a program for senior citizens conducted in campus facilities during the summer months, with a special curriculum to serve special needs of older citizens. The program was outstandingly successful and has been copied by other institutions. In 1979, 212 colleges and universities in 35 states conducted Elderhostel programs for over 13,000 participants. The small investment of Title I funds in this program has resulted in a valuable service to tens of thousands of people throughout the country.

The funds provided under the "Technical Assistance" provisions of Title I help this spreading of good programs and thus multiply the benefits from the expenditure of Federal funds.

These uses of Title I funds serve important needs of people for lifelong education. They provide efficient use of funds by extending the application of the resources of the educational institutions to serve more needs of society, and by providing funds needed to develop and test new programs that are continued without Federal funds.

The Congress through appropriations has recognized these important needs each year. Repeatedly the Congress has provided funds, even when the Executive budget erroneously asserted that these needs were of low priority or would be assumed by the states if not funded by the Congress. These are important functions that need to be continued and require federal support.

In FY 1978 Title IA received an appropriation of $18 million. The state grant portion alone, which received $15,850,000, directly served 301,571 people through workshops, conferences and educational programs and an additional 19,822,049 persons through the mass media. In addition, many more persons were served indirectly as many of the projects initiated with Title I funds were continued, expanded and replicated without federal money. The 1978 initiative was accomplished through 602 projects at 674 postsecondary institutions.

Of these 602 projects, over one-half were directed toward serving the needs

of underrepresented and low-income adults, including the handicapped, aging and minorities. Over 25 percent of the projects went toward funding local and state government training and technical assistance activities and twelve percent of the projects were designed to address environmental concerns, primarily energy conservation. Therefore, 87 percent of the Title I projects run by the states in FY 1978 addressed the critical needs of underserved adults, local and state government training and environmental concerns.

The funds we have requested for FY 1981 would provide for an increase in the level of support over that of FY 1980 and FY 1979 when the programs were slashed by 44 and 37 percent respectively, but would continue support at approximately the same level as in FY 1978.

In addition, we recommend the appropriation of $5,000,000 to assist the states in continuing to plan and implement Educational Information Centers under Section 418 of the Higher Education Act. This important section of the Act provides funds to the states to provide counseling services for adults to orient them to the world of adult learning, to inform them of their educational options and to guide them to the educational institution most able to meet their needs. This cost-effective brokering mechanism serves well as a partner to Title IA in serving the needs of underserved part-time adult students who are often unable to use the regular educational channels to gather information particularly relevant to their needs.

In closing, we would like to point out that the House and Senate Committees in charge of reauthorizing the Higher Education Act see an expanded role in the future for the programs we have been discussing. They have also focused the legislation to address even more directly the educational needs of the underserved adult attempting to complete his or her education. For example, the Senate authorizing committee included in its version of Title I some specific program initiatives to assist women in the workplace and to combat youth unemployment. We applaud the initiatives taken in both the House and Senate and urge the Appropriations Subcommittee to continue funding Title I so that the expanded potential for serving the needs of adults will not be lost.

STATEMENT OF ARNOLD L. MITCHEM, CHAIRMAN, NATIONAL COORDINATING COUNCIL OF EDUCATIONAL OPPORTUNITY ASSOCIATIONS

The National Coordinating Council of Educational Opportunity Associations and its ten constituent associations are recommending an appropriation of $170 million for the Special Programs for Students from Disadvantaged Backgrounds (TRIO) in fiscal 1981. This level of funding is imperative since:

1) There are a substantial number of youth who qualify for TRIO services who are not receiving them. Even at the $170 million level, less than 1% of the eligible population will be served by Educational Opportunity Centers, only 1.5% of the eligible population will receive Upward Bound Services, only 2.1% of the eligible population will receive Talent Search services, and less than 16% of the eligible population will be enrolled in Special Services projects.

2) The institutional demand for TRIO services is high and increasing.

3) TRIO is a relatively low-cost means of providing an avenue of upward mobility to the poor. The cost per client in Special Services this year is only $335, in Talent Search $77, in Upward Bound $1662, and in EOC's $71.

4) The effort to achieve equity in federal educational programs requires increased use of supportive services. Failure to invest sufficient monies in the Special Programs for Students from Disadvantaged Backgrounds will necessarily result in less than a full return on the billions of dollars which the Congress is committed to investing in the student assistance programs authorized under Title IV.

5) The TRIO Programs have been proven effective. For example, a recent study commissioned by the Office of Education suggests that Upward Bound programs impact significantly on access, persistence, and student aspiration.

At this time the Council would also ask this Subcommittee to go on record as opposing two administration initiatives: Special Emphais Upward Bound and New Concept Special Services which the Administration seeks to fund from the TRIO appropriation. These programs are not authorized and, while their goals are laudable, they cannot be funded except at the expense of currently existing programs with proven records of service delivery.

We are keenly aware that no group is able to come before this Subcommittee as it conducts its current hearings without first confronting the serious economic situation presently facing our country. Uncontrolled inflation raises the possiblility of social turmoil in the country and must be addressed squarely and prudently by responsible lawmakers. Above all, the citizenry's faith in its future must be guarded.

The National Coordinating Council of Educational Opportunity Associations and its ten constituent associations are recommending an appropriation of $170 million in fiscal 1981 for the Special Programs for Students from Disadvantaged Backgrounds (TRIO). We believe this investment in the future of disadvantaged youth in this country is particularly well advised at this time.

Higher educational institutions generally and compensatory programs in colleges and universities particularly have shown themselves remarkably adaptable over the past decade and have proven themselves to be effective vehicles of upward mobility for the poor. But as a growing percentage of the young people in the country come from disadvantaged backgrounds and as the skill levels necessary for labor market entry increase, the necessity of maintaining our commitment to equal educational opportunity in higher education increases also. That commitment is twofold: (1) to provide greater equality of access through the student fund aid programs and through information services such as Talent Search and Educational Opportunity Centers; and (2) to provide disadvantaged students an equal chance to compete and be retained in higher education through supportive service programs such as Upward Bound and Special Services for Disadvantaged Students.

The Changing Make-up of the Labor Force

Because of the increasingly technological nature of our society, the nature of the labor force is changing rapidly. The Bureau of Labor Statistics, for example, projects that while the U.S. economy will create twenty million new jobs by 1990, well over half of these will be in white-collar occupations--professional and technical workers, managers, and sales and clerical workers.[1]

By 1990, employment in professional and technical occupations such as scientists and engineers, medical practitioners, teachers, entertainers, pilots, and accountants is expected to increase by 2.6 million. Greater efforts in energy production, transportation, and environmental protection are expected to result in growing demand for scientists, engineers, and technicians. The number of health professionals is expected to grow as health services expand and the demand for workers to develop and utilize computer resources is also projected to increase.

About 2.1 million new jobs are expected to be generated for managers over the 1978-90 period. Changes in business size and organization have resulted in differing trends for self-employed and salaried mangers: The number of self-employed business managers will continue to decline as large corporations and chain operations increasingly dominate many areas of business.[2]

Blue-collar occupations--craft workers, operatives, and laborers--are expected to account for only about one-quarter of the Nation's employement growth by 1990. Employment growth of the highly skilled, craft worker group is expected to add 2.5 million jobs to the economy. Employment of nonfarm laborers, which include construction laborers and freight and stock handlers, is expected to grow slowly as machinery increasingly replaces manual labor.

Service workers--including cosmetologists, police officers, practical nurses, and child care workers--are expected to makeup the fastest growing occupational group, generating 3.8 million new jobs.[3] Employment of farm workers--including farmers and farm operators as well as farm laborers--will continue to decline as farm productivity rises and the number of farms continue to fall.

The pattern which emerges from these figures is clear: The need for workers with both basic academic competencies and more specialized academic competencies is increasing, while the demand for workers to fill jobs which require lesser skills is rapidly diminishing. At the same time, the percentage of our youth reared in low-income and minority homes is also increasing.

The Decline in Basic Skills

Concurrently, all too many youth are not acquiring sufficient discipline or even basic academic skills in elementary and secondary schools. In the Project Talent survey, Flanagan[4] reported that only 25% of twelfth grade students were able to answer half or more of a set of questions on typical paragraphs discussing national issues in Time magazine. Among twelfth grade students, 34% of those surveyed state that they would read passages over and over without being able to understand them. In mathematics, vocational education teachers surveyed by Long and Herr[5] noted that students generally needed remedial work in the areas of square roots; addition, division, and multiplication of fractions; and ratios and proportions. Consistent with these results is Flanagen's[6] finding that only 46% of high school seniors reported satisfaction with their progress when asked about the development of their abilities in reading, thinking, and writing. The problem is particularly acute among minority youth--an increasingly important segment of our population. In a recent survey of literacy, only 51.4% of black 17 year olds met a minimum performance standard while 91.8% of whites met that standard.

The TRIO Programs

The Special Programs for Students from Disadvantaged Backgrounds subpart authorizes six programs: Special Services for Disadvantaged Students, Talent Search, Upward Bound, Educational Opportunity Centers, Service Learning Centers, and a training authority for Special Program staffs. For fiscal 1979 the $140 million appropriated for the TRIO programs was allocated by the Department of Health, Education and Welfare as follows: $55 million to Special Services, $15.3 million to Talent Search, $61 million to Upward Bound, $2.4 million to the training authority, and $6.3 million to Educational Opportunity Centers. The Service Learning Centers program was not funded.

This funding allowed the provision of services to approximately 165,200 students in Special Services projects at an average cost of $335 per student, 198,800 individuals in Talent Search projects at an average cost of $77 per person, 35,391 students in Upward Bound projects at an average cost of $1662 per student, and 107,600 persons in Educational Opportunity Centers at an average cost of $71 per person. Additionally, 2,000 TRIO staff members received training in the areas of leadership, management, evaluation, instruction and counseling at a total cost of $2.4 million.

1. Special Services for Disadvantaged Students

Special Services programs are targeted upon students, enrolled or accepted for enrollment at the host institution who "by reason of deprived educational, cultural or economic background or physical handicap are in need of such services. In the past decade, the number of poor and minority students enrolled in college has climbed steadily. As an example, between 1972 and 1978 the percentage of minority students enrolled in our nation's State Universities and Land Grant Colleges climbed from 11% to 15.1%.[7] Also of note is the fact that the percentage of minority students attending integrated institutions also increased. In 1968, 60.8% of all Black students enrolled at state and land grant institutions attended historically Black colleges. Today 68.6% of Black student population at these state schools are at predominately white institutions.[8]

Disadvantaged students, however, often need remedial coursework as well as specialized academic and personal counseling if they are to overcome basic skill deficiencies and compete successfully. Yet these services are available to only a fraction of the disadvantaged students on our nation's campuses. An appropriation of $170 million for TRIO would allow the provision of better and more cost-effective services to additional students.

SPECIAL SERVICES

	Funding	Students Served	Cost Per Student	Percent of Eligible Population
At FY 80 Levels	$59.6 million	177,900	$335	14%
At recommended levels	$72.5 million	198,630	$365	16%

2. Upward Bound

Upward Bound services are directed toward secondary school students from poverty backgrounds with inadequate educational preparation. The Programs have consistently proven their effectiveness. A long-term follow-up of participants recently completed by Research Triangle Institute for the Office of Education concluded that for students participating in the projects studied, the "Upward Bound program is fulfilling the functions of providing skills, motivation and assistance necessary for entry into postsecondary education."

For example, about 91% of typical Upward Bound participants eventually enter some form of postsecondary education compared to 70% of comparable nonparticipants. Moreover, about 73% of typical Upward Bound participants enter a four year college or university as compared to a 50% rate of entry for participants. An appropriation of $170 million for TRIO would allow Upward Bound projects to maintain and build upon this record of effective service delivery.

UPWARD BOUND

	Funding	Students Served	Cost Per Student	Percent of Eligible Population
At FY 80 Levels	$62 million	37,350	$1660	1.4%
At recommended levels	$69 million	38,120	$1810	1.5%

3. Talent Search and Educational Opportunity Centers

Talent Search programs and Educational Opportunity Centers provide disadvantaged youth and adults information, assistance, and encouragement in applying for admission to college and in applying for financial aid. Data from the National Center for Educational Statistics[9] indicates that the number of low-income students applying for student assistance decreased between 1977 and 1979. This is probably due in part to the current economic situation which forces more poor youth and adults to work on a full time basis, and in part due to the difficulty many low-income students experience in applying for Basic Grants and other financial aids. The Basic Grants validation procedure, for example, selects a disproportionate number of low-income students and many such students require assistance in preparing documentation for this validation. Thus the access and information services provided by Talent Search and EOC's are especially crucial in mitigating this latter problem.

TALENT SEARCH

	Funding	Clients Served	Cost Per Client	Percent of Eligible Population
At FY 81 levels	$15.3 million	198,700	$77	2.1%
At recommended levels	$16.9 million	201,190	$84	2.1%

EDUCATIONAL OPPORTUNITY CENTERS

	Funding	Clients Served	Cost Per Client	Percent of Eligible Population
At FY 81 levels	$7.7 million	108,450	$71	.6%
At recommended levels	$9.2 million	119,480	$77	.6%

The NCCEOA recommends that the TRIO training programs continue to be funded at the $2.4 million level. This year the response of TRIO professionals to these programs has been extremely positive.

The Administration's Proposed Initiatives

In both its FY '80 and its FY '81 budget justifications, the Administration proposes to fund two Executive Branch initiatives: Special Emphais Upward Bound and New Concept Special Services.

Their laudable goals are encouragement of the development of mathematics and science achievement and of post-baccalaureate enrollment for disadvantaged youth. Many existing TRIO programs have already set these goals for themselves and are meeting these objectives. For example, the New Concepts Special Services program as outlined in draft documents prepared by the Office of Education would closely parallel procedures currently used in a number of Special Services programs presently in existence at four year institutions. The Special Emphasis Upward Bound program closely resembles the Biomedical Sciences program funded under the Elementary and Secondary Education Act as well as Pre-Engineering Upward Bound programs already established at some institutions. In our view, it is irresponsible to begin new initiatives when, as a consequence, effective projects with decade-long track records of service to disadvantaged students must then be discontinued.

The NCCEOA asks that the Appropriations Committee include in its report accompanying the FY '81 Labor-HEW Appropriations bill, language indicating that the monies appropriated for TRIO are to be utilized only for specifically authorized programs.

Demand for TRIO

The table on the following page illustrates demand and funding patterns for TRIO between fiscal 1977 and fiscal 1980. Between fiscal 1977 and fiscal 1980 the number of institutions applying for Special Services program increased by 43%; demand for Talent Search programs increased by 31%; and demand for Upward Bound programs increased by 22%. In FY '79 the Office of Education was only able to meet two-thirds of the demand for Special Services funds, 61% of the demand for Talent Search funds, 77% of the demand for Upward Bound funds, and 37% of the demand for EOC funds.

Cost Effectiveness

Currently 41.5% of the black population is 18 or under; 49% of the Hispanic population is 18 or under while only 28.4% of the white population is 18 or under. While some minorities are rapidly acquiring more education, better jobs and higher incomes, another group remains mired in poverty, an unyielding underclass with few qualifications.

Given the increasing size of this group, only two options are open to state and federal governments as they consider the plight of poor Americans generally, and the minority. poor particularly. The nation can choose to maintain the poor in poverty, or it can provide these individuals various means of egress from poverty. Listed below are Department of Labor fiscal 1979 estimates comparing the relative cost of providing these types of services.

DEMAND AND FUNDING PATTERNS

Program	Number of Proposals	Number of Projects Funded	Percentage Funded	Demand	Allocation	Percent Demand Met
Fiscal 1977						
Special Services	558	372	67%	57m	30.6m	53%
Talent Search	218	116	53%	22m	8.9m	40%
Upward Bound	448	345	77%	61m	41.5m	68%
EOC's	106	18	17%	20m	4.0m	20%
TOTAL	1,330	851		160	85.0m	
Fiscal 1978						
Special Services	651	487	75%	75m	47.0m	62%
Talent Search	190	131	68%	23m	12.0m	52%
Upward Bound	452	380	84%	68m	49.0m	72%
EOC's	72	22	30%	15m	5.0	33%
Training Authority	4	1			2.0m	
TOTAL	1,369	1,021		181m	115.0m	
Fiscal 1979						
Special Services	725	556	77%	83m	55.4m	67%
Talent Search	220	153	70%	25m	15.4m	62%
Upward Bound	489	413	84%	79m	58.8m	74%
EOC's	73	32	44%	17m	7.7m	45%
Training Authority		3			2.4m	
TOTAL	1,507			204m		
Fiscal 1980						
Special Services	797					
Talent Search	285					
Upward Bound	546					
EOC's	94					
Training Authroity						

	Cost Per Client
Job Corps	$13,754
Youth Community Improvement Program	8,000
Young Adult Conservation Corps	10,500
Youth Employment and Training Program	5,000
Youth Incentive Entitlement Projects	5,300

Certainly, when we consider that the cost per client for Upward Bound is $1,662, that the cost per client in Special Services i $335, and that the costs of EOC's and Talent Search are less than $80 per client, and when we also consider that the youth served by these programs generally come from backgrounds very similar to those of the individuals assisted by the various Labor Department programs, the cost of providing compensatory educational services through the Special Programs for Students from Disadvantaged Backgrounds are strikingly low.

TRIO offers low-cost programs of proven effectiveness. For this reason, the National Coordinating Council of Educational Opportunity Associations urges an appropriation of $170 million for TRIO in FY '81.

FOOTNOTES

[1]Data in this and the paragraphs following is taken from a Bureau of Labor Statistics news release (79-903) dated 12/27/79.

[2]Consequently, many more managers will require post-secondary training.

[3]Many service workers (e.g. beauticians, practical nurses and child case workers) are required to have some postsecondary training by state law.

[4]J.C. Flanagan, F.B. Davis, M.F. Shaycroft, D.B. Orr, I. Goldber and C.A. Neyman, Jr., The American High School Student (Cooperative Research Project No. 635, United States Office of Education), Pittsburgh: American Institutes for Research and the University of Pittsburgh, 1964.

[5]T. Long and E. Herr, "Teacher Perceptions of Basic Mathematics Skills Needs in Secondary Vocational Education," Mathematics Teacher 66:61-66, 1973.

[6]J.C. Flanagan, "Individualizing Education," Education 90:191-206, 1970.

[7]"Minority Enrollment at State Universities and Land Grant Colleges," Office of Communications Services, National Association of State Universities and Land-Grant Colleges, 1979.

[8]Id.

[9]Interpretative Paper, The College Board Washington Office, 2/80.

STATEMENT OF CHARLES E. HOLLERMAN, M.D., VICE PRESIDENT, HEALTH AFFAIRS, AND DEAN, UNIVERSITY OF SOUTH DAKOTA SCHOOL OF MEDICINE

MR. CHAIRMAN: I AM DR. CHARLES E. HOLLERMAN, THE VICE PRESIDENT FOR HEALTH AFFAIRS AND DEAN OF THE UNIVERSITY OF SOUTH DAKOTA SCHOOL OF MEDICINE, AND I AM PRESENTING TESTIMONY TODAY ON THE NEED FOR THE CONTINUATION OF LEGISLATION FOR HEALTH PROFESSIONS EDUCATION ASSISTANCE.

The University of South Dakota School of Medicine has consistently maintained a position of strong support for federal involvement in teaching of the health professions. In terms of medicine (physicians) specifically, it is our conviction that physicians still represent a national resource and all indications appear to support that conviction for the future. As such, we feel there is a strong justification for continued financial participation by the federal government. We further feel that a clear distinction should be made between supporting medical schools and directing medical schools. Both activities are valid for the federal government, but, in our opinion, there should be some base of general financial assistance without special requirements other than accreditation and then whatever supplemental assistance is appropriate to support such federal directions or initiatives as may be desired to meet special needs such as family practice/primary care, service to underserved populations (i.e., rural), special curricular offerings (i.e., geriatrics, nutrition, etc.) and minority admissions. We have definitive positions regarding the following:

1) General financial support for medical schools by the federal government. In our opinion, the federal government must provide some level of general financial support. Among the several alternatives which could be considered would be: a) Capitation, b) A formula based on geographical, population and local financing considerations, c) A formula based on a pre-determined base or critical mass faculty complement would be reasonably effective if agreement could be reached on the identification/quantification of such a critical mass. Geography, population and other considerations would be worthwhile supplemental considerations.
2) Future needs for federal funds for the modernization, renovation, or construction of undergraduate medical education facilities has

been available since the very early 1970's. Several areas of federal legislation (i.e., handicapped requirements, energy conservation, and other structural considerations) have combined with continuing growth of technology and broadening of all disciplines (basic and clinical) in medical education to produce a situation whereby many medical schools exist with facilities which are inadequate both in terms of size and structure. To the extent that federal legislation places burdens on medical education facilities and to the extent that medical education and medical research are national resources, the federal government should be involved in financing modernization, renovation and construction. The future needs for this type of assistance are on an accelerated growth curve due to their increasing magnitude, the inability of the institutions themselves to provide financing, and the compounding factor of inflation. The immediacy is obvious, the magnitude less clear. Based upon our institution alone, a figure of 20% - 25% of current value of existing facilities would address modernization and renovation. Additional space requirements at this institution would best be met by a minimum growth factor of 1% per year. Since our most recent construction was completed in 1969, we are approximately 10% below minimum desirable space requirements.

3) The appropriate government role in attempts to modify the geographic and specialty distribution of physicians. An appropriate role(s) for the federal government in modifying the geographic and specialty distribution of physicians includes the provision of incentives to practice in geographic shortage (physician) areas and/or specialties as well as the provision of support for education programs conducted in geographic shortage areas and/or focusing on needed specialties. With respect to the provision of support to education programs, this would compliment and supplement the general support discussed in 1) above. With respect to practice incentives, much clearer guidelines, for what is desired, than currently exist need to be developed.

4) The National Health Service Corps. In our opinion, the National Health Service Corps should be continued, enlarged and modified. The

accomplishments of any program, such as the National Health Service Corps, requires passage of considerable time (year) before it can be effectively evaluated. The NHSC, as it currently exists, would appear to need at least another decade in order to fully illustrate its impact. Our recommendation for enlargement is based on two observations -- 1) more students in our medical school apply for the NHSC Scholarship program than are accepted and 2) communities in our state, and surrounding states (including several Indian reservations) remain unable to obtain or retain physicians. Modifications to the NHSC could include specific provisions for continuity of service to designated communities, more direct participation between the NHSC program and state and local government, and the possibility of a direct relationship between groups of NHSC sites and academic health sciences centers (or medical schools) whereby support, consultative resources, continuing education, and possibly even *Locum tenens* would be provided.

5) Federal financial assistance to medical students. Given the cost of medical education and the need to eliminate financial barriers, if possible, to the acquisition of medical education, federal financial assistance should be made available. Because of the current unattractive financial climate, the long-term nature of medical student assistance (loans) and dramatic disparity among proximal (to medical schools) financial institutions, the federal government, as at least guarantor of loans, appears to be the single most appropriate entity for medical student financial assistance. Loan quarantees and "scholarships" which can be repaid through service (i.e., NHSC) appear the most effective mechanisms. However, student assistance should not be viewed as the mechanism through which the federal government satisfies its obligation to support medical education. Tuition paid by students, in state supported medical schools, does not accrue directly to medical school operations. Consequently, tuition increases do not provide increased support to some state supported medical schools.

The best mechanisms for medical student financial assistance would depend on the purpose for which assistance is being granted. If financial support alone is the purpose, the most appropriate mechanism may

well be a loan or loan quarantee program, with favorable interest rates. This approach allows, through loan repayment, the provision of support for future generations. Recognizing the unique problems encountered by "economically disadvantaged" students, some consideration should perhaps be given to provision of a scholarship and/or grant-in-aid program as a companion to loan and loan guarantee programs.

If the purpose of providing financial assistance is to influence the direction of students- i.e., into a designated specialty such as family practice or into a designated geographic setting such as a rural physician shortage area -- we would tend to favor the loan approach with specific forgiveness provisions based on time increments for practicing in the designated specialty and/or geographic area.

The expanding role of state governments in medical education has been fostered, or at least accelerated by, the instability and decline of federal support. In our experience, funding for medical education programs becomes progressively more vulnerable the more localized it becomes in the governmental hierarchy. This phenomenon can result in a more costly program, as support requires progressively more effort to obtain, and can easily remove educational direction away from "mainstream" concepts and into more parochial interests. Basic dangers in this occurrence are the dilution of a comprehensive curriculum and the disruption of continuity.

Another factor in opposition to the assumption by states of programs now conducted by the federal government under PL 94-484 is the fact that such a move would be clearly discriminatory against the more sparsely populated and less wealthy states. It is in these very states that the most serious maldistribution of specialties and disadvantageous physician-to-population ratios occur.

A proper funding balance for federal and state governments in the area of medical education would depend upon the resources of the respective state(s), the relative national, regional, state and local need for physicians, and the service impact value of a/the medical school. The provision of some stable base of financial support to medical education, as discussed earlier in this document, is, in

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our opinion a federal obligation. Clearly, states have a similar obligation, particularly to the extent that they directly benefit from the presence of a medical education program. The individual recipient of the medical education also has a definite responsibility, but is frequently constrained by an inability to pay, which should not be permitted to become a barrier to matriculation.

The general issue of federal assistance to medical education is an issue to which we have directed considerable attention at our institution. We would be pleased to elaborate more fully on the specific details of our institution's needs and how they might be best addressed if such a parochial perspective would be of benefit. Like other medical schools, we have participated in, and continue to participate in, a variety of federal programs. Two important realizations have emerged from our experiences. These are: 1) there is no other entity present in our state which could as effectively, if at all, accomplish the activities we have undertaken under federal assistance, and 2) our partnership with the federal government, in every measurable instance, has been successful. In the most direct analysis, our institution would probably not exist without federal assistance, but, likewise, many federal initiatives in our state would not exist without our medical school.

MR. CHAIRMAN, I THANK YOU FOR THE OPPORTUNITY TO PRESENT THIS TESTIMONY.

STATEMENT OF JASON NEWMAN, DIRECTOR, NATIONAL STREET LAW INSTITUTE

Mr. Chairman and members of the Senate Appropriations Subcommittee on Labor, Health, Education and Welfare, I am pleased to present this statement in favor of an appropriation for the Law-Related Education Act of 1978 (Public Law 95-561). As you know, law-related education is education to give persons, as part of their general education, understanding and skills pertaining to the law, the legal process and the legal system and the fundamental principles on which these are based. The purpose is to enable children, youths and adults to become more informed and effective citizens. Law-

related education is not academic legal education for lawyers, nor does it include direct training for careers in law.

In the past eight years that I have been active in law-related education, I have seen the individual efforts of teachers and public-minded lawyers to demystify the law by teaching about it in some of our nation's schools grow into an educational movement throughout the country to revitalize civics education and to help learners become informed about, understand, and deal with the laws which permeate our daily activities.

During that time, the National Street Law Institute was formed in order to develop curriculum materials about the law which affects our daily lives, to train teachers and others how to teach about law-related issues, and to provide assistance to both school and community based law-related educational programs. In the course of these activities, we have had the opportunity to observe the high interest of growing numbers of teachers in incorporating law-related education into their classrooms and the enthusiastic response of students of all educational abilities to relevant, realistic approaches generated in this area.

On behalf of the teachers and others professionally involved in law-related education and the learners who will ultimately benefit from these programs, I am grateful to this Subcommittee for initiating the approval of the $1 million appropriation, for FY 1980, which commenced the funding for the Law-Related Education Act through the Office of Education. This year, the Administration has carried on the initiative by requesting that the appropriation be continued at the same $1 million level for FY 1981. While we greatly appreciate the Administration's commitment to law-related education, we would ask you to consider a somewhat greater appropriation for FY 1980 to expand the delivery of authorized activities to the greater audience generated by the initial

appropriation and to prepare educators to reach the persons who will benefit from law-related education.

There are many reasons for a growing interest in this kind of education and for Federal support of it. The public wants to prevent the law-related problems that come up in their daily lives, and this can be done through learning basic concepts and practical knowledge of the law. The average person also wants to take responsibility for dealing with these problems, and in a cost-effective manner. Moreover, there is a widespread lack of understanding about the law and the legal system among both youths and adults. Promoting the "legal literacy" of citizens safeguards our democratic institutions, enhances our capacity for justice and is a national interest which justifies Federal support of this area. Yet little more than 10 percent of the nation's elementary and secondary school students receive meaningful law-related education.

The demand for this kind of education is growing, and will continue to grow. After publication of the preliminary regulations in the Federal Register, there were over 1,200 requests for them. There were seventy-five or more commenters on the preliminary regulations; these are being responded to in the final regulations. Also, I understand that an Office of Education public information official indicated that, after promulgation of the Education Amendements of 1978, which included the Law-Related Education Act, her office reveived more requests for information about law-related education than about any other provision in the Education Amendments.

It is evident from the great interest in the field and the limited funding available that only a small portion of the kinds of projects contemplated by the authorizing legislation and meritorious as potential grantees could be funded in FY 1980. Since studies have shown that educational innovations such as law-related education require more than one

year of seed funding in order to become self-sustaining, I anticipate that, without any increase over the FY 1980 appropriation, few new projects will be funded. This would be so even considering the declining federal share (and increased local match) for each funded project, as contemplated in the preliminary regulations.

The purposes of the legislation--to spread awareness of the content and methodology in this innovative field and to bring quality programs to all levels of learners throughout the country--would be enchanced by an expansion of the program to new areas. Our systems of democracy and justice rely on the participation of all people, who must understand and practice both their legal rights and responsibilities. It is for this reason that I urge you to consider an elevated appropriation over the FY 1980 mark of $1 million.

Thank you.

STATEMENT OF ROBERT D. EVANS, ASSOCIATE DIRECTOR, GOVERNMENTAL RELATIONS OFFICE, AMERICAN BAR ASSOCIATION

I am Robert D. Evans, Associate Director of the Governmental Relations Office of the American Bar Association, in which capacity I represent the Association in Washington on matters affecting legal education. I appear here today at the request of Association President Leonard S. Janofsky.

Your subcommittee is holding hearings this week on appropriations for Fiscal Year 1981 for the Departments of Labor and Health, Education and Welfare. In this era of budget austerity, great care is required to assure that limited federal dollars are spent where they may be expected to return the greatest benefit to society. We believe two Higher Education Act programs, both small in terms of dollars but large in their likely impact, should be given high priority in the appropriations process: the Title IX, Part D, Council on Legal Education Opportunity program; and the Title XI clinical legal experience program.

The Council on Legal Education Opportunity, or CLEO, provides training

and financial assistance to persons from disadvantaged backgrounds to permit them to attend law school. Our Association is one of five organizations which sponsor CLEO; the others are the Association of American Law Schools, the National Bar Association, the Law School Admission Council, and La Raza National Lawyers Association. The CLEO program has played a major role in opening the legal profession's doors to persons from economic and cultural backgrounds which have been underrepresented in the profession in the past. Over 1400 persons have received a law school education as CLEO scholars, and another 550 CLEO students are currently enrolled in law schools.

The CLEO program has received, since 1974, appropriations of approximately $1 million/year from the federal budget. No higher appropriation has been possible thus far due to the existence of a $1 million authorization ceiling. The Administration has recommended the lifting of that ceiling; and the Higher Education Act reauthorization legislation passed by the House, and now being considered by the Senate, would raise the ceiling to $5 million for Fiscal Year 1981. The increase is sorely needed to permit the program to return to 1974 real-dollar levels and to expand its outreach. But at this time, in view of the ceiling, we are requesting only a continuation of the current $1 million level of funding.

The clinical legal experience program, currently funded at $4 million, is a much-needed supplement to the $16 million being spent each year by law schools or clinical legal education. These clinical programs, like their counterparts in the medical schools, permit the student to gain experience in the actual provision of services to those in need and to assume the professional responsiblity of making decisions vitally affecting their clients. Clinical experience thus provides an invaluable ingredient in the student's training, greatly strengthening his or her ability to provide quality legal services to consumers upon graduation.

Such programs, however, necessarily involve close supervision and review of the students by law professors and practicing lawyers, and the student-teacher ratio must be far lower than in a conventional classroom

teaching experience. While the law schools have diverted funds from other educational activities to experiment with and improve upon clinical experience programs, they are finding it increasingly difficult to support further expansion and improvement of these programs.

The House, in its legislation to reauthorize the Higher Education Act, has recognized the value and importance of this educational initiative and has provided for a five-year reauthorization and an increase in the authorization ceiling from $7 million to $10 million. We believe this program has demonstrated clearly its effectiveness and should receive ongoing funding, and we urge your subcommittee to support an appropriation of not less than $5 million.

LETTER FROM MICHAEL E. HATCH, EXECUTIVE DIRECTOR, WORK OPPORTUNITIES, INC.

February 27, 1980

Senator Warren G. Magnuson
127 Senate Office Building
Washington, D.C. 20510

Dear Senator Magnuson:

I am writing in regard to President Carter's Fiscal Year 1981 budget request in the area of Rehabilitation of Handicapped Persons, and its effect on Rehabilitation Facilities. I have spoken to your staff person Jim Sourwine who was very knowledgeable regarding the projected budget. I thought that it might be helpful to put these thoughts in writing. The problem areas include the following:

Case Service funds should be increased to the full authorization level of $945 million. The budget request, minus Innovation and Expansion is only $842.5 million. The various states have the ability to match the higher level. As you probably know, inflation continues to eat away at purchasing power, and the emphasis on service to the more severely disabled person results in higher costs for the services.

I feel that Innovation and Expansion Grants should be a separate budget item funded at the 1980 level. Combining this with the basic State Grant program, gives more local control, but given the competing demands for increasing state grant funds, there is a distinct possibility that the Innovation and Expansion program will disappear.

The Facility Improvement Grant Program should be restored to the fiscal year 1979 level of 7.5 million. These grants provide assistance to facilities to improve

and expand services and equipment and train personnel, but the budget does not contain funds for this program.

As you know, the project with industries has been a very successful program for employment of the handicapped. This program should be increased to 10 million and not include the Business Opportunity Program.

The new Independent Living Program should be increased to 25 million. These services make the crucial difference between institutionalization and independent living and employment.

Thank you for your consideration and please feel free to contact me if you require further information.

Sincerely yours,

Michael E. Hatch
Executive Director

SUBCOMMITTEE RECESS

Senator WEICKER. The subcommittee will stand in recess until 2 o'clock this afternoon, when we will hear congressional testimony and futher public witnesses.

[Whereupon, at 12:13 p.m, Wednesday, March 12, the subcommitee was recessed, to reconvene at 2 p.m. this same day.]

(AFTERNOON SESSION, 2:07 P.M., WEDNESDAY, MARCH 12, 1980)

NONDEPARTMENTAL WITNESSES

CANCER RESEARCH AND FACILITIES PANEL

STATEMENTS OF:
THOMAS MERIGAN, STANFORD UNIVERSITY MEDICAL CENTER, DIVISION OF INFECTIOUS DISEASES
T. BYRON COLLINS, GEORGETOWN UNIVERSITY
SAUL B. GUSBERG, AMERICAN CANCER SOCIETY

Senator MAGNUSON [presiding]. All right, we will get started now. We may have to leave early because we have a caucus on the budget. Before you start—it's on budget restraint. [Laughter.]

Go ahead.

Mr. COLLINS. We will be very brief. I am Father Collins.

Dr. GUSBERG. I am Dr. Saul Gusberg, national president of the American Cancer Society.

Dr. MERIGAN. I am Dr. Thomas Merigan, professor of medicine, Stanford University.

GEORGETOWN UNIVERSITY—CANCER FACILITIES CONSTRUCTION

Mr. COLLINS. My statement will be about 2 minutes and Dr. Gusberg will pick up from there.

We are here on behalf of the National Cancer Institute. I support the specific program of the American Cancer Society in terms of construction. We have been a beneficiary of that program.

I do point out in another part of my testimony my concerns are also related to health research teaching facilities for a program that is related to the cancer program.

Dr. Gusberg?

[The statement follows:]

Statement of T. Byron Collins

Mr. Chairman, we are Frs. T. Byron Collins, S.J. and William L. George, S.J., Special Assistants to the President of Georgetown University.

In the Budget of the United States for FY'81 in the program of the National Cancer Institute, there is an item under Resource Development for Construction:

1979 (actual)	1980 (est)	1981 (est)
$22,937,000	$15,926,000	$3,941,000

Georgetown University Medical Center is constructing a cancer patient care-research facility titled the Lombardi Cancer Center. The cost of the project is about $13 million. A grant from the National Cancer Institute covers about 30% of the project. The Medical Center is providing, from a special fund raising program, the additional funds as well as borrowing for this essential project. This fund raising effort is the result of three years of intensive effort.

The 1981 Budget proposal of about $4,000,000 for Cancer construction is hardly able to start any new Cancer Center construction project.

HEALTH RESOURCES ADMINISTRATION

	FY'80	FY'81	
Health Teaching Facilities	$7,125,000	$4,300,000	(Exhibit 1)

Georgetown University has a problem for which the Medical Center asks for emergency assistance. The problem is a research teaching vivarium facility. This facility is a patched framework of temporary buildings. It's condition is such that the accreditation would be in serious jeopardy for the research and teaching programs that involve animals. In these patch work buildings, a $8 million dollar annual research and training program for the departments of the Medical School and major departments of the Dental School is conducted. An emphasis given to the research necessary for an integrated ambulatory patient and primary care program, especially the ambulatory care of cancer and heart programs.

For this essential research-teaching facility, we have striven to raise funds. Its fund raising appeal is rather limited.

We request emergency assistance under the Health Research and Facilities provision of Title VII of the Public Health Service Act, under Section 721 3(B). (Exhibit 2)

(CLERK'S NOTE.--Section 721 3(B)--Exhibit 2--can be found in Subcommittee's files.)

> "an application for a grant to assist in the replacement of existing teaching facilities, such application is for aid in construction which will replace facilities of ... an existing school of medicine, ... dentistry, ..., which facilities either are so obsolete as to require the school to curtail substantially either its enrollment or the quality of training provided ..."

This facility fulfills the program of both Sections of 720 a(1) for the construction of teaching facilities and 720 a(2) grants to non-profit private entities for construction of ambulatory primary care teaching facilities for training of physicians and dentists."

The estimated project cost for this replacement is $8,000,000.

We request an emergency grant in the amount of 50% of the project, i.e., $4,000,000.

We find it necessary to request loan funds under the Section 726 of the Public Health Service Act, loan guarantees and interest subsidies. This provision allows for the combination of grants and loans to cover 90% of the construction project.

A guaranteed loan amount of 40% of the project is requested in the amount of $3,200,000. The interest subsidy amount is 3% of the annual approved percentage. The period of time would be for forty years.

Georgetown University has raised some $600,000 for this project and will continue to strive to increase this amount.

IN SUMMARY:

An emergency need for Georgetown Medical-Dental School Vivarium is critical for the continued operation of the school programs because of accrediting procedures.

Request Grant	$4,000,000
Guarantee Loan	3,200,000
Georgetown Medical Center Resources	800,000
	$8,000,000

GEORGETOWN UNIVERSITY MEDICAL CENTER

THE NEED FOR A NEW ANIMAL RESOURCES FACILITY (ARF)

The use and care of experimental animals has been an integral and expensive part of most biomedical research. Research and educational activities using animals have made immeasurable contributions to the welfare of humans and animals. Valid, reproducible and meaningful data can be obtained only if healthy animals are used and kept in a suitable housing environment where they will receive humane care.

The current Vivarium, with a total of 12,000 square feet of service space, was built in the 1950s. This facility is inadequate and unsuitable for housing animals for the purposes of decent research, as it is not up to the standards stated in the 1978-revised NIH Guide for the Care and Use of Laboratory Animals. This deficiency has unfavorably affected the implementation and expansion of biomedical research at the Medical Center and has indirectly handicapped this Institution in attracting federal funding. In addition, Georgetown may be faced with the loss of its AAALAC accreditation, which would enormously affect its teaching, research and educational programs.

The ARF presently supports the research and teaching activities of 75 faculty investigators from the Departments of Pathology, Physiology, Pharmacology, Oncology, Microbiology, Surgery, Pediatrics, Ophthalmology, Anatomy, Nephrology, Medicine, Neurology and the Dental School. Approximately 9.0 million in research and training grants are directly or indirectly dependent upon the services of the ARF. The areas of major research include cancer, heart and lung cardiovascular diseases, prostaglandins, immunology and eye disorders. All of these research activities will be seriously jeopardized since the current ARF may be condemned.

Since the establishment of the Animal Welfare Act in 1966, most medical and research institutions (except Georgetown) in the United States have built modern animal care facilities to improve their animal research programs.

For the size of this Medical Center, and the scope of its research and educational activities by the faculty and staff, and the projected growth of the organization, Georgetown will require a centralized animal resources facility with approximately 42,000 square feet of space.

Due to the complex and stringent requirements for environmental control in an animal facility, the construction costs are usually higher than those for regular laboratories and offices. The estimated project cost (including fixed equipment), would be about $8 million.

The size, scope and complexity of the proposed animal resources building is based mainly on the institutional needs as well as microbiological, organizational and operational concepts developed to maintain "defined","high quality" laboratory animals of all species throughout the period of experimentation.

The design and construction of the animal facility will generally follow the guidelines listed in the following publications: 1) DHEW-NIH Guide for the Care and Use of Laboratory Animals, 1978; 2) Laboratory Animal Housing, ILAR, NAS, 1978; and 3) Laboratory Animal Houses, A Guide to the Design and Planning of Animal Facilities, 1976. Briefly, the facility should provide enough rooms for housing separately, by species, mice, rats guinea pigs, hamsters, gerbils, rabbits, birds, dogs, cats, new world primates, old world primates, large domestic animals and amphibians. Provisions for the separate housing of long and short term animals, animals for special projects, or biohazardous experiments should be included. A stress-free environment for the humane care of the animals should be a primary objective. Adequate and reliable mechanisms for environmental control such as temperature, heating, air ventilation and filtration, air conditioning, relative humidity, lighting, noise control, etc. should be enforced. The ARF building should be functionally and operationally subdivided into the following areas and their relative proportions (%) of total space as indicated in the attached table.

AMERICAN CANCER SOCIETY RECOMMENDATIONS

Dr. GUSBERG. A simple calculation which the American Cancer Society has done, with the help of the National Center for Health Statistics, shows that the Nation's cancer research and care community is extending the lives of some patients and saving the lives of others to the extent that patients are paying an estimated $1.9 billion into the U.S. Treasury every year that they would not otherwise have been able to pay.

The national cancer program, in other words, is putting back into the Treasury almost twice as much as cancer research is costing the Federal Government.

An explanation of the calculation is attached and fully documented.

For this reason, Mr. Chairman, the American Cancer Society feels that its request for a cost-of-living increase for the national cancer program at NCI is modest in the extreme. We ask only that the fiscal 1981 appropriation for the National Cancer Institute be $1.135 billion, or the same as last year plus a cost-of-living increase.

We don't break this into components of the budget because we are rather well staffed with the distribution made by NCI, but I will say there are two subtotals in which we are interested. One is the cancer center's budget which should be augmented by $10 million; if necessary it could be shifted from some of those programs which the NCI is now reorganizing. I will discuss the other subtotal shortly.

This committee, more than most in the Congress, is well enough acquainted with NIH processes to know that a biomedical program involving patients takes in most cases several months to plan, then possibly a year to recruit the subjects of a clinical trial, and in cancer—an additional 5 years to make sure there is a bona fide extension of life or

cure, and then finally a year to doublecheck the data to make sure that the calculations are accurate.

We are talking about a program that got its first director in March 1972 after the law passed in December of 1971; so one could say that, so far as the national cancer program is concerned, most of the work of the last 10 years won't be evaluated before 1985, with the earliest results coming in between 1979 and 1981.

CANCER STUDIES

Preliminary results have been extremely promising. The National Cancer Institute has just completed a still unpublished survey which compares the 5-year survival rates of cancer patients whose treatment began in the first 3 years of the decade of the 1960's, with those rates of cancer patients whose treatment began in the first 3 years of the decade of the 1970's. My attached table, attachment B, is the most conservative way of showing these results.

We show the 10 most frequent sites of cancer and find that, among white patients, the improvement during the 1970's as compared to the 1960's in these most frequently seen cancers is from 8.8 percent for colon cancer, for example, to 30.3 for prostate cancer. Some of the big killers show favorable trends, too, such as a 9.1-percent improvement for breast cancer, a 17.9-percent improvement for bladder cancer.

Among blacks the improvements have been even greater in many cases. For instance, in prostate cancer the improvement is 56 percent, and in bladder cancer 42.1 percent, while for breast cancer the 5-year survival rate improved 12.5 percent between the early 1960's and the 1970's. Not so many of the major cancers have produced statistically valid figures for blacks; however, the trends are up in all cases.

Why then does many a newspaper article give the impression that progress against cancer is very small, or nonexistent? There is a rational explanation for these stories.

Mr. Chairman, in the absence of positive scientific proof on a single cause for cancer, or even a group of causes, an extremely important tool for exploring the unknown is the discipline of epidemiology. The American Cancer Society long ago recognized this and mounted what is still the largest epidemiological study of all time, involving 1 million subjects reached by American Cancer Society volunteers who collected literally hundreds of pieces of data from each subject in lengthy interviews.

It is this study which produced much of what we know today about specific substances which cause cancer—cigarettes, asbestos, polyvinylchloride, and others. It is data from this study which provided the basis on which Federal regulatory agencies are now proceeding against these dangers.

Among the misleading impressions which several congressional committees have been offered in the last 2 or 3 years is the impression that overall—we've just looked at the individual organ site figures—that, overall there has been little progress against cancer.

The National Center for Health Statistics—the Government's own source of information, however, shows a different story in its figures.

They show the death rate from cancer per 100,000 population in a table which we atttach for selected years from 1950 to 1976.

It is true that there has been a slight rise in the death rate when all cancers are considered, from 125.4 per 100,000 to 132.3 per 100,000 in 1976—the latest figures. That is a 6.9-point rise, or a 5.5-percent rise.

But bulging out of these figures is the terrible rise in cancer of the respiratory system. The death rate from respiratory system cancer in 1950 was 12.8 per 100,000. It soared to 33.5 in 1976—a 20.7 increase or 161.7 percent more than in 1950. Particularly, lung cancer among women is rising so fast that it will exceed the incidence of breast cancer within 3 years.

Some of these misleading statistical impressions, which I am trying to correct, led to extreme criticism of the National Cancer Institute's bioassay work, the work designed to identify more chemicals, including those used in industry, which might be causing cancer.

We think that the Congress had several sound bases for criticizing that program. It was not working well. Understaffing at the National Cancer Institute put far, far too much a load on a staff severely limited by Office of Management and Budget personnel ceilings, and this put too much reliance on contract work.

NATIONAL TOXICOLOGY PROGRAM

Corrective action was taken and the work was brought up to date. At the same time a national toxicology program was created, largely with National Cancer Institute money. This has removed from National Cancer Institute control the Government's main work in bioassay testing.

The American Cancer Society in no way opposes this move to create the national toxicology program. It is a needed activity and deserves strong support.

We do oppose funding any programs with National Cancer Institute money that is not controlled by the National Cancer Institute. We think it is bad practice to put money into the hands of people who do not control it and bad practice for people to receive money for which they are not directly accountable.

The society therefore recommends to this committee that the national toxicology program be independently funded and that the money in the National Cancer Institute budget be controlled exclusively by the National Cancer Institute. For the NCI programs, the toxicology funds cutback should be brought back up to par within NCI.

We understand that this arrangement is supported by the National Institutes of Health and the Assistant Secretary for Health, though our information has been received on an informal basis.

That completes my statement.

[The statement follows:]

STATEMENT OF SAUL B. GUSBERG

Mr. Chairman, a simple calculation which the American Cancer Society has done with the help of the National Center for Health Statistics shows that the nation's cancer research and care community is extending the lives of some patients and saving the lives of others to the extent that patients are paying an estimated $1.9 billion into the United States Treasury every year that they would not otherwise be able to pay.

The National Cancer Program, in other words, is putting back into the Treasury almost twice as much as cancer research is costing the federal government.

An explanation of the calculation is attached and fully documented. (Attachment A)

For this reason, Mr. Chairman, the American Cancer Society feels that its request for a cost-of-living increase for the National Cancer Program at NCI is modest in the extreme. We ask only that the fiscal 1981 appropriation for the National Cancer Institute be $1.135 billion, or the same as last year plus a cost-of-living increase.

This Committee, more than most in the Congress, is well enough acquainted with NIH processes to know that a biomedical program involving patients takes in most cases several months to plan, possibl a year to recruit the subjects of a clinical trial, and in cancer an additional five years to make sure there is a bona fide extension of life or cure, and a year to double check the data to make sure that the conclusions are accurate. We are talking about a program that got its first director in March, 1972 after the law passed in December of 1971; so one could say that, so far as the National Cancer Program is concerned, most of the work of the last ten years won't be evaluated before 1985 with the earliest results coming in between 1979 and 1981.

Preliminary results have been extremely promising. The National Cancer Institute has just completed a still unpublished survey which compares the five-year survival rates of cancer patients whose treatment began in the first three years of the decade of the 1960's with cancer patients whose treatment began in the first three years of the decade of the 1970's. My attached table (Attachment B) is the most conservative way of showing these results, because it shows figures for "observed" results, which means that a cancer patient could have been hit by a truck and he'd still show up on this table as a

patient who failed to survive cancer five years. The more usual instance, of course is a cancer patient's surviving his disease, but dying of a heart attack, diabetes, or some other disease which, in this table, actually lowers the apparent success of cancer therapy. Even so, we show the ten most frequent sites of cancer and find that, among white patients, the improvement during the 1970's as compared to the 1960's in these most frequently seen cancers is from 8.8% for colon cancer to 30.3% for prostate cancer. Some of the big killers show favorable trends, too, such as a 9.1% improvement for breast cancer, a 17.9% improvement for bladder cancer. Pancreas doesn't show any improvement at all, but the number of cases found in this survey were not statistically significant. It means, certainly, that progress has been minimal in pancreas, but not necessarily as bad as it looks here.

Among blacks the improvements have been even greater in many cases. For instance, in prostate the improvement is 56%, and in bladder 42.1% while breast cancer five year survival improved 12.5% between the early 1960's and the 1970's. Not so many of the major cancers have produced statistically valid figures for blacks, however though the trends are up in all cases.

Why, then, does many a newspaper article give the impression that progress against cancer is very small, or nonexistent? There is a rational explanation for these stories.

Mr. Chairman, in the absence of positive scientific proof on a single cause for cancer, or even a group of causes, an extremely important tool for exploring the unknown is the discipline of epidemiology. The American Cancer Society long ago recognized this and mounted what is still the largest epidemiological study of all time, involving one million subjects reached by American Cancer Society volunteers who collected literally hundreds of pieces of data from each subject in lengthy interviews. It is this study which produced much of what we know today about specific substances which cause cancer -- cigarettes, asbestos, polyvinylchloride, and others.

Our society testified at the outset of the National Cancer Program that several research occupations were in critically short supply, including epidemiologists. One reason that this Committee has heard some clearly unsupportable epidemiological testimony from time to time is that the shortage of epidemiologists has severely confined the flow of accurate epidemiological data and also because there aren't enough epidemiologists to provide the

broad critical cross-checking of conclusions that ensues in scientific fields with higher competition among their practitioners. It is one of the reasons, too, that it is so hard to set national policy on such matters as low-level radiation, fluorides, saccharin, etc., since there simply aren't enough competing studies to provide the mix of data needed for hard conclusions.

Among the misleading impressions which several congressional committees have been offered in the last two or three years is the impression that, overall -- we've just looked at the individual organ site figures -- that, overall there has been little progress against cancer.

The National Center for Health Statistics, the government's own source of information, however, shows a different story in its figures. They show the death rate from cancer per 100,000 population in a table we attach (Attachment A) for some selected years from 1950 to 1976. It is true that there has been a slight rise in the death rate when all cancers are considered--from 125.4 per 100,000 to 132.3 per 100,000 in 1976, the latest figures. That is a 6.9-point rise, or a 5.5% rise. But bulging out of these figures is the terrible rise in cancer of the respiratory system. The death rate from respiratory system cancer in 1950 was 12.8 per 100,000. It soared to 33.5 in 1976, a 20.7-point increase, or 161.7% more than in 1950. Particularly, lung cancer among women is rising so fast that it will exceed the incidence of breast cancer within three years. (See Attachment A-1.) Over 70% of lung cancer is caused by smoking cigarettes. Clearly the respiratory cancer is primarily a problem which biomedical research has shown us the way to solve--quite smoking, and more and more people in the U.S. are doing just that. But for seeing clearly the overall effect of biomedical research one must discount that large increase caused by a factor science has identified.

The truth is that if the respiratory system cancers are subtracted from the total cancer mortality figure that science has rather importantly reduced the death rate from cancer from 112.6 per 100,000 in 1950 to 98.8 per 100,000 in 1976, or by 13.8 points, which is 12.2%, a rather nice percentage improvement any researcher could be proud of.

Some of these misleading statistical impressions which I am here trying

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to correct led to extreme criticism of the National Cancer Institute's bioassay work, the work designed to identify more chemicals, including those used in industry, which might be causing cancer.

We think that the Congress had several sound bases for criticizing that program. It was not working well. Understaffing at the National Cancer Institute put far, far too much load on a staff severely limited by Office of Management and Budget personnel ceilings, and put too much reliance on contract work.

The National Cancer Advisory Board and the entire top management of NCI, plus the President's Cancer Panel moved strongly to correct a bad situation and much corrective action was taken and a backlog of unfinished work brought up to date.

At the same time a National Toxicology Program was created, largely with National Cancer Institute money. This has removed from National Cancer Institute control the government's main work in bioassay testing. The American Cancer Society in no way opposes this move to create the National Toxicology Program. It is a needed activity and deserves strong support.

We do oppose funding any programs with National Cancer Institute money that is not controlled by the National Cancer Institute. We think it is bad practice to put money into the hands of people who do not control it and bad practice for people to receive money for which they are not directly accountable.

The Society therefore recommends to this Committee that the National Toxicology Program be independently funded and that the money in the National Cancer Institute budget be controlled exclusively by the National Cancer Institute. We understand that this arrangement is supported by the National Institutes of Health and the Assistant Secretary for Health, though our information has been received on an informal basis.

We in the American Cancer Society feel strongly that bioassay testing should proceed at a rapid practical pace, but we also warn this committee that some of the fundamental problems perceived during the days when this program was inside the National Cancer Institute are still with us and it would, therefore, be unfair to expect the new administrators of the program to move ahead at a speed remarkably faster than the program was moving at NCI.

For the record, I include here a few statements from the fiscal 1980 report of the National Toxicology Program (Attachment C) which point to specific research problems which must be solved before that program can move rapidly enough for the American people. New tests must be invented and tested before there is any chance at all for bioassay testing to catch up with the introduction of new chemicals into our environment.

Meanwhile, there is plenty to do to control the carcinogenic chemicals already identified by the ACS cancer prevention study. This, of course, is the duty of regulatory groups outside of the National Cancer Institutes. If anything on this topic has been made clear in recent years it is the fact that biomedical research should not be combined with regulation. Researchers are not good regulators. We believe that the Congress and the regulatory agencies are moving in the right direction in improving regulation of those carcinogens already identified as highly toxic, such as asbestos.

Attachment A

Cancer Therapy Saves Families in U.S. $13.7 Billion in 1980; Puts More Than $1.9 Billion in Federal Treasury Directly

1. Except for lung cancer the cancer death rate has dropped 12.2%.

Cancer Mortality, U.S. (per 100,000 population):

	1950	1955	1960	1965	1970	1971	1972	1973	1974	1975	1976
Malignant Neoplasms	125.4	125.8	125.8	127.0	129.9	129.7	130.7	130.7	131.8	130.9	132.3
Respiratory System Cancer only	12.8	16.0	19.2	23.0	28.4	29.1	30.3	30.8	31.8	32.5	33.5
All except Respiratory System	112.6	109.8	106.6	104.0	101.5	100.6	100.4	99.9	100.0	98.4	98.8

2. This means 266,900 persons with cancer this year will be cured (5 years or more disease-free).[a/]

3. The economic value of these lives is approximately $13.7 billion.[b/]

4. Cancer research costs $1 billion this year at the National Cancer Institute, only a small fraction of the economic value of lives saved.[c/]

5. $1.9 billion goes directly to U.S. Treasury in personal income taxes paid on $13.7 billion earnings during years of therapy-extended life.[d/]

Footnotes:

a. The American Cancer Society estimates 785,000 new cases of cancer will be diagnosed in the U.S. in 1980. The National Cancer Institute and the American Cancer Society estimate 34% of them will be cured (based on percentage of treatment outcomes where patients are alive 5 years or more after diagnosis). The estimated cures from new cases discovered in 1980 total 266,900.

b. Estimate derived from National Center for Health Statistics cancer cost data (391,000 cancer deaths in 1977); a lifetime earnings loss of $18.8 billion or $48,100 per death). The $13.7 billion "economic value of lives saved" in 1980 is calculated on the following assumptions: (a) No economic value of lives saved during first five years after a patient is diagnosed; economic value of 5-year+ survivors, only, considered. (b) A 6% discount rate is used to estimate the present value in 1980 of a death in 1985. (c) The estimate labor force mix, and estimated future earnings, make the 1980 value of a 1985 death $51,409 on the average in the United States. (d) 266,900 persons getting cancer in 1980 will be cured (N.C.I.'s estimated cure rate of 34% applied to 785,000 new cases).

c. Almost all federally supported cancer therapy research relies on the National Cancer Institute as a source of funds. The instant data provide perspective on one aspect of the productivity of those funds. No comment intended on N.C.I.'s or other agency's productivity in non-therapeutic cancer research (smoking, evironmental hazards, etc.).

d. Internal Revenue Service reports income taxes of $159 billion paid on $1,155 billion personal income in 1977 for an average tax rate of 13.8%. If $13.7 billion is 1980 value of lives saved, 13.8% of that is $1.9 billion.

Surgeon General Says Lung Cancer In Women Increases Dramatically

Attachment A-1

Rate Is Projected to Exceed Breast Malignancy's — Risks of Smoking Cited

By A. O. SULZBERGER Jr.
Special to The New York Times

WASHINGTON, Jan. 14 — With a warning that lung cancer among American women is increasing dramatically, the Surgeon General of the United States said today that within three years lung cancer could become the leading cancer killer of women, overtaking breast cancer.

The prediction is in a 400-page report to Congress that deals exclusively with the health consequences of smoking for women. At the heart of the report was a finding that women who smoke as men do will encounter the same risks as men. The report goes a long way toward dispelling a myth held by many smokers that women are somehow protected from the problems inherent in smoking.

"This report points out that the first signs of an epidemic of smoking-related disease among women are now appearing," the report said. "Within three years, the lung-cancer rate is expected to surpass that of breast cancer," now the greatest cancer danger to women.

Risks to Pregnant Women

The report also says that pregnant women who smoke run an increased risk of problems before, in and after childbirth. These problems can include spontaneous abortions and babies that weigh less than average at birth. It says the long-term growth and intellectual development of children born to smoking women may also be adversely affected.

Behavioral research into smoking raises questions about the benefits of switching to low-nicotine cigarettes. Page C1.

While there is nothing completely new in the report, it is the first time that all of the scientific documents pertaining to women and smoking have been brought together in one volume. The Department of Health, Education and Welfare has submitted to Congress an annual report on the health consequences of smoking for 12 years.

Mrs. Harris Skips Ceremony

"This report is one of the most alarming in the series," Patricia Roberts Harris, the Secretary of Health, Education and Welfare, wrote in a cover letter accompanying the report.

Unlike her predecessor, Joseph A. Califano Jr., whose outspoken opposition to smoking embroiled the Carter Administration in running battles with the powerful tobacco industry in the South, Mrs. Harris has remained quiet on the issue. She did not attend today's news conference at which the report was made public.

The Tobacco Institute, which represents the industry in Washington, attacked the report, labeling it simplistic.

"Part of the reason for the rise could be better detection methods," Connie Drath, assitant to the president of the institute, said of the increase in lung cancer among women. She added that the increase might be much smaller than indicated, but offered no specific figures.

Questions Affects on Children

Miss Drath also said that the institute believed that there was no proven relationship between smoking mothers and the mental or physical development of their children.

Almost all previous studies on the effects of smoking have centered on men. One of the major reasons for this is that women, on the whole, did not take up smoking in great numbers until around World War II, decades after men. The average woman who smoked started later in life, consumed fewer cigarettes per day, was less likely to inhale and more likely to use a filtered brand or milder cigarettes than the average male smoker.

But as these women grow older, and continue to smoke, doctors have been able to trace the same symptoms and problems as those suffered by men.

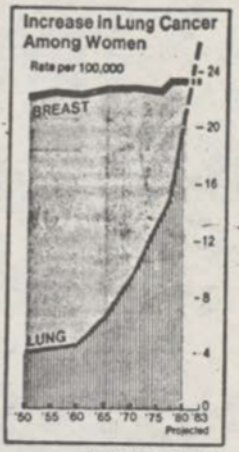
Early Sign of Emancipation

"Cigarette smoking, an early sign of woman's social emancipation, is now a major threat to her personal health and her ability to bear healthy children," said the Surgeon General, Dr. Julius B. Richmond.

The death rate for women by lung cancer remained fairly steady, at fewer than five per 100,000 people, until the early 1960's. But the rate began to grow, first slowly, and then with increasing speed. In 1978, the rate was nearly 15 deaths per 100,000, a threefold increase. This translates into about 25,000 deaths per year.

Scientists project that by 1983 the rate will approach 25 deaths per 100,000.

Cigarette smoking, by both men and women, is declining over all. In 1965, 51 percent of all men smoked, a rate that has since dropped to 36.9 percent. For women, the figures are 32 percent in 1965 as against 28.2 percent now.



The New York Times / Jan. 15, 1980

However, there are now more girls and women between the ages of 17 and 24 smoking cigarettes than there are among boys and men in the same age group. Among the 17- and 18-year-olds, only 19 percent of the boys smoke as against 26 percent of the girls.

The report says that babies born to women who smoke in pregnancy are, on the average, 7 ounces lighter than babies born to comparable nonsmoking women.

"The risk of spontaneous abortion, fetal death and neonatal death increases directly with increasing levels of maternal smoking during pregnancy," the report says.

The report also says that the proportion of fetal deaths and premature live births increases directly with maternal smoking levels. Up to 14 percent of all premature deliveries in the United States can be attributed to maternal smoking, the report found. However, there was insufficient data to support a judgment on smoking increased the risk of congential malformations of babies, the report says.

Attachment B

Rate of Survival among Cancer Patients Five-Years after Diagnosis
Comparison of Experience in 1960's with 1970's

Observed[a] Five-Year Survival Rate among White Patients

Ten Most Frequent Sites of Cancer	Date of Diagnosis 1960-1963	Date of Diagnosis 1970-1973	Percentage Survival Improvement
Corpus uterus	64%	72%	12.5%
Breast	55	60	9.1
Cervix	53	59	11.3
Bladder	39	46	17.9
Prostate	33	43	30.3
Colon	34	37	8.8
Rectum	30	35	16.7
Stomach[b]	8	10	25.0
Lung	7	8	14.3
Pancreas[b]	1	1	0.0

Observed[a] Five-Year Survival Rate among Black[c] Patients

Ten Most Frequent Sites of Cancer	Date of Diagnosis 1960-1963	Date of Diagnosis 1970-1973	Percentage Survival Improvement
Corpus uterus	26%	37%	42.3%
Breast	40	45	12.5
Cervix	42	56	33.3
Bladder	19	27	42.1
Prostate	25	39	56.0
Colon[b]	28	30	7.1
Rectum[b]	23	24	4.3
Stomach[b]	7	10	42.9
Lung[b]	4	6	50.0
Pancreas[b]	1	2	100.0

Footnotes

a. "Observed" rate means survival overall, whether nonsurvivors died of cancer or any other disease. (See related Table No. 57 for definition of "relative" survival.

b. Data on these lines may not be statistically significant changes attributable to something other than chance even though they appear to be moving encouragingly. Statistical significance has not been calculated.

c. The data bases and cancer experiences of White patients are quite different from Black patients, hence the two tables.

Source: National Cancer Institute, based on experience recorded at University of Iowa Hospital, Charity Hospital in New Orleans, entire state of Connecticut, and the California Tumor Registry; 185,393 cases for all cancers, including those shown in table.

The universe of chemicals to which humans are exposed is therefore so large that the task of preventing human exposure to toxic chemicals might appear impossible.

Fortunately, most chemicals are relatively non-toxic and require few if any controls to protect human health. It appears that only a small fraction of these chemicals are highly toxic. Thus, to protect the public health and to prevent disease, this fraction should be accurately identified and rigidly controlled.

This then is a major task of the National Toxicology Program -- to identify those toxic chemicals that must be controlled to prevent disease.

Carcinogenesis Lifetime Bioassay

What scientific tools do we have to do this? The standard tool is the two-sex, two-species lifetime study of experimental animals, usually rats and mice, -- beginning at weaning, ending at death, using multiple dose levels of the chemical being tested. Such a study can provide worthwhile information on the kinds of toxic effects caused by the chemical and the doses or concentrations causing these toxic effects. This standard test determines if a chemical causes cancer and produces damaging effects on certain organ systems -- liver, lung, kidney, endocrine systems, etc. This test is weak at predicting effects on reproductive capacity, pre- and postnatal growth and development, certain neurobehavioral functions, and at identifying chemicals that damage genetic information transfer -- mutagens. Further, the study of even a single compound is expensive, costing hundreds of thousands of dollars, taking up to four years to complete, and requiring hundreds of hours of scarce professional time.

It is unreasonable even to attempt to study all 48,000 chemicals in this way. Current known world capacity permits the initiation of perhaps 300 such chemical tests each year, and the results published this year are from the tests begun four or more years ago. This capacity -- even

if financial resources were not limiting -- could be no more than doubled in the next 5-10 years. At this rate, it would take an additional 80 years to study all currently existing chemicals. Further, approximately 500 new chemicals are introduced into commerce each year, and this would result in an additional backlog of some 40,000 untested chemicals. Implementation of the Toxic Substances Control Act will impact on the overall issue of testing, yet the final result remains the same -- in the next 80 years the chemical testing backlog would be decreased only moderately.

Thus, we cannot perpetually rely on two-species lifetime studies to identify those chemicals which need strict control because:

(1) These tests have scientific limitations -- they can miss certain critical toxic effects.

(2) They are time consuming and expensive.

Nonetheless, the long term testing of compounds which are currently untested or inadequately tested, and for which there is significant human exposure, will continue and if resources permit will continue at an increased rate. Additionally, each compound will be tested more thoroughly than in the past.

Newer Testing Methods

Therefore, the National Toxicology Program must develop and validate new test methods that will allow us to determine more quickly and less expensively the full toxicologic potential of a compound.

INFECTIOUS DISEASES RESEARCH AND INTERFERON

Senator MAGNUSON. All right; who is next?

Dr. MERIGAN. For several years I have studied a substance that occurs naturally in the body, called interferon. It is a protein produced by infected cells to inhibit virus infection of nearby healthy cells. In the last year you have undoubtedly become aware of this substance as a potentially useful antiviral and anticancer substance which is under preliminary investigation in man. Present clinical trial results are quite encouraging in both areas, although they are limited in scope because of the high cost of production of the material by current methods.

Although not as well publicized, very exciting findings also have recently been reported in regard to the fundamental properties of this material. Several different human interferons have been completely purified and their structures and properties evaluated. This means that their synthesis and molecular modification are possible in the near future.

Other advances have been made, such as the finding that interferon functions not only as a naturally occurring host defense, but as a regulator of cell division and differentiation, particularly in immune cells. The interferon gene has been isolated and cloned in bacteria and in fact some synthesis of human interferon by such bacteria has been observed. Also, a much clearer understanding has emerged of the way interferon acts against viruses at the molecular level—see the appendix of my statement.

I am sure that you have also heard of the unprecedented commitment by the American Cancer Society of $5.7 million for the purchase of interferon for clinical trials. In addition, a larger scale clinical evaluation program has been set up by the National Cancer Institute because of your additional funding last year for such a program.

Senator MAGNUSON. We acknowledged last year that interferon is something that we should pursue further, and we suggested in our report that the NIH and Cancer Institute direct some of their activities toward looking at this. We can do the same thing now.

Dr. MERIGAN. I think it's very important.

Senator MAGNUSON. The American Cancer Society took cognizance of that and also designated some money for this purpose.

Dr. MERIGAN. The reason I'm here is to speak in regard to the involvement of the National Institute of Allergy and Infectious Diseases with interferon research.

Senator MAGNUSON. The Allergy Institute also? You testified we shouldn't divert the funds, Dr. Gusberg. We shouldn't separate them?

Dr. GUSBERG. They should be separated.

INTERFERON FUNDING FOR THE ALLERGY AND INFECTIOUS DISEASES INSTITUTE

Dr. MERIGAN. I'm here because though your awareness of this is primarily in the cancer application, the lead has been taken by the Allergy and Infectious Diseases Institute in developing interferon as a drug in this country.

I think we need further studies on the basic aspects of the interferon system as it relates to viruses and immunity and I think there are new areas of viral infection in which we can pursue it. I have been funded by the Allergy and Infectious Diseases Institute myself, but there is a broader need for a commitment of $20 million for a program in this area.

This can only occur if additional funding is added to the Institute's budget. I believe we should not compromise other important efforts of that agency by diverting funds from other projects.

Senator MAGNUSON. The whole field of virus infection has been an exciting field for me in cancer research. Within the total research area, I think we should direct ourselves more to what you're talking about.

Dr. MERIGAN. I appreciate that. I think that we have to understand the fundamental mechanism of action of this material to really apply it clinically. As we understand, it has a more fundamental role in the immune system and cell growth, it opens up whole new fields of investigation.

I think we are learning how genes are regulated, how they are turned

on and turned off, and this material appears important, as important perhaps as the control over carbohydrate and fat and protein we learned about 20 years ago.

INTERFERON SYNTHESIS

I want to tell you about this gene cloning work. The fact that the interferon has been cloned by recombinant DNA techniques in several labs means that there is a distinct possibility that, as with the better known hormones, this will become the cheapest way to make interferon in the future.

Further advances in increasing the yields of interferon from bacterial cells bearing the interferon gene will provide general methods useful with other proteins. The "Andromeda Strain" type fears regarding DNA which prevailed until recently have put the U.S. efforts in this area well behind those of other countries. For example, at the present I am not aware of any bacterial clones containing the interferon gene being produced in this country, whereas a Japanese report has already appeared in the literature and a Swiss one is currently being submitted. I have heard reports of successful work in this area in both Israel and France as well.

COST OF INTERFERON PRODUCTION

Senator MAGNUSON. Is the cost higher in this country?

Dr. MERIGAN. No; because those synthesis systems have not yet been perfected, it's not cheaper in the other countries at present, but they have potential for being much cheaper because they have their systems more advanced.

Senator MAGNUSON. In other words, we haven't gone along far enough to make a comparison of costs.

RESEARCH APPLICATION OF INTERFERON

Dr. MERIGAN. Exactly; they haven't produced enough. But the potential is really there. With interferon made in Finland from human white blood cells, we have been looking at diseases like hepatitis or herpes viral infection—even the common cold, and we have found very encouraging results.

Now, I think we will need to begin to do more research in infectious diseases because the cancer application has made interferon more generally available. For example, most of us have herpes viruses in our bodies. It would be important to eradicate them. When cells are weakened by cancer and certain drugs, that virus can kill us.

This fall I spent a month at various research centers in the People's Republic of China speaking about out studies with interferon in the United States. They invited me to present that work because that country has a high incidence of this infection as well as liver cancers. Liver cancers appear to be, in part, the result of such infections.

There is also a tumor in China associated with a viral infection called nasopharyngeal carcinoma. It appears to be related to infectious mononucleosis, just as the same virus is associated with a lymphoma in children in Africa.

With long-term interferon treatment of individuals diagnosed as being at high risk for these tumors, it may be possible to prevent such sequences of chronic infection.

Cytomegalovirus, another herpes virus, is a major cause of mental retardation in infants. We have found that this virus can be suppressed by interferon treatment. This same virus also produces problems in our heavily immunosuppressed heart transplant patients at Stanford. Interferon should be explored in both these settings in larger scale studies to see if eradication of the infection will benefit these patients and/or prevent spread of the agent to others.

The Federal funding impact was primarily on the Cancer Institute. There were no specific funds designated for the Allergy and Infectious Diseases Institute. They pioneered this technique. This material is very important to their research.

Senator MAGNUSON. We didn't have sufficient knowledge of what you're talking about. There is a wide range in which interferon could be applied it seems. We thought we did know; good examples were shown in the cancer field, we thought, to at least direct interferon to cancer.

But apparently your studies and the rest of them worldwide have found it has a broader application. I don't know why the Cancer Institute couldn't proceed with it, however.

Dr. MERIGAN. They can, but their application is primarily cancer.

Senator MAGNUSON. I know. Their application is a limited one.

Dr. MERIGAN. The infectious diseases area is very exciting in the antiviral agents research area today. I think we are beginning to see the first agents that are really producing impact on human diseases; agents which are safe enough to be used widely.

For example, I'm going to Cairo at the end of the month to look into treating symptomatic rabies patients in that city where there are 40 cases of symptomatic diseases in the population each month.

INTERFERON PROGRAM DEVELOPMENT

Senator MAGNUSON. At page 47 of last year's report on interferon, we did direct it toward cancer; but did say the committee expects within 30 days following the passage of this bill that the Institute will develop and send to the committee a spending program on what is to be done on this very high-priority program. This should have included what is being done to coordinate the efforts with the Allergy and Infectious Diseases Institute.

Whether or not we got that report is something else. I understand we got a report—it was one page. It was also 6 weeks late. They didn't do a very good job on it. We sent it back.

Dr. MERIGAN. I heard of this. It's good to know you're aware of it. I think the important thing is that we have another year——

Senator MAGNUSON. We were at a loss to know just how to proceed. We directed the Cancer Institute to give us some idea of what you're talking about.

Go ahead.

Dr. MERIGAN. All right.

I think it's also of great importance to explore, as far as a spray or by injection, interferon as a means of preventing or treating respiratory infections including the common cold and influenza. All of these studies, as well as the basic work, need to be supported through additional funding to the National Institute of Allergy and Infectious Diseases.

Unfortunately your legislation of last year only made an award to the National Cancer Institute for extending its studies of interferon in the treatment of malignant disease.

Beginning in the late 1960's the National Institute of Allergy and Infectious Diseases supported the initial studies of this material in the United States, and it would be quite unfortunate if their important work could not be expanded now that a full-scale exploration of its potential is so near at hand.

We speak of the so-called drug lag in the United States, and often the FDA and restrictive legislation is blamed. On the other hand, it must be recognized that European science, including clinical investigation, has improved greatly in its quality in the last two decades. American science and technology leadership is being challenged in many different areas.

Interferon is an agent which seems quite likely to become an important drug. An increased commitment to support of this area, both at the clinical and fundamental basic science levels, is required if we are to continue to lead in this area and adequately extend our present studies.

Leadership in the area of biomedical investigation has been an asset to our country in the past, and the failure to sustain or in selected instances to expand support can only have an adverse effect in economic as well as medical terms.

I hope my testimony leads you to make an increased appropriation to the National Institute of Allergy and Infectious Diseases for the purpose of expanding its interferon and antiviral studies.

INTERINSTITUTE COOPERATION

Senator MAGNUSON. I think you have given us some important testimony. The problem we have is trying not to concentrate a research problem that spreads across the board into one Institute, but it seems to me the institutes could work this out together.

There are so many of these problems that spread across several Institutes. I suppose you could put all these appropriations under general medical and have all programs work together. We're contemplating encouraging interinstitute cooperation. I know there are feuds that go on and people protect their own turf.

We have a real problem of priorities within the National Institutes of Health. I can remember when we first started. We didn't have any problems then.

But the start was the Cancer Institute. The Institute is trying to do a good job, but there has to be some interinstitute cooperation. I think cooperation in the interferon drug research program is a good example of what we need to encourage.

Thank you very much.

[The statement follows:]

STATEMENT OF THOMAS MERIGAN

I am Dr. Thomas Merigan, Professor of Medicine at Stanford University. For several years I have studied a substance that occurs naturally in the body, called interferon. It is a protein produced by infected cells to inhibit virus infection of nearby healthy cells. In the last year you have undoubtedly become aware of this substance as a potentially useful antiviral and anticancer substance which is under preliminary investigation in man. Present clinical trial results are quite encouraging in both areas, although they are limited in scope because of the high cost of production of the material by current methods.

Although not as well publicized, very exciting findings also have recently been reported in regard to the fundamental properties of this material. Several different human interferons have been completely purified and their structures and properties evaluated. This means that their synthesis and molecular modification are possible in the near future. Other advances have been made, such as the finding that interferon functions not only as a naturally occurring host defense, but as a regulator of cell division and differentiation, particularly in immune cells. The interferon gene has been isolated and cloned in bacteria and in fact some synthesis of human interferon by such bacteria has been observed. Also, a much clearer understanding has emerged of the way interferon acts against viruses at the molecular level. (see appendix)

I am sure that you have also heard of the unprecedented commitment by the American Cancer Society of 5.7 million dollars for the purchase of interferon for clinical trials. In addition, a larger scale clinical evaluation program has been set up by the National Cancer Institute because of your additional funding last year for such a program. However, there is still need for increased funding to the National Institute of Allergy and Infectious Diseases. Closely directed or targeted research could expand the scope of basic investigation of the interferon system as it relates to viruses and immunity. Additional funds will also allow that Institute to contract for clinical trials in new areas of infectious disease.

I have been funded for my work in both clinical and basic aspects of interferon by that Institute since I began studying interferon at Stanford in 1963. I believe the commitment of $20,000,000 to this program is a high priority and should only occur if additional funds are added to the Institute's budget. I believe we should not compromise other important efforts of that agency by diverting funds from other projects. I feel we can only

fully exploit the clinical potential of this system against viruses if we have much greater understanding of its mechanism of action and method of production. For example, the findings that interferon modifies the immune system and tumor cell growth have opened up whole new fields of investigation which must be pursued if its optimum use in treatment of patients is to be achieved. The fact that interferon alters the function of uninfected cells has revealed the existence of previously unknown pathways of control of gene expression within cells. This potentially could be as important as our insights into the mechanism of replication of DNA gained during the 1960's, and of the metabolic pathways for carbohydrate, fat and protein discovered during the 40's and 50's. It is quite possible other methods of effecting this sytem, which may have clinical application, will be identified in future years -- if additional funding is provided to expand present studies.

The fact that the interferon gene has been cloned by recombinant DNA techniques in several labs means that there is a distinct possibility that, as with the better known hormones, this will become the cheapest way to make interferon in the future. Further advances in increasing the yields of interferon from bacterial cells bearing the interferon gene will provide general methods useful with other proteins. The Andromeda-strain-type fears regarding DNA which prevailed until recently have put the United States efforts in this area well behind those of other countries. For example, at the present I am not aware of any bacterial clones containing the interferon gene being produced in this country, whereas a Japanese report has already appeared in the literature and a Swiss one is currently being submitted. I have heard reports of successful work in this area in both Israel and France as well.

Last year I told your Committee about our studies at Stanford University injecting interferon into patients with various serious viral infections to see if we could modify disease. Studies to date indicate that a type of interferon made from human white blood cells, and hence called human leukocyte interferon, has great potential in treating a variety of human viral infections, including hepatitis and several herpes viral diseases. I have also done work at the Common Cold Unit of the Medical Research Council in Salisbury, England. There I collaborated with British investigators to evaluate the possibility that, if this material were sprayed in the nose, it would inhibit the infection of humans with respiratory viruses. The studies demonstrated for the first time that the common cold virus could be inhibited in man. Now, because of the developments with interferon as an anticancer agent, there is

a potential for more material becoming available for evaluation in infectious diseases. There are important areas of viral disease in which interferon's role has not yet been sufficiently explored. We have been able to eradicate the infection from some of the chronic hepatitis B patients we have treated. Such efforts seem worthwhile against other chronic viral infections, such as herpesviruses, which virtually all of us have today in our body. These agents usually bother us only occasionally with cold sores or other minor difficulties unless our host defenses are weakened by cancer, or by certain therapies which decrease our immune response. Thus, herpesvirus infections can be a fatal disease so development of effective therapy is quite important.

This fall I spent a month at various research centers in the People's Republic of China speaking about our efforts to eradicate hepatitis B. They invited me to present my work because their country has a very high incidence of this infection and liver cancer appears to be, at least in part, the result of such infection. Also, there is another tumor which is very common in China that seems to be associated with a herpesviral infection--that is, nasopharyngeal carcinoma. Apparently it is related to infection by the infectious mononucleosis virus--just as the same virus is associated with a lymphoma in children in Africa. With long term interferon treatment of individuals who are diagnosed as being at high risk for these tumors, it may be possible to prevent such sequelae of chronic infection. These are the sort of studies the Chinese scientists wanted to plan with me.

Cytomegalovirus, another herpesvirus, is a major cause of mental retardation in infants. We have found that this virus can be suppressed by interferon treatment. This same virus also produces problems in our heavily immunosuppressed heart transplant patients at Stanford and interferon should be explored--in both these settings--in larger scale studies to see if eradication of the infection will benefit these patients and/or prevent spread of the agent to others. I also feel it is of great importance to see if interferon will lower the mortality of rabies infection in man if it is given early in the disease. At present I am discussing the possibility of such a study with the Navy Research and Development Group in Bethesda as a possible overseas study in their unit in Cairo, Egypt which I will be visiting at the end of this month.

Finally, I feel that it is of great importance to explore further the potential of interferon administered by spray or by injection as a means of preventing or treating various respiratory viral infections, including the common cold and influenza. All these studies, as well as the basic work, need to be

supported through additional funding to the National Institute of Allergy and Infectious Diseases. Unfortunately, your legislation of last year only made an award to the National Cancer Institute for extending its studies of interferon in the treatment of malignant disease. Beginning in the late 60's the National Institute of Allergy and Infectious Diseases supported the initial studies of this material in the United States, and it would be quite unfortunate if their important work could not be expanded now that a full scale exploration of its potential is so near at hand. We speak of the so-called "drug lag" in the United States and often the FDA and restrictive legislation is blamed. On the other hand, it must be recognized that European science, including clinical investigation, has improved greatly in its quality in the last two decades. American science and technology leadership is being challenged in many different areas. Interferon is an agent which seems quite likely to become an important drug. An increased commitment to support of this area, both at the clinical and fundamental basic science levels, is required if we are to continue to lead in this area and adequately extend our present studies. Leadership in the area of biomedical investigation has been an asset to our country in the past, and the failure to sustain, or in selected instances to expand, support can only have an adverse effect in economic as well as medical terms. I hope my testimony leads you to make an increased appropriation to the National Institute of Allergy and Infectious Diseases for the purpose of expanding its interferon and antivirals studies.

APPENDIX—PRESENTED AT NEW YORK ACADEMY OF SCIENCE MEETING ON INTERFERON, OCTOBER 1979—CLOSING REMARKS MADE TO THE CONFERENCE ON REGULATORY FUNCTIONS OF INTERFERONS, BY THOMAS C. MERIGAN, M.D.

During recent years and especially at this meeting, Interferons have now achieved a new status. They are not just loosely defined factors, but now they are a group of full fledged glycoprotein hormones, each one of which, within a given animal species, has a somewhat different structure, and are now awaiting our precise definition of their individual functions. Such definition may allow practical applications which we have not yet dreamed of. Although, unfortunately for those who must purify them, these hormones are not the products of a specific gland from which they may be extracted in bulk. Each interferon is capable of producing a plethora of specific changes within cells, even when they are purified to homogeneity. For those of us who are trying to use them as crude materials clinically, this latter point is reassuring in that we now can expect any beneficial

effects we observed will also be seen with the pure material which will be used as a drug in the future.

Very efficient and simplified methods for interferon purification have been presented. New standards for characterization of interferon have been set at this meeting. Fortunately, this sometimes just represents a verification of the original investigator's impression. Some interferons are now very well defined structurally, with partial amino acid sequences having been determined. The structural homology between one pair of mouse and human interferons are reassuringly in keeping with the expected extent of evolutionary divergence from a common primordial parental form mediated by point mutations associated with single base changes. In addition, the homology should reassure the skeptics that contaminants are not being sequenced. Furthermore, for the genetic engineer with a DNA synthetic bent -- the homology somewhat restricts the possible triplets for each amino acid codon. Finally, I believe that with complete structural definition, many rational pharmacologic innovations will be possible - even possibly targeting its delivery within certain tissues.

Now, virtually no one can have doubts about the significance or existence of the interferon system. Its importance for the whole animal is underscored by the difficulties in identifying natural deficiency mutants and the presence of this mechanism in virtually all vertebrates species in which it has been sought.

The development of several quite reproduceable in vitro translation systems has been facilitated by the great potency of interferon's biologic activity. As with globin , such systems will be of great assistance in isolation of an interferon gene. The information on chromosomal location of interferon production presented at this meeting also should be helpful in genetic engineering efforts to produce interferon. For example, an appropriate synthetic cDNA or mRNA might be used to locate an interferon gene within the DNA of a specific chromosome. Because of the great interest and many laboratories working the recombinant DNA approach to interferon, we undoubtedly will begin to hear of results in this area in the near future.

Several biologic roles of interferons have been defined, for example by use of neutralization with specific anti-interferon serum. We know interferon is but one component of what is fortunately a multi-tiered host defense system against viruses, other intracellular parasites and tumor cells. In order to maintain their pathogenicity, all such agents have developed mechanisms

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to elude host defenses. Therefore, there can be no one single critical defense mechanism which some investigators would have preferred for simplicity.

Considering the demands on cell differentiation, it is also critical that the regulatory effects of interferon not be simplistic, whether it is examined in the immune or hemopoietic systems, or for its action on other normal or neoplastic cells. In fact, the need for very stringent control of all regulation demands multiple regulatory and feedback mechanisms.

The molecular level mechanism of interferon's action is also better understood. Now, it is not defined just through its application to each advance in definition of viral replicative cycles, but, instead interferons are now revealing the existence of new intracellular regulatory pathways such as the (2'5') oligo A system. This situation is analagous to work done with insulin in the past. That hormone has been utilized to discover new metabolic pathways for the utilization of carbohydrates, lipid and protein as fuels. So, interferon appears to be revealing pathways for regulation of genetic expression. As these must be closely regulated, it should not be surprising that "too much of a good thing is bad".

The molecular biologists forte is the separation, isolation, and in vitro reconstitution of genetic elements. The mechanism by which DNA is expressed and RNA and protein are synthesized has now been clarified by such approaches in the least complex systems. Currently, the mechanism of eucaryotic gene expression is under intense study, and I would not be surprised at all if the pathways which interferon plays upon turn out to be critical controlling elements. For example, the finding that heme controls globulin synthesis through phosphorylation of Initiation Factor 2 suggests their generality. Of course the final result of such regulation may be expressed on the cell's surface as well as within the cell.

As we have seen, mouse immunogenetics provides many powerful methods for taking apart the complexity of immunoregulation. However, a multiplicity of soluble factors other than interferon as well as direct cell-to-cell interferons have been identified for certain well defined immunoregulatory functions such as suppressor T cell actions. On the other hand, as demonstrated at this meeting, I do believe now, most immunologists are quite interested in interferon and we can expect much more activity in this area by them as well. In fact, considering all the new faces, the significant advances and high quality of the work presented at this meeting, we can expect much progress in defining interferon's regulatory actions at the molecular, cellular and whole animal levels.

LABOR DEPARTMENT PROGRAMS

STATEMENTS OF:

ROBERT BURKHART, CALIFORNIA CONSERVATION CORPORATION

EDWARD WALLACE, NATIONAL CAUCUS ON BLACK AGED, INC.

CALIFORNIA CONSERVATION CORPORATION—YACC FUNDING

Senator MAGNUSON. Our next panel is on programs of the Labor Department. Who will speak first?

Mr. BURKHART. Mr. Chairman, I'm here as a representative of the California Conservation Corporation which is a program similar to the CCC of the 1930's. We are a State and federally funded program, receiving YACC money as well, and I'm here to urge your support for full funding of the YACC program.

I have with me two representatives of the corps members: Chester Davis from Pittsburgh, Calif., and Delores Nato, from Fresno, Calif., who are among the 1,500 young Californians fighting floods, currently; in the summertime they fight fires, plant trees, et cetera.

We have the single largest YACC program in the country in terms of a residential program. We have been in existence since 1976 providing job training and developing the work ethic of young people.

Basically our motto is hard work, low pay, and miserable conditions. We have in the past 3 or 4 years planted about 4 million trees, fought several hundred different fires, performed a whole variety of public service conservation work.

As one aspect of the overall YACC program, we represent just one part of one State's effort. We are receiving enthusiastic support from the legislature and the people of California, particulary in connection with flood efforts.

FEDERAL-STATE FUNDING BREAKDOWN

Senator MAGNUSON. How much money has the legislature given you?

Mr. BURKHART. The California State Legislature—25 percent of the $25 million program comes from a State grant. We are about $18 to $19 million State funded. We are anticipating a $31 million program for fiscal year 1980 and about $18 or $19 million of that again would come from YACC.

Senator MAGNUSON. Again, what proportion of that is Federal?

Mr. BURKHART. Twenty-five percent roughly of our State program comes from the Federal grant administered through YACC.

Senator MAGNUSON. My State is interested in this too.

Mr. BURKHART. I know that, sir.

Senator MAGNUSON. I don't know what the State legislature contributed to it. They are still in session.

Mr. BURKHART. There are only half a dozen States which have a significant program, and where there is a cooperation between the Federal Government and the State. In California, we represent the largest State-Federal cooperative effort.

Senator MAGNUSON. Well, some bad news for you.

The budget restraint crew wants to cut it out altogether. They are proposing that.

Mr. BURKHART. I understand they're proposing that. That's one of the reasons I'm here, to urge that the State of Washington help the rest of the country.

Senator MAGNUSON. Of course, I'm a great believer in the survival of this program. It has been very worthwhile.

Mr. BURKHART. It's a double investment, sir. It's an investment not only in conserving natural resources and planting trees, but in the youth as well.

Senator MAGNUSON. In my State they figured out that the investment we made in the OCC camps, which are similar, paid off in fire insurance 10 to 1.

I'm not sure but I think the President's message will come out in a few days advocating cutting it out——

Mr. BURKHART. I understand that to be the case; which is why we are here to ask for assistance.

Senator MAGNUSON. We will take a look at it. It's one matter to ask a reduction across the board, but to cut it all out would be wrong.

Mr. BURKHART. Recently in the New York Times there was a study showing minority employment in this country, in terms of the long-range projection, to be pushing toward 50 percent. It seems to me a strong argument can be made that it's a disastrous policy not to provide training and job opportunities for minorities in this country. We are being delivered a ticking time bomb and it's very important for us to respond to that.

Senator MAGNUSON. We will take a look at it.

Mr. BURKHART. I very much appreciate that, Mr. Chairman.

Senator MAGNUSON. For the record, the original budget, fiscal year 1980, was $250 million for this program, Mr. Burkhart. Fiscal year 1981, which was sent up in January, upped that about $14.5 million.

Mr. BURKHART. My figures were for only the State of California.

Senator MAGNUSON. This is total. So I wanted to put that on the record.

NATIONAL CENTER FOR BLACK AGED

Mr. WALLACE. Good afternoon. It's a pleasure for me to be here this afternoon to testify on behalf of the National Center for the Black Aged. I'm testifying this afternoon on funding for older Americans programs.

My organization, the National Center for Black Aged, and indeed the entire aging community recognized fully that the mood of the times calls for decreases in the budget and Federal spending—certainly not increases in Federal spending.

We do believe, however, that while we totally support this view, there are areas where funding in certain functional categories deserves a closer look to determine when cutbacks or holding the line is appropriate—even in a period of extreme austerity. Every program should stand on its own merits. Quite clearly, there are certain programs that deserve well-timed and well-conceived funding increases because of special circumstances, national goals, or simply because of the needs that are to be met and the good they can do.

Older Americans, perhaps more so than any other group in our so-

ciety, are victimized by rapidly escalating costs. For them, it is essential that we get a rein on the inflationary spiral. But for black older Americans, their fundamental need is simply to have a more adequate income, or additional services to make their limited dollars go further. Today's elderly blacks were raised at a time when widespread discrimination existed. They typically attended inferior schools, notwithstanding the so-called separate but equal doctrine, and were forced to drop out of school to help at home or for other reasons. To a very large degree, they were shortchanged in being given necessary tools to compete in a society that has become highly complex, more urbanized and industrialized. Today they pay a heavy price because of their cultural, educational, and economic deprivation during their formative years. The net impact is that proportionately more blacks enter old age with little or virtually no financial resources.

By any standard one would choose to use, elderly blacks are among the most economically deprived groups in our society today. Nearly 50 percent of all elderly blacks are either poor or near poor.

For these elderly poor, it is obvious that neither social security nor supplemental security income assistance has helped enough. They need additional income—they need to work.

SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM

The senior community service employment program, since its inception, has provided a much needed source of income for older Americans. It has provided an opportunity for them to help themselves while helping others in their communities. The program has been enormously effective, not only from the standpoint of older Americans, but also from that of the communities being served. Moreover, it has been a well-administered program, free of fraud and abuse.

The evidence is clear and convincing that there is a substantial number of low-income persons 55 and older who are ready, willing, and able to work in the SCSEP. At present, approximately 52,250 older Americans work in fulfilling and useful jobs in their communities. But, the need is clearly much greater. This point has been emphasized repeatedly at NCBA's rural senior community service employment program, which provides jobs in six Southern States—Alabama, Florida, Kentucky, Mississippi, North Carolina, and Tennessee—for approximately 480 economically disadvantaged persons 55 years of age and older. As of last month, there were more than two persons on the waiting list for each position available in the program. This ratio could be much higher, but NCBA does not want to raise the hopes of the disadvantaged, only to have them shattered because no realistic hope exists for a job opening within the immediate future.

The administration's budget request of $267.1 million for program year 1981–82 would simply maintain the senior community service employment program at its current slot level.

Senator MAGNUSON. For the record, in 1979 it was $220 million-plus. Then it was up in 1980 to $266 million but the fiscal 1981 budget only made it $267 million, so you are standing still.

Mr. WALLACE. That's the point. We should not be standing still. We

are asking for increases. The reason we are asking for increases is that the people have been so enormously successful and it has given to those older persons who have had the opportunity to work a new lease on life. They are now useful citizens; employed; they are taxpayers.

The program should be increased. We are recommending a modest increase of only 10 percent. We could easily have come in for an increase of 30 percent. That won't begin to touch the need. The 10-percent increase would help somewhat. A substantial increase in job slots would be clearly justified and the money would be well spent. But given the budgetary realities, NCBA is proposing a 10-percent increase in funding to boost the number of jobs available under the program from 52,250 to 57,475. We also recommend that these new jobs be available in January 1981 rather than July 1981. This would be consistent with the Senate's action last year on the senior community service employment program.

The value and worth of the senior community service employment program has been amply demonstrated over the years. The SCSEP has provided useful and fulfilling jobs for persons unemployed for longer periods of time—in some cases 8 to 10 years; it has provided essential services to communities with an insufficient tax base to respond to the needs of their citizens; and it has provided an important stimulus to economically depressed rural areas.

We request you concur with our requested increase in this program. I would now like to look at two other areas if I may.

NATIONAL INSTITUTE ON AGING

NCBA urges the subcommittee to approve the administration's budget request of $75.3 million for the National Institute on Aging. Important but still unanswered questions about growing old present powerful reasons for support of biomedical, social, and behavioral research and training related to the aging process.

Moreover, the sheer numbers of the subjects involved must spur us on to unlock the mysteries of aging. One out of every nine Americans are 65 or older. In the next 50 years it's projected the number will more than double reaching an estimated 55 million by the year 2050. At that time nearly one out of every five persons in the United States will be an older American. And we know so little about the many factors which contribute to the infirmities and the disabilities that are a part of the aging process. But worse than that, we know even less about the factors that cause the great disparities between the mortality and longevity rates of blacks and whites. The U.S. Public Health Service report to the Congress reaffirms what we already know: That "minorities, especially the 23 million black Americans, still endure poorer health care, higher death rates, lower life expectancy, and a reduced sense of general well-being than whites." Between the ages of 25 and 44, the death rates of blacks is nearly 2.5 times the white rate, and black males can expect to live 7.9 years fewer than white males.

Mr. Chairman, we know the statistics. What we don't know is why. Why are black males dying of cancer in numbers that are far greater in proportion to their numbers in the population? Why are the ravages of

hypertension so devastating among blacks? Why are the nonwhite death rates from diabetes and kidney disease so much higher than the death rates for whites from those same diseases? We must find answers to those questions, for only then can we raise the level of health for all of this Nation's citizens so that all of us can live to a healthy old age.

Therefore, NCBA strongly recommends that this subcommittee not only support the research funding for the National Institute on Aging, but that you include report language urging the NIA to direct a significant portion of its resources to the study of the aging process among minorities. There are reasons why blacks and other minorities die 7 to 10 years earlier than whites and we must uncover those reasons.

RESEARCH UNDER OLDER AMERICANS ACT

Finally, NCBA urges the subcommittee to maintain the $8.5 million funding level for applied research under title IV of the Older Americans Act.

I have discussed the need for additional research into the various health and physiological aspects of aging. There is also a need for policy or program-oriented research. The Administration on Aging administers these extremely valuable and highly directed research projects. By means of this research program, AOA is able to determine how the limited aging dollars can be spent more cost effectively. They can determine what policy changes are needed and determine spending priorities. This research has quicker payoffs and should aid in designing more focused programs with highest impact.

However, the current budget proposal for the Administration on Aging would cut $1.5 million from the AOA title IV research program and could seriously threaten a badly needed body of research.

It could be a crippling blow to the minority data base that is now being established. The information that is being developed via this research program is of tremendous value to AOA, to the Congress, and to other national policymakers. While certainly a strong case can be made for a sizable increase in funding for aging research, we fully appreciate the realities of the current budgeting situation. For this reason, NCBA recommends only that research funding for AOA be restored to the fiscal 1980 level of $8.5 million, rather than being cut back by $1.5 million.

SUMMARY

The National Center on Black Aged, in its role as an advocate on behalf of the minority elderly, recommends: A 10-percent increase in funding for the senior community service employment program, thereby increasing the number of job slots available under the program. The Center also recommends that these new job slots be available January 1981, rather than July 1981. The Center recommends a $2.5 million increase in funding for the senior opportunities and services program which would increase the number of elderly poor receiving those services that enable independent living; and the Center recommends approval of the administration's budget request of $75.3 million for the National Institute on Aging to support biomedical, social, and behav-

ioral research, and training related to the aging process. Moreover, NCBA recommends that appropriate language be included urging NIA to pursue the study of the aging process among minorities; and we urge restoral of the $8.5 millon funding level for research under title IV of the Older Americans Act to insure the continuation of a most valuable research service on behalf of our Nation's elderly.

The modest proposals recommended by the National Center on Black Aged will help to insure that progress continues to be made in response to the growing problems confronted by the nation's elderly. We urge your support.

Senator MAGNUSON. We will give it consideration. The only question is that I'm wondering if we should specifically designate minorities or whether we should do it for all aging. You're not against assisting the other aging groups?

Mr. WALLACE. Certainly not.

Senator MAGNUSON. There is a discrepancy we agree, and in the report we could point out—whatever we do with the money—there should be more research directed on aging because the facts are that older people are more susceptible to disease. We can do that.

Mr. WALLACE. I would appreciate that.

What about the title 5 program, senior community service employment program. That 10-percent increase we were asking?

Senator MAGNUSON. We will have to look at it.

Mr. WALLACE. Very good, sir. I appreciate it.

[The statement follows:]

STATEMENT OF EDWARD C. WALLACE

Mr. Chairman and members of the Labor/HEW Appropriations Subcommittee. I appreciate the opportunity to testify this morning on behalf of the National Center on Black Aged concerning funding for older Americans' programs. NCBA recognizes fully that the mood of the Congress is to reduce federal spending, and not to increase it. While we support this objective as it relates to total federal spending, we do believe that funding in certain functional categories deserves a close look to determine whether cutbacks or holding the line is appropriate even in a period of extreme austerity. Every program should stand on its own merits. Quite clearly, there are certain programs that deserve well-timed and well-conceived funding increases because of special circumstances, national priority goals, or simply because of the needs that are to be met and the good they can do.

Older Americans, perhaps more so than any other group in our society, are victimized by rapidly escalating costs. For them, it is essential that we get a rein on the inflationary spiral. But for Black older Americans, their fundamental need is simply to have a more adequate income or additional services to make their limited dollars go further. Today's elderly Blacks were raised at a time when widespread discrimination existed. They typically attended inferior schools, notwithstanding the so-called "separate but equal" doctrine, and were forced to drop out of school to help at home or for other reasons. To a very large degree, they were shortchanged in being given necessary tools to compete in a society that has become highly complex, more urbanized and industrialized. Today they pay a heavy price because of their cultural, educational, and economic deprivation during their formative years. The net impact is that proportionately more Blacks enter "old age" with little or virtually no financial resources.

For a significant proportion of these individuals, there is no tomorrow; their time is now.

By any standard one would choose to use, elderly Blacks are among the most economically deprived groups in our society today. Nearly 50 percent of all elderly Blacks are either poor or near poor. The net impact is that one out of two aged Blacks in the United States either lives in poverty or so close to it that he or she really cannot appreciate the difference.

For these elderly poor, it is obvious that neither Social Security nor Supplemental Security Income assistance has helped enough. They need additional income -- they need to work.

THE SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM

The Senior Community Service Employment Program, since its inception, has provided a much needed source of income for older Americans. It has provided an opportunity for them to help themselves while helping others in their communities. The program has been enormously effective, not only from the standpoint of older Americans, but also the communities being served. Moreover, it has been a well-administered program, free of fraud and abuse.

The evidence is clear and convincing that there is a substantial number of low-income persons 55 and older who are ready, willing and able to work in the SCSEP. At present, approximately 52,250 older Americans work in fulfilling and useful jobs in their communities. But, the need is clearly much greater. This point has been emphasized repeatedly at NCBA's Rural Senior Community Service Employment Program, which provides jobs in six southern states (Alabama, Florida, Kentucky, Mississippi, North Carolina, and Tennessee) for approximately 480 economically disadvantaged persons 55 years of age and older. As of last month, there were more than two persons on the waiting list for each position available in the program. This ratio could be much higher, but NCBA does

not want to raise the hopes of the disadvantaged, only to have them shattered because no realistic hope exists for a job opening within the immediate future.

The Administration's budget request of $267.1 million for program year 1981-1982 would simply maintain the Senior Community Service Employment Program at its current slot level -- 52,250 positions. The effect of this action would be to continue the program at the same operating level for more than two years. However, most economic forecasters are projecting a recession this year, and a sharp rise in unemployment which will continue into 1981. In fact, the Administration's own Economic Report forecasts a 29 percent jump in the unemployment rate from 1979 to 1980, from an average level of 5.8 percent in 1979 to 7.5 percent in 1980. Older workers will undoubtedly be affected when unemployment rises. Once unemployed, they usually experience much greater difficulty in locating new employment than younger workers.

NCBA strongly believes that the Title V Senior Community Service Employment Program should be expanded to meet the pressing needs of low-income older Americans who want and need employment. A substantial increase in job slots would clearly be justified, and the money would be well-spent. But given the budgetary realities, NCBA is proposing a 10 percent increase in funding to boost the number of jobs available under the program from 52,250 to 57,475. We also recommend that these new jobs be available in January 1981 rather than July 1981. This would be consistent with the Senate's action last year on the Senior Community Service Employment Program.

The value and worth of the Senior Community Service Employment Program has been amply demonstrated over the years:

* It has provided useful and fulfilling jobs for persons unemployed for longer periods of time -- in some cases, 8 to 10 years;

* It has provided essential services to communities with an insufficient tax base to respond to the needs of their citizens; and

* It has provided an important stimulus to economically depressed rural areas.

But perhaps most important of all is the psychological rewards for economically disadvantaged older persons. NCBA has been told time and time again by the enrollees that their jobs have lifted their morale to the point that they "feel like new persons."

The Senate Labor/HEW Appropriations Subcommittee has provided important leadership to enable the Title V program to grow to its present level. We are grateful for this past support, and urge your support now for the modest increase that we have proposed.

SENIOR OPPORTUNITIES AND SERVICES

Another program which has been effective for the elderly poor is the Senior Opportunities and Services Program administered by the Community Services Administration. SOS provides a wide range of services to meet the special needs of low-income persons 60 years of age and older. In fiscal year 1979, nearly 200 SOS projects provided a wide range of essential services to more than 1 million low-income persons 60 years and older.

SOS projects have directed their greatest attention to enabling the aged poor to live independently in their communities, instead of being unnecessarily or prematurely institutionalized at a much higher public cost. Older Americans have received comprehensive and helpful services, including homemaker, home health, visiting nurse, home delivered meals, weatherization assistance, home repairs, and others. In addition, SOS provides other essential services to assist older Americans:

* Access and advocacy services to help the elderly poor to receive the benefits to which they are entitled;

* Transportation services in rural areas to enable the elderly to function in their localities; and

* Elderly crime victimization prevention and assistance services.

The Administration's budget request of $10.5 million would simply continue SOS at its present level. However, nearly 100,000 persons 60 years of age or older were added to the poverty rolls from 1977 to 1978. It is quite likely that more older Americans will have been added to the rolls when the new Bureau of the Census data are released.

The need for a sharp increase in funding for SOS is compelling. But, given the present tight budgetary situation, NCBA recommends that appropriations be raised only by $2.5 million, from $10.5 million to $13 million. This comparatively small increase, though, could yield important dividends. An estimated 250,000 more elderly poor could receive essential services to enable them to live independently in their communities or to assist them with their day-to-day existence.

NATIONAL INSTITUTE ON AGING

NCBA also urges the Subcommittee to approve the Administration's budget request of $75.3 million for the National Institute on Aging. Important but still unanswered questions about growing old present powerful reasons to support biomedical, social and behavioral research and training related to the aging process. Moreover, the sheer numbers of the subjects involved must spur us on to unlock the mysteries of aging. Approximately 25 million Americans, or about one out of every nine are 65 years of age or older. In the next 50 years, it is projected that the number of older Americans will more than double, reaching an estimated 55 million by the year 2030. At that time, nearly one out of five persons in the United States will be an older American, and we know so little about

the many factors which contribute to the infirmaties and the disabilities that are a part of the aging process. But worse than that, we know even less about the factors that cause the great disparities between the mortality and longevity rates of Blacks and whites. Though I have not read the report, information that I have obtained from the 1979 Report of the U.S. Public Health Service to the Congress reaffirms what we already know: that "minorities, especially the 23 million Black Americans, still endure poorer health care, higher death rates, lower life expectancy, and a reduced sense of general well-being than whites." Between the ages of 25 and 44, the death rate of Blacks is nearly 2.5 times the white rate, and Black males can expect to live 7.9 fewer years than white males.

Mr. Chairman, members of the Subcommittee, we know the statistics. What we don't know is 'why'. Why are Black males dying of cancer in numbers that are far greater in proportion to their numbers in the population? Why are the ravages of hypertension so devastating among Blacks? Why are the non-white death rates from diabetes and kidney disease so much higher than the death rates for whites from those same diseases? We must find answers to those questions, for only then can we raise the level of health for all of this nation's citizens so that all of us can live to a healthy old age.

Therefore, NCBA strongly recommends that this Subcommittee not only support the research funding for the National Institute on Aging, but that you include report language urging the NIA to direct a significant portion of its resources to the study of the aging process among minorities. There are reasons why Blacks and other minorities die seven to ten years earlier than whites and we must uncover those reasons.

ADMINISTRATION ON AGING RESEARCH

Finally, NCBA urges the Subcommittee to maintain the $8.5 million funding level for applied research under Title IV of the Older Americans Act.

I have discussed the need for additional research into the various health and physiological aspects of aging. There is also a need for policy or program-oriented research. The Administration on Aging administers these extremely valuable and highly directed research projects. By means of this research program, AOA is able to determine how the limited aging dollars can be spent more cost effectively. They can determine what policy changes are needed and determine spending priorities. This research has quicker payoffs and should aid in designing more focused programs with highest impact. With your permission, Mr. Chairman, I would like to have inserted in the record a listing of research programs concerning the minority elderly that are being administered by the Administration on Aging.

Mr. Chairman, NCBA recognizes that research may be a prime target, especially now when the Administration is considering massive cutbacks in funding.
However, the current budget proposal for the Administration on Aging that would cut $1.5 million from the AOA Title IV research program could seriously threaten a badly needed body of research.

It could be a crippling blow to the minority data base that is now being established. The information that is being developed via this research program is of tremendous value to AOA, to the Congress, and to other national policymakers. While certainly a strong case can be made for a sizeable increase in funding for aging research, we fully appreciate the realities of the current budget situation. For this reason, NCBA recommends only that research funding for AOA be restored to the fiscal 1980 level of $8.5 million, rather than being cut back by $1.5 million.

SUMMARY OF RECOMMENDATIONS

The needs of aged Blacks and other minority groups are pressing. Many suffer from a multiple jeopardy due to age,

race, health and educational circumstances. The National Center on Black Aged, in its role as an advocate on behalf of the minority elderly, recommends:

- a ten percent increase in funding for the Senior Community Service Employment Program, thereby increasing the number of job slots available under the program. The Center also recommends that these new job slots be available January 1981, rather than July 1981;
- a $2.5 million increase in funding for the Senior Opportunities and Services program which would increase the number of elderly poor receiving those services that enable independent living;
- approval of the Administration's budget request of $75.3 million for the National Institute on Aging to support biomedical, social and behavioral reserach and training related to the aging process. Moreover, NCBA recommends appropriate language be included, urging NIA to pursue the study of the aging process among minorities; and
- restoral of the $8.5 million funding level for research under Title IV of the Older Americans Act to ensure the continuation of a most valuable research service on behalf of our nation's elderly.

The modest proposals recommended by the National Center on Black Aged will help to ensure that progress continues to be made in response to the growing problems confronted by the nation's elderly. We urge your support.

COMMUNITY SERVICES ADMINISTRATION

STATEMENT OF CAROL WERNER, NATIONAL CONSUMER LAW CENTER

Senator MAGNUSON. Next is Carol Werner, National Consumer Law Center.

Ms. WERNER. The National Consumer Law Center works closely with legal services programs around the country, as well as community action agencies, and the over 40 CSA State energy advocacy programs throughout the country.

Therefore, we have had a great amount of contact with low-income people subjected to increasing pressures as a result of the severe energy crunch and spiraling prices.

Therefore, this afternoon I would briefly like to address the whole question of energy assistance appropriations, as well as the low-income weatherization program.

FUNDS FROM WINDFALL PROFITS TAX

Senator MAGNUSON. Now, Carol, you are talking about funds out of the windfall profits tax——

Ms. WERNER. As far as the dollar amount set aside from the conference——

Senator MAGNUSON. We don't have much to do with that here.

Ms. WERNER. As you are aware——

Senator MAGNUSON. The conference is about ready to conclude. I have an interest in it. I don't know just what they will do on certain items.

Ms. WERNER. The conference report provides for a set-aside of $3.115 billion for low-income energy assistance. The President's request for energy assistance for this year——

Senator MAGNUSON. We haven't gotten the report yet. How do you know that?

Ms. WERNER. That is what is in the conference report, which has to be approved. It now has to be approved.

Senator MAGNUSON. They are about ready to report.

Ms. WERNER. They have reported. On the House side they are now before the Rules Committee to get a rule to take the conference report to the floor.

Senator MAGNUSON. They have reported?

Ms. WERNER. Yes; the report was out on Monday.

Senator MAGNUSON. I didn't know that. On Monday? OK.

Ms. WERNER. The reason I brought this up is that we feel that the dollar figure that those conferees suggested is a more appropriate level of funding for energy assistance than what is in the administration's request of $2.4 billion.

The reason is that the program that was approved by the Senate in S. 1724, which is also part of the Windfall Profits Conference Agreement, provides for a larger eligible population than what the 1980 energy assistance program does.

It provides for a difference of at least 3 to 4 million households; which automatically increases the financial demand upon the program.

In addition, between the heating seasons of 1979 and 1980, we saw the prices of fuel oil doubling, and that price continued to climb into this past winter and will into the future.

Fuel oil is heavily used for home heating in the Northeast and the North-central States, which have obviously the coldest, longest winters, and also contain nearly half of the low-income population.

In 1979, it was estimated that energy costs consumed between 25 and 45 percent of a low-income family's income; and if you include housing in that, if a low-income family heated with heating oil, that consumed 92 percent of their total income.

INCREASING LOW-INCOME ENERGY ASSISTANCE

Therefore the need is great, and the figure needs to be raised in order to provide any kind of measure of adequate assistance.

Senator MAGNUSON. You are suggesting that we up the Community

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Service Administration eligibility levels on low-income energy assistance?

Ms. WERNER. Yes.

Senator MAGNUSON. The 1980 appropriation is $1.6 billion. The 1981 request is $2.4 billion. In the community service agencies, we have had an argument of who was going to administer this fund. We decided the Community Service Administration had done a better job, for instance in New York and other places, and they should have charge of the money.

Ms. WERNER. And the Appropriations Committee will have to make a decision on that question, too, right?

Senator MAGNUSON. I don't know what they will do with this. This was subject to some discussion in our meetings in the last 4 or 5 days. Whether they will postpone it, defer it, or stick to the $2.4 billion, I just don't know. We will know, I hope, before the week is out.

The President will soon send down a revised budget. This was one of the items under consideration. I don't think we came to any definite conclusions as far as the Congress is concerned. We discussed it: some were for cutting it. Some were for going back to the 1980 levels because of the fact that this has been a milder winter.

Ms. WERNER. We are not guaranteed that happening again.

Senator MAGNUSON. Spring is about ready to arrive, we hope. Therefore, it might be deferred. I don't know. I think that it shouldn't be deferred, because the preparation of the original, older income assistance program didn't take place until after the winter started.

Ms. WERNER. Which is a serious mistake.

Senator MAGNUSON. They need time to prepare for next year's low-income energy assistance.

Ms. WERNER. I could not agree more.

Senator MAGNUSON. I don't know whether we will be that lucky next year or not, but anyway, whatever the amount is, we ought to go ahead with it now so we are ready for it—rather than face all of the confusion that took place at the beginning.

Ms. WERNER. I certainly concur with those remarks. We hope to receive the higher dollar figures, especially since there is an argument for it to come out of the windfall profit tax receipts. We hope that it's directed in that way.

Senator MAGNUSON. The only thing about windfall profits—everybody is trying to get in on the act as to where it will go.

Ms. WERNER. At least the conferees agreed to put this in.

Senator MAGNUSON. Fine; but the amount coming in for next year will be far less than anticipated.

Ms. WERNER. Well, I would like to see——

Senator MAGNUSON. It will get better as it goes along. It will achieve probably the full amount the conference agreed upon.

But this coming year, the receipts won't be as much.

Ms. WERNER. It was felt this figure would be feasible in terms of the 1981 receipts.

LOW-INCOME WEATHERIZATION

The second area I would like to address briefly is the question of low-income weatherization. This again involves an important policy question for the Appropriations Committee.

Recently, the Senate overwhelmingly passed S. 1725, which is a comprehensive weatherization conservation bill. We strongly supported this legislation, and this bill provides for a $500 million authorization level for fiscal 1981 for a CSA-run program.

Because the investment in weatherization conservation pays for itself over and over again, because it's the only way to minimize the need for energy assistance payments, we would like to recommend that it be funded at the full level the recent 1725 legislation authorized, which is $500 million.

TRANSFER PROGRAM TO CSA

Now, there is, as I mentioned, another question involved with this. The program is now at DOE, and we would urge the Appropriations Committee to transfer the weatherization program to CSA, feeling that the program would have much more priority in that agency than it has, certainly, at DOE.

Senator MAGNUSON. Well, it has all been moved to Interior Subcommittee, appropriations. It's not in Labor-HEW Subcommittee anymore.

Ms. WERNER. All right, but the bill S. 1725, which passed this Senate about 10 days ago, provides for weatherization at CSA, so we were encouraging this subcommittee and the full committee to put funding in CSA to run the low-income weatherization program. DOE has a transfer authority under section 413(e) of the Energy Conservation and Production Act to transfer unexpended funds to CSA, and we would recommend that the Appropriations Committee ask DOE to do that.

I think the reasons for why the program should be at CSA as opposed to DOE are manifold.

Senator MAGNUSON. The Labor-HEW 1980 budget has zero in it and also zero for 1981. They moved it all to Interior appropriations under the Department of Energy.

Ms. WERNER. We are asking it be moved back.

Senator MAGNUSON. How will we do that?

Ms. WERNER. Because CSA already has existing authorization for low-income weatherization. And there was S. 1725, which passed the Senate about 10 days ago, which provides for the weatherization program to be at CSA.

Senator MAGNUSON. It doesn't make any difference whether it's the Interior Subcommittee or Labor-HEW Subcommittee. The full committee must look at it.

Ms. WERNER. But we wanted to make sure this particular subcommittee was aware of the problem, and would make that recommendation to the full committee.

Senator MAGNUSON. Then there is a move to have the Appropriations Committee all put together. No more subcommittees?

Ms. WERNER. I guess you will make that decision.

Senator MAGNUSON. I don't think it makes much difference where the

program is located, except the funding, that is what we are talking about—the amount that is involved.

Ms. WERNER. Certainly the amount, and we recommend the higher amount, since the program does pay for itself. Also because it has an effect upon the whole labor-unemployment situation.

Senator MAGNUSON. A lot of members of the Labor-HEW Subcommittee are on the Interior and vice versa.

Ms. WERNER. It's a full committee decision, but it's one that needs to be made. We hope you will make that change in the full committee.

[The statement follows:]

STATEMENT OF CAROL WERNER, NATIONAL CONSUMER LAW CENTER, INC.

I appreciate this opportunity to present the views of the National Consumer Law Center on low-income energy assistance and the low-income weatherization program. The National Consumer Law Center is a nonprofit organization which provides technical support and related assistance to legal services offices, community action agencies, and CSA state-energy advocacy programs throughout the country. Energy assistance and weatherization are, therefore, critically important issues to the clientele served by the Center.

Energy Assistance

The need for a comprehensive energy assistance program was well documented and broadly accepted by both Houses of the Congress when an emergency supplemental appropriations bill was passed late last fall. It was clearly recognized that something had to be done to assist low-income households in the face of ever-increasing energy costs - or many people simply would not have heat. A total of $1.6 billion was appropriated for energy assistance for FY 1980. The President's budget calls for $2.4 billion for energy assistance in FY 1981. However, the windfall profits tax conference committee agreed that for FY 1981, $3.115 billion of those tax receipts should be set aside for energy assistance to low-income households. We strongly recommend funding at the $3.115 billion level for several reasons - even in the wake of budget cutting fever.

Between the heating seasons of 1979 and 1980, the price of fuel oil had doubled and the price has continued to steadily move upward with no stop in sight. Fuel oil is heavily used for home heating in the Northeast and the North Central states which not only have the coldest, longest winters but also contain nearly half - 49 percent - of the low-income population. For example, energy costs constituted from 25% to 45% of a Midwestern low-income family's income during the winter in 1979. Low-income households spend four times the proportion of their income on energy that middle-income households do. The situation has only worsened for these families in the last year, since energy is not the only cost that has been soaring upward.

By the end of January, according to data gathered by CSA officials, over one-half of the 1980 energy assistance funds had been expended at the local level to individual clients. Considering that February would be the most active month in many states due to weather conditions and also the fact that programs were then firmly in place, the money available was actually being spent a little faster than it should have been. It is also felt that the 50 percent figure is on the conservative side because of delays in reporting in numerous states. Our Center, as well as CSA, have received reports from the field that several states are now out of money or will be out of funds within the next 3-4 weeks. According to a March 9, 1980 article in the Cleveland Plain Dealer, the local energy crisis assistance program (ECAP) was out of money as of the end of January after having served 8000 households with a total allotment of $2,356,000. The program was out of funds before their coldest month, February, had begun.

This simply illustrates the need and gives us clear indications that a much higher allocation figure is absolutely critical and that figure should be no less than the $3.115 billion set aside by the windfall profits tax conferees.

First of all, prices are continuing to spiral with no end in sight. This year will see the impact of decontrol in addition to absorbing probable OPEC price hikes. On top of that, with an inflation rate of eighteen percent, low-income households will have even fewer dollars next year to pay for fuel costs and other basic necessities which also have taken mighty jumps upward in price.

Second, the energy assistance bill passed by the Senate and accepted by the windfall profits tax conferees for FY 1981 serves a low-income population several million households more (18 million) than those eligible for FY 1980 assistance (15 million). This automatically expands the program's financial demands. At the same time, the need to serve low-income households which are not current participants in public assistance programs is imperative. Approximately only 50 percent of those households at or below 125 percent of the poverty level are reached through public assistance. Their need for some assistance to allay energy costs is, therefore, acute.

In addition, the 1980 program did not provide an adquate design for inclusion of renters. As a result, many low-income renters were denied assistance this winter; they were told the program was not for them. The 1981 program contains a much stronger provision for renters. Therefore, considering that about half of all low-income households reside in rental property, next winter's program should see a large increase in participation among this sector. This again emphasizes the need for a much higher dollar figure.

Many states also placed unrealistically low caps on the benefit level per household, e.g. $200/household in Maine. When one considers that many heating bills alone run well over $1,000 in a season, the adequancy of assistance to families who may well face termination of service becomes a very serious question.

Low-income households have already been trying to cut their consumption of energy because they cannot afford to pay for it. So although we talk about the gigantic savings to be made through conservation, these people cannot turn their thermostats down any further. Large conservation could come through home weatherization but these households simply do not have the dollars to do it initially, no matter how many times the investment may pay for itself. Coupled with the fact that the low-income weatherization program is essentially just now getting off the ground, most of these households have no way to respond to their soaring energy bills.

Finally, we have been very lucky that this winter has been unusually mild in most parts of the country. We cannot count on that two years in a row. Despite the mild weather, the program being put into the field so late, and the other factors previously discussed, this year's funding is being used up at a slightly higher rate than it should be and several states or areas have already run out or will within the next few weeks.

Therefore, funding needs to be at the $3.115 billion level if reasonable assistance is going to be provided the eighteen million eligible low-income households. This is the amount authorized in the Senate-passed energy assistance program and the amount to be set-aside from the windfall profits tax receipts. To appropriate less makes the increasing burden of spiraling energy costs and inflationary pressures virtually unbearable for the poor.

Low-Income Weatherization

The Senate recently overwhelmingly passed S.1725, a comprehensive weatherization/conservation bill to serve low-income households. We strongly supported this legislation. The bill provides a $500 million authorization level for FY 1981 for a CSA-run program. Because an investment in weatherization/conservation pays for itself many times over, is a critical component of helping this country drop its rate of energy consumption, and provides the only way to lessen the need for energy assistance dollars which are necessarily simply burned up, we urge the Appropriations Committee to fund the low-income weatherization program at the amount authorized in S.1725. It is in the best interest of the country, as well as the intended recipients, that this program proceed as fast as possible. Low-income households reside in the poorest housing stock, do not have the capital to themselves pay for weatherization, and as a result much of the little energy they do use is lost, making their environment even more uncomfortable and unhealthy.

Providing an extensive weatherization program also provides an assist to an ailing economy with a growing unemployment rate. Weatherization is labor-intensive; surely it is better to encourage development of needed new skills to the unemployed and keep those employees in the tax base rather than further erode the tax base and at the same time make higher unemployment payments.

There is a critical policy question involved with the program which we feel is correctly addressed by S.1725. We strongly believe that despite the belated attempts by the Department of Energy to remedy the absolutely disastrous management of their weatherization program, the program should be transferred to the Community Services Administration. We recommend not only that this year's appropriation be made to CSA but also that DOE be required to use its explicit transfer authority under Sec. 413(e) of the Energy Conservation and Production Act to transfer its unexpended funds (approximately $400 million) to CSA.

The reasons for the transfer are many:

1. DOE had virtually brought the program to a standstill in many parts of the country because of its refusal to allow funds to be used for labor where CETA-labor was not available and its inflexible weatherization-related repair limit of $100 per dwelling.

As a result, DOE has around $400 million in unexpended funds and in three years weatherized only 185,000 dwellings as compared to an internal program goal of 1.1 million homes. The Inspector General of DOE castigated the management of the program in a report last summer.

2. In the slightly more than three years when CSA developed and ran the program, a total of 405,311 homes were weatherized.

3. Weatherization is as much a delivery of services program as it is an energy program. It makes sense that the agency with the mandate to serve a targeted constituency should run the program. CSA is in the business of serving poor people and coordinating services to that population; DOE, with its multi-billion dollar R&D programs is not. Furthermore, the weatherization program is simply not of sufficient size to attain the priority in DOE necessary to make it run well; as has been seen, it too easily becomes buried amid all the other crisis-laden policy issues before DOE.

4. It is inconceivable that an anti-povery agency can be seen as really addressing the needs of its constituency if it is not addressing the impact of energy costs upon the poor. It should be the purveyor of weatherization/conservation services and conservation education to the poor. It is uniquely qualified to deal with that constituency.

5. DOE currently utilizes the CSA vehicles (community action agencies) at the local level. However, making the CAA's unnecessarily responsible to different federal agencies with dissimilar reporting procedures, accounting, etc., only serves to confuse and use more money in administration, hardly a cost-effective approach.

6. The hearing record on both the House and Senate side overwhelmingly indicates the need and support for the transfer to CSA.

We strongly urge you to take this action. We would be happy to provide anyadditional information you might need on these questions of critical importance if the weatherization program is going to be effective in the long run.

PUBLIC WITNESS SUMMARY

Senator MAGNUSON. Now, for the record, we had 147 witnesses so far—outside witnesses. We have one more day left of hearings.

The increases suggested and added by public witnesses just this afternoon are $1,143,000,000. Added. Just this afternoon.

We will have to take a look at these.

Thank you.

RELATED AGENCIES PANEL

STATEMENTS OF:
HOMER BABBIDGE
WALTER SCHAAR
HENRY CAUTHEN
FRED REBMAN, ASSOCIATION FOR PUBLIC BROADCASTING

FUNDS FOR PUBLIC BROADCASTING

Senator MAGNUSON. The next witness is Walter Schaar, Association for Public Broadcasting, and Homer Babbidge.

Mr. BABBIDGE. I would like to point out that we appear on behalf of the public broadcasters of the Nation in support of fully authorized appropriations for fiscal year 1983. Unlike other witnesses, our presentation has to do with 1983 appropriations, though we do support the request for a supplemental in 1980.

I should explain to you——

Senator MAGNUSON. Forget about supplementals. That's not to say I forget about it. I consider myself sort of the father of public broadcasting. I started it. I don't like to see my protege knocked about too much. But if you are thinking about supplementals, better forget about it.

Mr. BABBIDGE. I have been involved as a lay trustee for 18 years. I am now involved as a lay trustee in the new Association for Public Broadcasting. I have heard you referred to as the father of public broadcasting in the United States many, many times. I would like to say just two things. You should be a proud papa, because what has been accomplished since you became the father, as far back as 1958, is really extraordinary.

Senator MAGNUSON. It really accomplished a great deal.

Mr. BABBIDGE. It has. I say that as a lay citizen not involved professionally in broadcasting.

I am accompanied today by three pros whose aggregate experience in public broadcasting exceeds 50 years. I know Walter Schaar needs no introduction to you. Henry Cauthen is here, president of the South Carolina ETV network and so is Fred Rebman, the general manager of WJCT in Jacksonville, Fla.

I am well aware that to the father of the system our testimony on public broadcasting may sound a bit like quoting scripture to the preacher, but we thought it was important to hear directly from the field about the accomplishmnents and the problems that confront this wonderfully decentralized and diversified system of stations that you have helped to create. If you don't mind, I would like to ask Walter Schaar if he would say a few words about one kind of station which you are familiar with.

Senator MAGNUSON. Before we do that, just quickly for the record, the funding history is $152 million for 1980, $162 million for 1981, and $172 million suggested for 1982. But the fiscal 1980 level in the President's request was $182 million

Mr. BABBIDGE. For 1983?

Senator MAGNUSON. No; 1981. In 1983, you are suggesting, as I understand it, $220 million.

Mr. BABBIDGE. Which is the authorized sum. You will recall that you built into the public broadcasting legislation, I think very wisely, a matching requirement. What we seek to do in asking you for the full appropriation in 1983 is to take full advantage of the matching principle. Our members, our viewers, are raising the money to match that authorization.

But I would like, Mr. Chairman, if I may, to invite Mr. Schaar to speak.

KSPS-TV—SPOKANE

Mr. SCHAAR. I bring you greetings from Spokane, KSPS-TV, especially from Dr. Hitchcock, our superintendent. Our school board operates our station. They have asked the staff at the station to stretch our resources as far as we possibly can to hold up their end of the bargain with this mixture of funds.

In so doing, they have also asked us to look into new technology. We have something going that we hope to show you. It's about finished. Very unique. We have been looking into new technology. By doing so, we pulled together a consortium of the community colleges, Washington State University, Eastern Washington University, and the city of Spokane and the medical community to program seven channels of cable TV out of our small building, in addition to the television station, and that adds a total of 25,000 hours of additional programing, most of which is instructional, all across the gamut, for the people of Spokane. Of course, you know the location there, being right next to the border, our signal television-wise goes into North Idaho, Montana, Oregon, as well as Washington. If you needed any other argument for Federal funds, that would be good enough, as far as that is concerned.

KSPS-TV, being licensed to the schools, does a good job of meeting the instructional television needs of children in that four-State area. But one of the things that surprised me, when you count heads, is that there are about 15 million youngsters across the United States who get their instruction from television from one station or another. In our State, you are familiar with the stations in Seattle, Yakima, Spokane, and the Tacoma area. Well over 35 percent of all the time that we are on the air is devoted to instructional television, again devoting that to children.

Senator MAGNUSON. Do you exchange perhaps with, say, the UW Seattle station?

Mr. SCHAAR. Yes; but what we do together comes in a different form. Often we will acquire the same programs, but do it collectively to keep the price down.

Senator MAGNUSON. Washington State University has a fine communications school, a fine television station—they are one of the pioneers.

Mr. SCHAAR. Their radio station is one of the oldest in the country.

COMMUNITY SERVICE GRANTS

Senator MAGNUSON. I was thinking of a State network where everybody——

Mr. SCHAAR. You will be made aware soon that the Washington State Legislature finally took action a week ago. There is now a State commission with some money, so that a network will start to go together. I think it will work out. What I really need to share with you today is our concern in Spokane about the community service grant that you authored as part of the whole Public Telecommunications Financing Act. That really is the backbone of our ability to produce things at the local level. For the production of local programs for the general public, it is absolutely necessary that we have that community service grant.

The matching concept you built in works. We use it all the time to generate more funds. It's the greatest incentive that has come down the pike. Even though it only represents 15 to 20 percent of the total budget, it generates five to six times that much in community support, our being able to tell people that they have to hold up their end and the Federal Government will do theirs. It works very well. We just mentioned down the road an authorization of $220 million with a budget appropriation suggested of $182 million. That would make a difference of $500,000 in Washington alone among the five stations. $100,000 would be in Spokane. With that $100,000 for local production, we could double our output of local public affairs, minority, and cultural programs. So we are right at the point where that community service grant means a great deal to us. We have to have it maintained.

Senator MAGNUSON. The difference between $182 and $220 million, which is $38 million—that would supplement Spokane another $100,000?

Mr. SCHAAR. That would do a lot of local production in Washington, for example. Almost $200,000 in Seattle. Roughly $100,000 in Tacoma. Yakima is in there too. It's a total of $517,000 for all of the Washington State PTV stations.

Senator MAGNUSON. Is that station in Tacoma a new one?

Mr. SCHAAR. That is channel 62.

Senator MAGNUSON. We will look at funding. The administration has always been skeptical about the budget. But they did up it $10 million.

Mr. SCHAAR. Yes.

Senator MAGNUSON. I think they revised when we were going to take another look at it. I don't think I have been the purveyor of doom. I don't think the revised budgets will hurt this item.

Mr. SCHAAR. I hope not. We can't say it loud enough or long enough. It makes a great deal of difference to us in the State of Washington.

SOUTH CAROLINA NETWORK

Mr. CAUTHEN. We are doing in South Carolina something on a statewide basis similar to what Walter is doing in the Spokane area. We have a statewide cable television system in addition to a broadcast sys-

tem supported by the State of South Carolina. South Carolinians put in better than $4 per capita in support of our system.

Senator MAGNUSON. You use cable?

Mr. CAUTHEN. Yes; we lease cable.

Mr. SCHAAR. Cable and over the air both.

Senator MAGNUSON. We don't have too much cable, do we?

Mr. SCHAAR. Spokane has a 35-channel system. Seattle too. There is quite a bit more than you might think. In our case, it's the biggest system in the State. Lots of access for education.

Senator MAGNUSON. You go statewide?

Mr. CAUTHEN. Yes, with a cable system begun 20 years ago and leased lines. Now using the cable systems has sprung up everywhere. This puts the program in the public schools, higher education institutions and services such as that. For instance, we are serving 5,000 people in higher education who are getting degree programs through television in South Carolina. South Carolina is a small State, 2.8 million people, and yet one out of every six is receiving some formal course of instruction through television. It's a very utilitarian device in South Carolina.

COST SAVINGS USES OF TELEVISION NETWORK

To give you some example of some of the use: This year 72,000 South Carolinians will be involved in statewide televised conferences where otherwise they would have driven to Columbia. They are doing it by television. This saves something like 2 million miles of driving and hundreds of thousands of gallons of gas that would have been used otherwise though the old process of driving.

We had one school conference where they were talking about the energy crisis. They were going to drive to Columbia to talk about this. We suggested maybe they do it by television. They did.

There is much indication that television can be used as a very economical way of doing things that in the past we have been doing in other ways. We are doing that very rapidly in South Carolina and other parts of the country. The importance, though, of the community service grant to us is that it allows us to do the sort of thing that State funding doesn't provide for. It provides for our community service public affairs, minority, and children's programing. It buys all our public television programing in the evening. And it's a leverage that allows us to raise lots of money in support of our operation.

In our development department, which is in charge of going out and fundraising, we put $150,000 in the past 3 years into our development department. It raised over $7 million. This is the kind of leverage that this Federal money gives us that we couldn't use State money for. It's really critical and central to the growth of our system. One of the things that disturbed me very much, and you have watched the system grow, is that it has been painfully slow for some of us. I think you perhaps share that feeling with us. I think we are right now at the point where we are about ready to blossom out and realize for the first time some of the potential we have. To see it cut off and slowed down at this time would be a real tragedy.

FUNDING FOR FULL POTENTIAL

Senator MAGNUSON. It wouldn't be cut off. It would be slowed down. That is what bothers me. We haven't used the full potential. You come closer to the full potential than anybody with a statewide cable system, but at home we haven't reached the full potential. Until we reach the full potential of the TV process, I think we ought to provide sufficient funds. They don't amount to much in the $100 billion budget.

Mr. CAUTHEN. It's one of the best buys the Federal Government can make in providing service to people. I think you share that feeling.

Mr. BABBIDGE. Our viewers are raising the money to meet that match.

Senator MAGNUSON. The Pentagon spills this much every day. [Laughter.]

It's a question of priorities with us here. We have tried to up it a little bit, but I don't think we have reached our full potential. Your request is very modest.

Mr. BABBIDGE. Could we ask Fred Rebman to say a few words?

STATE OF FLORIDA PUBLIC TV SYSTEM GROWTH

Mr. REBMAN. On the Senator's mention of the word "priority," our State legislature in Florida takes a good look at that. We have now 100,000 citizens in Florida, a lot of senior citizens probably, but 100,000 that pay their taxes, pay their gas bill and still dig into their pocket—100,000 people in one State have become members of public broadcasting. Our legislature is very impressed. They are trying to search and set their priorities according to the priorities of some of our citizenry. As we look at the Nation, Homer Babbidge mentioned tremendous increases. Well, we are now up to 2½ million members nationwide and this incredible growth is happening right as we sit here on every public TV station in America.

We are in a membership drive. I can report to you that our drive is up 21 percent and the projections are that at the end of the drive, in a week, we will be up 30 percent. Local voluntary giving to public broadcasting, a priority indicator we contend, will be up 35 percent this year.

All of us know we are resetting our priorities in our hopes for our families. To have that kind of record we think you have an awful lot of people following what you began. Our Jacksonville station, WJCT has 2,300 volunteers that will work this year for public broadcasting.

Senator MAGNUSON. What do they do?

Mr. REBMAN. Everything you can think of. They are on advisory boards for television programs, for environmental programs in Florida—which are popular programs with us. They serve on boards of trustees, of course; governing boards; they run auctions. Another indicator is their membership work.

Senator MAGNUSON. Do they help with raising funds?

Mr. REBMAN. Yes, sir; they are on the phones 50 at a time, in and out—children, old people; people of all walks of life. In the State of Florida, for instance, we have support from well over 15,000 small, medium, and large corporations. That is more than one of the most active chamber of commerce memberships in the United States.

COMMUNITY SERVICE GRANTS

That is, I think, an indicator of how private enterprise feels about public broadcasting in the State. Those numbers play out throughout the country. This community service grant is a tremendous rarity. It's 15 percent of the money going into local stations. But it generates a lot of State funding. The State people are all aware of how their Federal money plays in and the need to match them. The city of Jacksonville and many other cities give, according to their matching, as do the country school systems, the corporations and the individuals. We are all aware of what you have created.

Senator MAGNUSON. What we were trying to do, was prevent the Federal money taking the place of the local contribution. In other words, the local people say, "Oh, well, the Federal Government will do this." We wanted the Federal money to be supplemental on top.

Mr. REBMAN. A pump primer.

Senator MAGNUSON. Seed money; on top—that is why we started out small, $200 or $220 million is not very much. It's still supplemental. It's supplemental to all the activity that occurs in the periphery of a local educational TV station.

Mr. REBMAN. Still, look at Laverne and Shirley costing $250,000 a half hour. That exceeds the annual budget for local programing in most public TV stations in America—with all of the needs that are coming to us from people that want better children's programing, more wholesome programing for their youngsters. The pressures are immense. The needs are great. But that's one example of what we have to work with. You know, Laverne and Shirley, as far as I know, is probably a good program for an awful lot of citizens. But $250,000—that is more than what we have for our whole annual station budget on public affairs.

Senator MAGNUSON. Well, we will look at it.

SUMMARY

Mr. BABBIDGE. May I say one thing in conclusion?

We are all eminently conscious of the decisions you have to face and you may well wonder why in such times we should be here requesting additional funds for support of public broadcasting. But I think the evidence you heard today of growth in viewership, in voluntarism, and in dollar contributions may well suggest that what we have to offer in public broadcasting is specially needed in these difficult times. I would say once more that I think public broadcasting has become, thanks in large part to you, a great resource to this Nation.

Senator MAGNUSON. You must have consumer-oriented programs.

Mr. BABBIDGE. We serve the public.

Senator MAGNUSON. For a small amount of money it does more to help offset the inflationary process than anything else.

Mr. BABBIDGE. Given your report on the supplemental, we have added nothing to that huge figure that you announced earlier. [Laughter.]

[The statement follows:]

Statement of Homer D. Babbidge

Mr. Chairman and members of the Committee, I am Homer D. Babbidge, Chairman of the Board of Trustees of the Association for Public Broadcasting, and Chairman of the Connecticut Educational Telecommunications Corporation. With me is Walter J. Schaar, General Manager of KSPS-TV, Spokane, Washington, which is a public television station licensed to Public School District #81.

We appreciate the opportunity to appear before you today on behalf of the nation's local public television stations, in support of appropriations for public broadcasting, which you are now considering in the request of the Corporation for Public Broadcasting (CPB).

The Association is a non-profit membership organization established in January 1980 by the nation's public television licensees to organize their common efforts in the areas of research and planning, and to help present their views to the government, interested communications organizations and agencies and to the public at large. A description of the Association, and a list of its Board of Trustees and the biographies of those testifying today, are attached. (Attachments 1 and 2).

CPB APPROPRIATIONS

This testimony is directed to the FY 1983 appropriation, and an FY 1980 supplemental request, for the non-profit non-governmental Corporation for Public Broadcasting (CPB).

As you know, the Congress has provided forward funding for public broadcasting via the Corporation. Thus the appropriation to which we refer is for FY 1983, but is contained in the Administration's FY 1981 budget. In addition, the federal funds appropriated to the Corporation are not released fron the U.S. Treasury until they are matched by non-federal funds, currently at the rate of $2.50 of non-federal funds for each $1 federal. For fiscal years 1981, 1982 and 1983, the matching ratio will be $2 non-federal for each $1 federal, as a result of changes introduced by the Public Telecommunications Financing Act of 1978--changes intended to ease the burden on the public broadcasting community of meeting the higher matching requirement, while maintaining a strong and direct incentive to increase local support. The match itself or an appropriation ceiling in the law limit the total amount of federal funds in any year.

The public television licensees believe that federal

funds, representing approximately one quarter of annual system resources, are a vital contribution toward the continued growth and development of public broadcasting's services to the American people--television, radio and other communications services. The Administration's budget proposal --$182 million for FY 1983--is not in keeping with the Congressional and public commitment to these services, expressed repeatedly through Acts of Congress and through growing public contributions of time, interest and support. Nor is the Administration proposal sufficient to meet the needs and public expectations (outlined below) of the non-commercial public broadcasting system just as it is beginning to flourish and succeed in its mission in so many ways. We here urge your Committee to recommend the full amount authorized by the Congress: $220 million. In addition public television supports a supplemental appropriations of $3.2 million in FY 1980. The justification for these sums follows.

THE CENTRAL VALUE OF THE FEDERAL CONTRIBUTION

Public television believes the forward-funding process, enacted in 1975, reaffirmed in 1978, reaffirmed in 1978, and based on a match of federal to local contributions, has been salutory to public broadcasting. After eight years of one- or two-year authorizations, a Presidential veto, and great financial uncertainty, the process provides a needed degree of stability to the planning and financing of local stations and their national services. It provides the crucial stability and lead-time necessary to the development of television programming and the retention of talent. For example, programs such as The Adams Chronicles, 3-2-1 Contact (the new children's science series from The Children's Television Workshop), and the upcoming Cosmos series, featuring Dr. Carl Sagan, simply would not be possible without it. In addition local licensees benefit greatly from the stability and insulation to conduct their affairs which this process can afford. This unique and beneficial process also links national support to public satisfaction and confidence in public broadcasting as measured by increasing local public support.

This more stable financial environment and the increasing commitment to public broadcasting by the Congress, have led to a period of solid growth and accomplishment in public service by the public broadcasting community.

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THE PUBLIC TELEVISION COMMUNITY

Public television is a complex community of local, regional and national organizations and of thousands of individuals. It operates a variety of technical communications services, including broadcast stations, cable activities, satellites, microwave relays and recorded and printed materials.

But public television is fundamentally a story of the local public broadcasting licensees. They are responsible for obtaining the licenses, building the transmitters and other distribution systems, raising the funds, ascertaining community interests, acquiring or producing the programs, and delivering them to the public--seven days a week, 365 days a year. In short, it is the licensees who are the heart of public telecommunications services in the United States.

The licensees are the source of almost all non-federal funds raised in the public broadcasting system and are responsible for expenditure of the majority of the federal funds appropriated to the Corporation.

In public television there are now 285 public television transmitting stations licensed to 156 non-profit community organizations, public school systems, universities and state commissions in 48 states, the District of Columbia, and of Guam, Puerto Rico, American Samoa and the Virgin Islands.*

These stations broadcast or distribute educational, instructional, general information, and other public programs 14-18 hours a day, seven days a week, year-round--an average of nearly five thousand hours per station. In 1978, children's programming accounted for 35% of those hours, while news/public affairs/informational programming accounted for another 35%.**

In 1979, over nine thousand employees made these services possible. Of those, women constituted 36.6% (up 11.3% from the previous year) and minorities 14.2% (up 9.7%) of the the public television workforce.

Thousands of citizens serve on station or national boards of directors, community advisory boards or as volunteers, and more than two and one-half million individuals or

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* While the states of Wyoming and Montana currently have no full service public television stations operating within their boundaries, a number of opportunities are being explored--including "mini-cable" systems--to bring local public television service to the more sparsely populated areas.

**Unless otherwise noted, all figures are most recent available.

families make contributions to or are members of their local public television station.

Public television's financial support (based on FY 1978) comes from state and local governments (31.5%), fundraising efforts (14.6%), businesses)9.5%), universities (7.6%) and the federal government (28.4%) and various other sources (8.6%--e.g. foundations, income from commercial and non-commercial subsidiaries, advertising in program guide magazines, etc.).

Almost 90% of the American public is within reach of a public television signal--broadcast or cable--of moderate strength. Nearly two-thirds operate in the UHF band (channels 14-83), where the average costs of broadcasting are considerably higher than on the VHF channels (2-13). Some 60% of the public television licensees are involved not only in broadcast, but also in non-broadcast distribution of their programs--e.g. on cable, ITFS, closed circuit, cassette, etc.

Almost two-thirds of America's television households--49.1 million--watched public television in the course of one month last year (1979). In terms of the composition of its audience, public television is truly "public": well over half of every major demographic group, white and non-white, blue-collar and white-collar, college-educated and high-school educated, watched public television. In fact, a November 1979 survey revealed that 60% of public television's audience consists of homes headed by a blue collar worker or someone not in the labor force.*

These are the broad statistics. The aggregate figures tend to obscure the wide differences among stations, and the complexity and diversity of this nationwide public television community. Rather than create a mythical "average" station, Attachment 3 gives a sense of how varied the local public television stations are, reflecting differences from community to community.

FINANCING PUBLIC TELEVISION STATION SERVICES

What do the requested federal funds mean to these local public service institutions? The brief answer to that question is: programming, maintenance or expansion of local service, and continued technical improvement of the public broadcasting system.

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*"November 1979 PTV Program Carriage and Nielsen Television Index (NTI) Audience Estimates," PBS Research, January 29, 1980.

It takes a significant amount of effort to establish and maintain a bare-bones telecommunications operation--before a single program is ever aired. And specific examples are cited below of the increasing costs of maintaining current levels of service in the fact of 15-20% inflation alone in the public broadcasting industry. In non-commercial public broadcasting, the "last dollar in" is usually the most important in terms of the production of programming and the development of services. Federal funding, especially through Community Service Grants, is anticipated but is generally the "last dollar in". It is available for use at the public television station's discretion under the existing Community Service Grant program and it provides the margin of difference in public television services.

The best, and longer, answer to the question, however, comes from a closer look at the activities of the public television community and at the successes and advances achieved over the last few years in large part as a result of federal financial support.

Local Public Television Programming

One of the most important, although least understood, activities of the local public television stations is production of programming in and for their communities or states. Because local programming varies so widely, in context and purpose, it is not highly visible nationwide. And because it does not lend itself to the gathering of audience statistics nationwide, it is too often overlooked in audience reports about public television's programming. Nevertheless it is a fundamental component of the services of public television.

Local public television stations produce a wide range of 'local' programs. Most produce a daily or weekly news public affairs program, for example:

1. "Mountain View Tonight," a daily survey of area news by WWVU/Morgantown, West Virginia;

2. "7:30 Newsroom," a statewide news magazine four nights a week, and two weekly programs intended for minority audiences, "For the People" and "Jobman Caravan," produced by the South Carolina network;

3. "Albuquerque News," focusing on city issues, produced weekly by KNME, Albuquerque;

4. "Spokane Weekly," an investigative newsmagazine, and two weekly hard-news programs for classroom use, by KSPS, Spokane.

These programs can take on a vital nature. For example, the Pennsylvania Public Television Network produced the only on-going, full-time news and emergency information service

from within the evacuated area throughout the Three Mile Island crisis. It was a public affairs staffer of the San Francisco station who was the go-between in the Patty Hearst manhunt.

Many stations showcase or present local cultural and sporting events, some of which eventually gain wider than local distribution. Others, such as the Kentucky, Nebraska, Oregon, and South Carolina networks, produce significant amounts of instructional (ITV) programming for their area schools and universities (as well as for nationwide distribution). Still others, such as KOCE/Huntington Beach, California, lead production activities for college credit courses, in this case in conjunction with Coast Community College.

An example of a growing and especially valuable service is coverage or facilitation of the activities of the State legislature. The West Virginia and Florida stations and many others provide live coverage of legislative sessions and activities. Of special note, however, are the new and effective uses to which some stations are now putting their facilities. In South Carolina and Connecticut legislative hearings are conducted via public television interconnection. In South Carolina thousands of poll watchers for the recent primary election these were trained via television at home, rather than travelling through all to sessions elsewhere. In Maryland, the local officials gathered in a teleconference on urban governance issues with officials in Ohio.

A final example of innovative local programming are two licensees in the North Central states. WHA/Madison, Wisconsin produces "Tryout TV," a program which monthly provides all the necessary support to allow an individual within the community to produce a program of his or her own design. In addition to its local current affairs, sports and interview programs, KFME/Fargo, North Dakota, provides an hour per week of local 'access programming,' available to interested local groups.

Local programs produced by public television stations have won numerous awards. Attachment 4 lists some recent ones.

Directions in Local Programming

More and higher quality programming is the first priority of almost every public television station responding to a recent Association survey. Local production was listed almost unanimously as the licensees' top unmet program priority. It is in this area that stations plan to spend current incremental funds and new funds in coming years.

The public television stations estimate that new local programs alone--produced locally for local audiences above and beyond maintenance or improvement of current programs--would cost upwards of $15 million annually. Many of them are long planned, often awaiting funds for a go-ahead, and others represent the unmet needs and interests of the community, long stifled by lack of adequate discretionary funds. They include such programs as:

- "Experience in Black," a series of field productions by WKPC on the black community in Louisville, Kentucky;
- a history of labor in West Virginia, focusing on the importance of the state in the national labor arena, to be produced by the West Virginia Educational Broadcasting Authority and WMUL/Huntington;
- a series on agriculture and agricultural markets in Florida, by WUFT/Gainesville;
- "Black Perspective: Cleveland," a studio and field production covering issues of concern to the local black community, by WVIZ/Cleveland;
- "Contours," a series on performing artists in the state of Connecticut, by the Connecticut Educational Telecommunications Corporation;
- "Profiles," a documentary series on people living in western Massachusetts, by WGBY/Springfield, Massachusetts;

All public television licensees list in this survey an increase in the percentage of hours devoted to local programming and the improvement of the quality of those programs as priority goals for FY 1983.

Financing Local Programming

Where does the money for local programs come from? In general terms, nearly 70% of the federal money distributed in FY 1980 to the public television stations by CPB in the form of Community Service Grants (CSGs)--i.e. nearly $53 million of a total of some $76 million--is targeted for the production and acquisition of programming, both local and national. While there is some local underwriting of local programming, it is the federal funds--because of their flexibility and heretofor assured stability noted above--which support local programming in non-profit public television.

A look at some individual stations will illuminate:

- At KUED/Salt Lake City, Community Service Grants and viewer donations are the only source of funds for the production of local programs;

- o On the Iowa Public Broadcasting Network, almost all local production (130 hours/year) is funded by the Community Service Grant.

- o Nearly 85% of South Carolina's Community Service Grant funds go directly to the production or acquisition of programming, much of it local.

- o KAID/Boise, Idaho, would use any increase in its CSG to fund the programs it currently cannot afford.

Because it is produced entirely by or through the local station, the relative cost of this type of programming is higher than the cost of simply obtaining programs already produced elsewhere. The interest and commitment to this service is so strong, however, that some stations spend over 50% of their total budgets in order to produce the five or six percent of their schedule which local programming comprises. That so many licensees devote by far the largest single portion of their resources to this effort is a testimony to the importance their communities attach to this service.

Clearly, the federal funds under consideration by this Subcommittee are of critical importance to the local program service efforts of the stations. Community Service Grants in particular in the last few years have aided an unprecedented level of interest growth and development in public television in states, cities and towns across the country.

These funds are equally important to the licensees as they coordinate their efforts through regional organizations and PBS to create complete schedules for their communities. This is summarized in the following section.

More-Than-Local Public Television Programming

Both the high costs of television program production and the common interests of many licensees in certain types of programs have led the public television licensees to pool their resources in a number of unique, progressive, and cost-sharing ways.

Four regional organizations assist licensees in the production and acquisition of programs of particular interest to the member stations of those organizations.* Thus CEN is the umbrella organization for the production of Farm Digest, a weekly agricultural program for the midwest farm states.

* They are: Southern Educational Communications Association, SECA, headquartered in Columbia, S.C.; Central Educational Network/CEN, Chicago, Ill.; Eastern Educational Network/EEN, Boston, Mass.; and Pacific-Mountain Network/PMN, Denver, Colo.

EEN has established an office to assist stations in their efforts at consortium production. All of the regional organizations help their members obtain already-produced programs, for both daytime and prime-time use, at lower cost through group purchases than would be possible on an individual station basis. This activity is particularly important with regard to in-school instructional programming, which makes up a major portion of most licensees' daytime broadcasts. As the newest regional organization, PMN is now analyzing what role its members want it to play in this field.

The largest cooperative programming effort conducted by the licensees--in production and financing--is known as the Station Program Cooperative (SPC). The SPC is unique in the world of television programming. Through a computer-assisted selection process, each local station "votes" for the programs it needs for its community. Through this democratic marketplace process and other joint station programming efforts, stations supported directly 25% of the programming costs of the entire schedule distributed by PBS in FY 1978. Forty-six public television stations produced programs distributed on the PBS schedule in that year (For a more complete explanation of the SPC and other 'national' productions, see Attachment 5.)

While these programs are considered 'national' in the sense that they are distributed and used by most stations nationwide, it should be noted that many of public television's best-known 'national' programs began as local program efforts by individual licensees: Julia Child, McNeil-Lehrer, Evening at Symphony, and the GED (Graduate Equivalency Degree) Series, among others.

Just as the local program efforts of the public television licensees rely on the federal funds provided to them in the form of Community Service Grants, so too do the licensees' cooperative efforts for more-than-local programming. Much of the money spent by the licensees in the Station Program Cooperative and in consortia productions for regional or other use comes from each licensee's Community Service Grant distributed by CPB.

In fact, far more of the federal contribution to public television via CPB ends up in programming--both local and national--than would be apparent from examining CPB's budgeted expenditures: roughly 50% of all CPB funds, counting both Community Service Grants and direct CPB television program expenditures.

Technological Advancements in Public Television Service

The recent achievements of public television in the technology of telecommunications are fairly well known:

- development and implementation of the world's most extensive (and the only American) domestic satellite system for broadcast television;
- development and installation of the first audio system for television which provides multiple channels for stereo sound and simultaneous program translation in several languages (Digital Audio for Television, DATE);
- development and operation of a captioning system for the hearing impaired;
- research and developmental work in the improvement of UHF broadcasting.

In each of these cases, public television stations, working together toward a common goal, have taken the initiative.

These accomplishments not only improve the quality and variety of public television service to the American people, but they also take advantage of cost-effective technologies, often advancing their utilization in the communications industry altogether. For example, public television achieved a landmark in American broadcasting history by distributing recently live coverage of a major news event (Presidential candidate debates in South Carolina) in two languages simultaneously, Spanish and English.

Expansion or Provision of Services Through Utilization of Non-Broadcast Technologies

In addition to these major accomplishments, however, the public television licensees over the past decade have made extensive use of non-broadcast distribution systems, well before they began to attract widespread attention as harbingers of a telecommunications "revolution." Approximately 30 stations operate cassette duplication and distribution systems, often in concert with other institutions; many have ITFS systems; and at least 20 are taking advantage of second (and sometimes more) channels on area cable systems for new services. Overall, almost 60% of the public television stations are already involved in regular non-broadcast distribution and another 9% anticipate becoming involved in the near future. All of these activities enhance local community service.

The licensees also continue to experiment with and to design other forms of public telecommunications services.

For example, KUON/Lincoln, Nebraska, with support from CPB, is experimenting with the production of educational programming for videodisc. And licensees KCET/Los Angeles and WETA/ Washington, D.C. are now or will soon be testing public service uses of broadcast videotex systems.

The importance and flexibility of the current levels of unrestricted Community Service Grants, in combination with other resources, in these activities cannot be overemphasized.

PUBLIC TELEVISION POISED FOR THE NEW DECADE

In order to improve their ability as a system to take advantage of new means of production and distribution, to encourage greater amounts and types of programs from all sources, and to marshall their limited resources more effectively, the public television licensees in the summer of 1979 voted to restructure their national program organization (PBS). At the heart of this reorganization, which is now underway, is the ultimate development of three distinct national program services (where currently there is one).

One of these three program services will be devoted essentially to prime-time programming (PTV 1). Another will seek out and distribute long-form current events, special interest programs, series and other program pilots, and new programming forms (PTV 2). The third program service will focus its attention exclusively on home and school educational programming (PTV 3). Each program service is intended to be directly designed, controlled and responsible to its licensee-users, who may use the programs for primary broadcast or second broadcast or cable channels as necessary in each community. At the same time the services are meant to give each kind of programming its due--many of them unique to public television--and to encourage its full development. This arrangement provides a needed focus and coordination for these varying types of programs while ensuring continued station discretion over the ultimate use of the programs distributed.

This dramatic move, meant to position public television more sensibly for its growing mission in the coming decade, will require--more than ever--the ability to plan based on solid financial projections and to draw on the support and strengths of all public television licensees to succeed.

(Part of the strength of public television community necessary for future years will be the ability to complete coverage of the population with at least one public television signal, and to seek out, train, and retain talented people to

work in the field. The public television licensees and CPB can and should play a leading role in each area. A primary responsibility of the Public Telecommunications Facilities Program, in the Department of Commerce, is the extension of signal coverage. Attachments 6 and 7 provide overviews of the value of some means of federal support to these two crucial activities.)

RECOMMENDATIONS REGARDING APPROPRIATIONS TO THE CORPORATION FOR PUBLIC BROADCASTING

For FY 1980-82, public broadcasting's growth in service from federal funds will be at a standstill or will actually decline. The Administration's proposal for FY 1983--a 5.8% increase over FY 1982--would continue the actual erosion of service the public broadcasting community will experience over the next two years (Table I, Attachment 8).

Yet, encouraged by the match, and valuing the public television service, the public continues to show its support (see Table II, Attachment 8).

Our projections of non-federal income over future years indicate that public broadcasting will raise far more than is necessary to match federal funds even at the highest authorized levels (see Table III, Attachment 8).

Under the administration proposal, therefore, the federal contribution to public broadcasting, through its appropriations to the Corporation, would continue to decline as a percentage of total public broadcasting income (see Table IV, Attachment 8) In fact, the Administration proposal represents the lowest percentage of the authorization since FY 1976.

This discouraging fact comes at a time when:

- public television programs are reaching more and more people--nearly 150 million in any month. The total cost per viewer of public television was only $4.00 in FY 1978 and the cost to the federal government was only $1.16 per viewer.

- New local and national public service opportunities and possibilities are planned and possible, as described above.

- Non-federal support has risen on a per capita basis from $1.28 in 1975 to $1.79 in 1978, in response to the Congressional intent to encourage through the to match this growth in public support.

- Operating costs are increasing dramatically--energy, personnel, programming, copyright, etc.: so much so that in public broadcasting we can estimate that fully $219 million of the FY 1983 authorization would be used (under prevailing economic conditions) just to maintain current services as projected.

The difference--in direct support to the public television stations--between appropriations of $182 million and $220 million would mean nearly $75,000 for smaller licensees and up to some $1 million for each of the largest stations. (This assumes that CPB will continue to allocate at least 50% of the total appropriation to unrestricted television Community Service Grants, as it has in the past and as Congress has endorsed.) This difference will affect directly each stations' ability to:

- o afford local and more-than-local programming;
- o expand the number of broadcast hours, to provide more flexible service;
- o increase local production, especially for specific population or interest groups;
- o expand coverage to unserved areas, where they exist; and,
- o improve the quality of programming, which often involves better training, hiring new staff and utilizing new production technologies.

Because the benefits of direct federal support to public television stations are proven, and because the stations are in the best position to judge--as they have consistently demonstrated--the best next steps for public television service in their communities, public television believes that the current Community Service Grant program should be maintained in FY 1983, at 50% of the total appropriation, or $110 million. These funds should be distributed on the existing formula basis, which was devised by negotiation among the public television stations themselves (i.e., a base grant, plus an incentive grant reflecting non-federal support generated by each licensee).

To the public television system as a whole--indeed to all of public broadcasting--the $220 million also would allow significant and essential increases in the activities funded directly by the Corporation: significant levels of program development, appropriate support for expansion of signal coverage to unserved areas, training, and technical and audience research.

CONCLUSION

In 1967, Congress established as a matter of national policy, the encouragement and development of public broadcasting at the local level. It provided federal funds to support that policy, including a mandated distribution of Community Service Grants since 1976, and the ensuing decade

has witnessed the development of public telecommunications into a national public service employing thousands of persons, daily utilizing the potential of the television and radio media for education and information, and touching the lives of millions of Americans. In countless communities throughout the nation, citizens have demonstrated their desire to obtain the services public television and radio provide by establishing stations and the organizations necessary for their support. They continue to prove the importance of such services to their communities by voting local and state tax dollars to support them and by contributing millions of dollars personally to them.

Congress has long recognized the importance of providing matching support for public broadcasting. The provision of federal funds on the matching basis has stimulated increasing and first-time contributions from state and local governments and from businesses, labor, foundations, and individuals; it is, in a way, a contract with the American people. In addition, the matching principle has been and continues to be an important means of assessing the success of the public broadcasting enterprise. The Administration budget proposal for FY 1983 would relegate the matching principle--so carefully crafted and overseen by the Congress to support the growth and development of public broadcasting--to history.

Public television urges this Committee and the Congress to continue the strong progress of the local public broadcasting service by appropriating the full authorized amount of $220 million in FY 1983, and a supplemental amount of $3.2 million in FY 1980.

We would be pleased to answer any questions you may have.

CONGRESSIONAL WITNESSES

STATEMENTS OF:

THE HONORABLE MELVIN H. EVANS, DELEGATE TO THE CONGRESS, FROM THE VIRGIN ISLANDS

THE HONORABLE JOHN H. CHAFEE, U.S. SENATOR FROM RHODE ISLAND

THE HONORABLE TONY COELHO, U.S. REPRESENTATIVE FROM CALIFORNIA

THE HONORABLE QUENTIN N. BURDICK, U.S. SENATOR FROM NORTH DAKOTA

THE HONORABLE JOHN MELCHER, U.S. SENATOR FROM MONTANA

Senator MAGNUSON. Congressman Evans.

Mr. EVANS. I am here on behalf of my district. My testimony is quite brief. I am sure you will agree with much of it. I am prepared to answer any questions you might want to pose.

EDUCATION AND TEACHER TRAINING ASSISTANCE

Basically, I am here to request your assistance in recommending appropriation of $5 million for fiscal 1981 related to the Labor-HEW appropriations bill for the purposes of general education systems in the Virgin Islands; and $2 million for teacher training assistance in all of the U.S. territories as authorized by Public Law 95–561, sections 1524 and 1525. As you may recall, the amount of $5 million was earmarked by Congress to fund these two sections last year. We in the U.S. Virgin Islands thank you for your continuing strong support of the financial condition of our local educational system, especially in light of the Nation's economic situation. The appropriation of these moneys continues to be of extreme necessity in coping with the ever present financial difficulties encountered in the Virgin Islands educational system.

The public education system in the Virgin Islands has undergone dramatic changes and has been put under tremendous stress during the past 10 years as a result of the passage of Public Law 91–225 by the Congress, which permitted an almost uncontrollable influx of children of aliens into the Virgin Islands. In 1969, the public school enrollment was slightly over 9,000; by 1973, it had increased to about 26,000—an almost 200-percent increase.

While we doubled school capacity during those years we still fell far short. This was combined with an attempt to reduce the class size and make education meaningful. It was a tremendous problem. During those same years school construction was accelerated, with a doubling of the school capacity, but still falling behind. St. Thomas and St. John constitute 34 schools, both primary and secondary schools. Obviously, the tremendous increase in school facilities, plus the concomitant attempt to improve the quality of education by such factors as class size

reduction and improvement in equipment caused a tremendous increase in the operating budget of public education. In terms of actual figures, costs increased from $9,748,665 in 1969, to $40,687,128 in 1979, and in terms of actual percentage of total Government outlay, from 17.7 percent in 1969 to 27.12 percent in 1979.

Another spinoff problem related to the student population is the negative impact on the curriculums. Many of the noncitizen children enter the public schools deficient in the language, arts, mathematics, vocational education and other disciplines. The academic deficiency has caused the Department of Education to gear many of its programs to remediation. A substantial percentage of the school population is involved in remediation programs. This is evident at the elementary and secondary levels.

Although the Department of Education has attempted to reach a substantive number of children in need of remedial programs for certain academic deficiencies through such programs as ESEA programs and services, new curriculums need to be developed that would have some relevance to the Virgin Islands way of life, its culture, heritage and relationship to the United States.

TITLES I AND IV ELIGIBILITY

Senator MAGNUSON. Are you recipients of title I?

Mr. EVANS. Yes.

Senator MAGNUSON. You are; you are included in title I?

Mr. EVANS. Yes.

Senator MAGNUSON. And title IV?

Mr. EVANS. Yes; there was one problem. Under the program which was geared to the remedial work for isolation minorities, we became disallowed when section 3 was deleted 2 years ago. It turns out the intent was not private territories, but the interpretation was—that doesn't concern the question you asked. The big problem is this: When Congress passed this law, Public Law 91-225, we don't think——

Senator MAGNUSON. Wait a minute. We have had this a long time in this committee. Senator Stevens also took up the cudgels for the Virgin Islands, because he worked out there at one time. Always the argument is that you are eligible for title I, title IV, and you are eligible for all the school programs.

Mr. EVANS. Most of them. I am not sure about all.

Senator MAGNUSON. Why do you want this extra amount?

Mr. EVANS. I think Mr. Chairman, you would find it hard to identify another area in the country where in the period of 4 years there has been almost a 200-percent increase in the public school population. Not only a simple increase but an increase brought about by people coming from a different soup barrel.

We have problems where we need special classes because of age differences. Kids have been out of school and don't understand the vernacular of the area, whose culture is quite different. It's a very unusual problem.

Also I think, Mr. Chairman, while I can give you the exact formulas, it's important to know in the Territories that the formulas which are often applied in some of these grants don't have the floors under them the States have and, therefore, we don't get the full impact.

Senator MAGNUSON. The argument was made, as I remember, that you had a special problem that the formulas that apply to the States didn't quite fit some of the problems in the Virgin Islands.

Mr. EVANS. Without knowing the details, I am sure that is true. I did want to point out the Virgin Islands is making a great effort to help itself. It increased the percentage it spends for education from 17 to 27 percent. But the peak which seems to have passed in the States where school enrollments are dropping hasn't been reached in our case. We are dealing with a serious but continuing problem.

Senator MAGNUSON. You have a teacher problem too.

Mr. EVANS. We attempted to handle that by accelerating the rate at which our college changed from a 2-year to 4-year college to train teachers.

We still have to import a tremendous number of teachers because of the rapid growth. I can say to you that our school facilities doubled.

INFLUX OF ALIEN CHILDREN

Senator MAGNUSON. You point out the uncontrollable influx of children of aliens in the Virgin Islands. Where do these aliens come from?

Mr. EVANS. Practically all islands in the Southeast. All the way down to Trinidad. When Congress passed their law permitting the people who are in the United States to bring their spouse and all minor children, it just flooded—we had children coming in from minors up to 16, some of whom had never been in school. When you get a child aged 15, and the law says he must be in school, and he is qualified for the fourth grade only, that is yet another problem. It's a tremendous problem.

Then the Federal courts ordered us to put them in school which, of course, I suppose is quite reasonable, so that we had to initiate school construction at a rapid rate. We rented schools, leased buildings, brought in trailers and relocated—everything, but it still is a heroic problem.

Senator MAGNUSON. Well, the influx of so-called alien children I can see is a terrific problem. As the economy increases in the Virgin Islands, you will get more of them.

Mr. EVANS. We will, though that big increase probably has petered out because the original ones, the workers who came in, are no longer coming in in such large droves.

One of the bad effects is that despite all this money spent, the quality of education in the public system vis-a-vis the private sector has decreased to the point where the private schools have attempted to pick up some of the slack which tends to produce other problems, as you could imagine. It's really a serious problem. It's a very serious problem.

Senator MAGNUSON. We are quite familiar with this problem.

Mr. EVANS. I am sure you are.

Thank you for your sympathetic attitude.

Senator MAGNUSON. We appreciate your testimony. Thank you very much.

[The statement follows:]

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Statement of Delegate Melvin H. Evans

Mr. Chairman and distinguished members of the Senate Appropriations Subcommittee on Labor-Health, Education and Welfare, I wish to extend my appreciation to you for allowing me this opportunity to appear here today on behalf of my home district the United States Virgin Islands. My testimony here today will be brief, and I would welcome any questions which you may wish to ask.

I come before you today to request your kind assistance in recommending the appropriation of $5,000,000 in the FY 1981 Labor-HEW Appropriations Bill for purposes of General Educational Assistance in the Virgin Islands, and $2,000,000 for teacher training assistance in all of the United States territories, as authorized by P.L. 95-561, Sections 1524 and 1525. As you may recall, the amount of $5,000,000 was earmarked by the Congress to fund these two sections last year.

We in the United States Virgin Islands thank you for your continuing strong support of the financial condition of our local educational system, especially in light of the Nation's economic situation. The appropriation of these monies continues to be of extreme necessity in coping with the ever present financial difficulties encountered in the Virgin Islands educational system.

The public education system in the Virgin Islands has undergone dramatic changes and has been put under tremendous stress during the past 10 years as a result of the passage of P.L. 91-225 by the Congress, which permitted an almost uncontrollable influx of children of aliens into the Virgin Islands. In 1969, the public school enrollment was slightly over 9,000; by 1973, it had increased to about 26,000, an almost 200% increase. From figures made available to me recently, 25% of the present public school enrollment is comprised of non United States citizens, with 75% of all students in secondary schools attending double sessions; that is, one half of the students attend classes in the mornings, with the remainder attending in the afternoon.

During those same years, school construction was accelerated, with a doubling of the school capacity, but still falling behind. Presently, the total number of public schools on St. Croix, St. Thomas and St. John constitute 34, both primary and secondary schools. Obviously, the tremendous increase in school facilities, plus the concomitant attempt to improve the quality of education by such factors as class size reduction and improvement in equipment caused a tremendous increase in the operating budget of the public education in terms of actual figures that increased from $9,748,665 in 1969, to $40,687,128 in 1979, and in terms of actual percentage of total government outlay from 17.75% in 1969 to 27.12% in 1979.

Another spin-off problem related to the student population is the negative impact on the curricula. Many of the non citizen children enter the public schools deficient in the language, arts, mathematics, vocational education and other disciplines. The academic deficiency has caused the Department of Education to gear many of its programs to remediation. A substantial percentage of the school population is involved in remediation programs. This is evident at the elementary and secondary levels.

Although the Department of Education has attempted to reach a substantive number of children in need of remedial programs for certain academic deficiencies through such programs as ESEA, ESSA, SAFA and Titles I and IV, they are in need of additional programs and services. New curricula need to be developed that would have some relevance to the Virgin Islands way of life,

its culture, its heritage and its relationship to the United States.

The infusion of the Federal funds authorized in Section 1524 of the Education Amendments of 1978 would assist the Virgin Islands in addressing the problem outlined.

The Teacher Training Provision will greatly assist the Virgin Islands Department of Education and the College of the Virgin Islands in providing viable teacher education programs for Virgin Islanders. Statistics now show that 1555 teachers are currently employed in our local public schools.

Presently, the Department of Education relies heavily on the importation of instruction professionals from the United States mainland. Most of these professionals experience a "culture shock" that in most instances results in empty classrooms or unattended children for long periods of time. It also creates a teacher shortage problem for the public education system in the Virgin Islands.

The Department of Education is developing a new strategy to deal with the problem of staffing. It is envisioned that qualified young Virgin Islanders will be recruited from the public and private secondary schools in the Territory to become "teachers of the future". However, funding is limited to implement the plan. It is hoped that the funding authorized in P.L. 95-561 can be used to train local Virgin Islanders as teachers. This plan would be a cooperative effort of the Department of Education and the College of the Virgin Islands.

The requested funds will also be used to train United States mainland professionals in the public school system to cope with the cultural and social aspects of the community. This will eventually aid them in becoming better teachers in the public system, thereby improving the teaching/learning process to the benefit of all of the children of the Virgin Islands.

In closing, let me say that my request for this appropriation is urgently needed in the Virgin Islands, and should you require any further justification, I would be most happy to furnish it.

Thank you for your consideration of this important matter.

STATEMENT OF SENATOR CHAFEE

Senator MAGNUSON. Senator Chafee.

Senator CHAFEE. Mr. Chairman, first I want to say that——

Senator MATHIAS. I just came to support and encourage the great Senator from Rhode Island.

Senator CHAFEE. First I want to say I don't envy you in your duties. Everybody is looking for something, and I imagine there are very few who——

Senator MAGNUSON. I will tell you something. Just this afternoon, up to this point we have requests for $1,142,000,000.

Senator CHAFEE. Those aren't all cuts. [Laughter.]

Senator MAGNUSON. No; these are all add-ons. And we have had 147 witnesses so far. This is just this afternoon. $1,143,000,000. That doesn't include the last panel's request for public broadcasting, which is a good request. That testimony was very good.

Senator CHAFEE. I think they are all good. Does anybody come in asking for a cut?

Senator MAGNUSON. Only 1 of the 147 so far asked for a cut, and I understand they came in and wanted a cut in the amount of money used for the fluoridation of water. That is the only one.

Senator MATHIAS. If anybody provides for a renegotiation board, I will ask for a cut.

Senator MAGNUSON. Here are two members with us of the Appropriations Committee too. I don't know what Senator Burdick will ask for.

Senator BURDICK. Very nominal.

Senator CHAFEE. I will make this brief.

SUPPORT FOR PREVENTIVE MEDICINE

I am a strong believer in preventive medicine. Spending money to keep healthy. The Surgeon General put out a really extraordinary report, which Joe Califano sent on, that deals with what can be achieved through various efforts to keep people healthy. The basic rules are very simple. They all have to do with attempting to change the lifestyle of American citizens. Eat less. Get more exercise. Don't smoke cigarettes. Watch the diet. Do very simple things. What seems to me to be out of bounds is we spend so little on this so-called preventive medicine, and so much on the very, very sophisticated research that someday might find a possible cure for cancer, for example. But meanwhile, we can perhaps keep people from dying of cancer, if we just follow and publicize these simple rules.

Results have already been achieved in extraordinary fashion. Through the efforts that have been made, we've extended lives in the United States through reduction in heart disease.

So last year we passed an authorization for elementary and secondary education amendments which gave grants to local schools and State public education agencies to enact comprehensive health programs, so that they can teach the youngsters these things. A great program—but it was never funded.

I am here not requesting billions. I am here for $5 million. And the money would be used for the local programs. This is the way it would be used: You go to the Department of Education to award grants to 30 local education agencies and to 15 State agencies to work out a decent health program to teach in the schools. I might just suggest where you could get the money, where the money is. I think some of these research programs could be cut, because you will save a lot more lives by keeping people healthy than by doing their research.

EARMARKING FUNDS FOR PREVENTION

Senator MAGNUSON. We could take it out or direct one of the health institutes, take cancer for example—we could require that a portion of their money be directed to education programs. Or with diabetes funds for instance. I never realized that is so prevalent in kids. Then we have the Center for Disease Control. Immunization programs, things of that kind. We on the committee—Senator Burdick will tell you about it too—we tried to shift all this money. We started out, as you know—I helped create this——

Senator CHAFEE. John Fogarty worked with you.

Senator MAGNUSON. Right; we started out with just customers and found out we weren't paying enough attention to prevention activities. It's been the most difficult job to get HEW and Education—I hope the new department will do something about it—to start school health education programs.

Senator CHAFEE. They have the authority but don't have the money.

Senator MAGNUSON. They have the money. As you pointed out, they can take some of the vast amount of money they have to do it. Disease control is a special item. It deals mainly with immunization.

Senator CHAFEE. That is part of it. A lot of it is education. Making them aware if they watch their weight——

Senator MAGNUSON. We have a little money for nutrition education, which is good. But we haven't done enough.

Senator CHAFEE. Well, I will quit while I am ahead. [Laughter.]

This would go to the DOE, Department of Education—it wouldn't be DOE. We have two of them?

Senator MAGNUSON. I guess so. Department of Energy and Department of Education.

Senator CHAFEE. DOED.

Senator MAGNUSON. Thank you.

[The statement follows:]

STATEMENT OF SENATOR JOHN H. CHAFEE

I am pleased to be here today to encourage this Committee to take a close look at funding for health education and other health promotion and disease prevention programs, and specifically to request an appropriation of $5 million to support projects designed to establish and support comprehensive health education in elementary and secondary schools.

I would like to make a few simple points:

One, the people of this country spend almost $200 billion a year on health care, primarily to treat and cure disease and illness.

Two, a great majority of the health problems which are responsible for these expenditures could be prevented, through actions within the control of each individual. It has been estimated that as much as half the deaths in this country are due to unhealthy behavior or lifestyles.

Three, health education and promotion of healthy behavior is the key to the prevention of many of the illnesses which cause premature death and disability today.

There is no doubt about the growing concensus that prevention of today's health problems is not only possible, but is essential if we are to improve the health of Americans. Despite this concensus, however, the Federal government spends less than 4% of its total health budget on health promotion and disease prevention.

An encouraging sign of progress is the release of the first Surgeon General's Report on Health Promotion and Disease Prevention entitled Healthy People. I would like to quote Secretary Califano at the time this report was released:

> "Let us make no mistake about the purpose of this, the First Surgeon Generals Report on Health Promotion

and Disease Prevention. Its purpose is to encourage a second public health revolution in the history of the United States."

Mr. Chairman, I am thankful for the small increases which were included in the budget for health promotion and disease prevention programs for Fiscal Year 1981, particularly in view of the fiscal crisis we are facing today. However, I must say that the levels requested by the President suggest something less than a "revolution" and I believe a close examination of the budget would allow some reallocation of resources for this purpose, without increasing the overall budget.

If we are truly to encourage a revolution, health education in the public schools is the first place to start. However, the President's budget contains no funding for Section 301, Title III, Part I of Public Law 95-561 -- the Elementary and Secondary Education Act Amendments of 1978, which provides grants to local and state education agencies to support programs of comprehensive health education in elementary and secondary schools. As one of the background papers prepared for the Surgeon General's report, Healthy People, stated, "Health education in the school is especially important because both lifelong behavior patterns and development of chronic disease have their roots in childhood."

This is a very small amount considering the overall health and education budgets, and I suggest that the Committee consider reallocating this amount from other health programs. While I recognize the need for an adequate health research capability, it makes no sense to ignore the knowledge we have already acquired. A few million dollars could be taken from the health research budget with no detrimental affect on research.

I also note that the health budget contains a great deal more than this amount for buildings and facilities alone, for example $7 million in the Health Services Administration's Budget, $30 million for the Center for Disease Control and almost $12 million at the National Institutes of Health. I question whether bricks and mortar should be a greater priority than health education. The budget also calls for significant increases in alcohol, drug abuse, and mental health research and programs. I believe that some of this money could be put to good use in school health education, and other health promotion activities, and have a measurable impact on these same problems.

Other programs which I hope the Committee will consider favorably include the activities of the Office of Health Promotion and Disease Prevention, and the Prevention Formula Grants Program authorized in 1978 to provide grants to States for health promotion and disease prevention activities.

Mr. chairman, I am not asking for an increase in overall Federal spending in health and education, but I do believe it time we reevaluated our priorities and that Federal programs reflected a concept that is widely accepted -- that prevention is not only less costly, but more effective, than cure in improving the health of Americans.

I would like to request that the remainder of my statement, which provides a more detailed explanation and justification for Health Education Special Projects, be inserted into the hearing record.

Thank you.

SPECIAL PROJECTS TO DEVELOP SCHOOL HEALTH EDUCATION PROGRAMS -- ELEMENTARY AND SECONDARY EDUCATION ACT

This program emphasizes "comprehensive school health education" to indicate that effective health education must include more than single-subject programs. One of the problems with Federal activities in this area is that they have developed in a piece-meal fashion.

For example, the Department of Health and Human Resources supports programs for smoking prevention education, with a major target population being school-aged children. The Bureau of Health Education is also awarding grants to State Departments of Health to establish risk reduction programs, and many State Departments have indicated that education programs for public school children will be a component of their programs. The Department of Agriculture supports nutrition education in public schools. In addition to Congressionally mandated programs, the American Lung Association, the American Heart Association, the American Dental Association, the American Dairy Council, the American Cancer Society, Weight Watchers International, and a host of other organizations are developing special interest health education materials and curricula for childre in schools.

State Directors of Health Education -- those responsible to Superintendents of Public Instruction, and professionally prepared school health educators have been overwhelmed with this disorganized approach. These people have been inundated with special interest group requests -- all with good intentions -- seeking access to children through school programs. Many of these health education units and materials prepared outside the schools are not readily adoptable to

school curriculum and structure. Schools need help in modifying these programs developed outside the school for use in the school, tailoring them to the needs of school-aged children, and coordinating and integrating these single-subject programs into comprehensive health education courses. This program would provide the funding to develop models which can be effectively used in public schools.

The proposed regulations state that school health projects develop and strengthen curricula in areas such as smoking and health, nutrition and food, the value of exercise, weight control and obesity, immunization and communicable disease prevention, first aid and cardiopulmonary resuscitation, chronic disease risk factors and prevention, and environmental conditions affecting health.

Five million dollars would allow the Department of Education to award grants to 30 local education agencies averaging approximately $75,000 and to 15 state education agencies averaging $150,000.

NEUROLOGICAL AND COMMUNICATIVE DISORDERS AND STROKE

Mr. COELHO. Thank you. I am testifying on behalf of neurological and communicative disorders and strokes. Your committee last year was largely responsible for the increased appropriations for NINCDS, and I want to express my personal thanks to you for the effort of the committee last year. My particular concern is the continuation of the research and treatment programs it undertakes, because of my personal involvement as a member of the implementation task force for the Commission on the Control of Epilepsy and Its Consequences and my involvement on that task force.

EPILEPSY RESEARCH

As I indicated to you last year, my personal reason is that I am an epileptic and I understand and appreciate some of the problems of the epileptics. My concern is that proper attention be devoted to this particular disorder.

My personal experience with epilepsy has heightened my awareness

of the tremendous good which has been done and that which remains to be done through Federal support for research into the causes and cures not just of epilepsy, but also of the many neurological and communicative disorders, such as Huntington's disease, stroke, and even Joseph's disease.

JOSEPH'S DISEASE

I am sure you probably have not heard of Joseph's disease. Its a little-known cerebral disorder which occurs exclusively among the Portuguese people of Azorian descent. In your particular State of Washington, and mine of California, also in Arizona, New York, and Illinois and several others, there are a lot of Azorians and they have this particular disorder. Joseph's disease has been only identified recently.

There are no Federal funds in this. The research is done mainly by private funds now. I hope that those who have Joseph's disease may some day benefit from the basic research that is being done in NINCDS.

NINCDS BUDGET REQUEST

For the coming fiscal year the President is requesting for the National Institute a total funding figure of $249.8 million, just $7.8 million over the amount that you got for us last year. The President's request is not enough to even cover inflation which is generally running with medical research about 14.5 percent.

In order to cover inflation, NINCDS would need an additional $35 million for their next fiscal year. The President's request isn't even adequate to maintain our research training efforts which are vital, as you well know, and which must be maintained if we are to be able to assure quality research. The funding figure I support is $285 million or $43 million more than last year's figure. This figure is supported by the Epilepsy Foundation of America and by the consortium concerned with developmentally disabled.

I understand you heard from the Epilepsy Foundation this morning. I would like to point out for the record that I endorse the funding recommendations made by the Epilepsy Foundation for rehabilitative programs, but I am focusing my statements this afternoon on NINCDS. The bulk of the $43 million I discussed is to allow the Institute to keep pace with inflation, to sustain current research activities and to maintain current research training programs. The remaining $8 million is to allow the Institute to move forward on special projects and initiatives which have been identified by the Epilepsy Foundation and other commissions concerned with neurological diseases and disorders.

With your committee's help last year, Mr. Chairman, and I particularly want to stress this with you, we got enough money in there to go ahead with the sixth comprehensive epilepsy center. NINCDS notified me Monday of this week that the proposals for that center have been received and they hope to make an award on the sixth center by June 1. I think that is a move in the right direction and your help last year is what helped us, and I appreciate what you have done for us. I know we face a very tight year economically and our budget priorities must be reviewed with a great deal of care. We need to support medical re-

search and need to insure our supply of trained researchers if we are to sustain our efforts at prevention and treatment, so that few of our citizens will become incapacitated because of disease, injury, or neurological disorders. Such incapacitation is a drain on our economy and the taxpayers in terms of loss of productivity and dependency on welfare programs for support.

I am convinced the dollars we spend on research and treatment are well spent. They are an investment in our future, investment in productivity and the dignity and well-being of our people.

Again I want to stress my appreciation for the money you got us last year. As one who has epilepsy and is willing to discuss it and talk about it, it's important that people like you understand these particular concerns and are willing to help out in areas of this type.

Senator MAGNUSON. Thank you. We will look at it.

[The statement follows:]

STATEMENT OF REPRESENTATIVE TONY COELHO

MR. CHAIRMAN, thank you for allowing me to come before you today to express my support for an increase in funding for the coming fiscal year for the National Institute of Neurological and Communicative Disorders and Stroke, which I will hereafter refer to as NINCDS. My remarks will be brief.

Your committee's effort last year was largely responsible for the increased appropriation NINCDS was granted for the current fiscal year, and I would like to express my personal appreciation for that effort. My particular concern about the mission of NINCDS and my support for the continuation of the research and treatment programs it undertakes stem from my personal involvement as a member of the Implementation Task Force of the Commission on the Control of Epilepsy and Its Consequences; and my involvement on that Task Force, Mr. Chairman, stems from the fact that I have epilepsy. My personal experience with epilepsy has heightened my awareness of the tremendous good which has been done and that which remains to be done through federal support for research into the causes and control not just of epilepsy, but of so very many neurological and communicative disorders such as Huntington's Disease, autism, stroke, or even Joseph's Disease--a little known cerebral disorder which almost exclusively affects Portuguese persons of Azorean ancestry. This disorder is of particular concern to Portuguese Americans in my district in California and in the States of Washington, Arizona, New York, Illinois, Connecticut, Oregon, Florida, Minnesota, Ohio, and New Jersey. I have learned that the very limited research which is being done in an effort to learn the cause of and to identify an effective treatment for this disorder is currently supported by private funds, but I hope those who have Joseph's Disease may one day benefit from the basic neurological research being done at NINCDS.

For the coming fiscal year, the President is requesting for NINCDS a total funding figure of $249.8 million, just $7.8 million over the amount approved last year. The President's request is not enough to cover inflation which is generally running at 14.5% for medical research, and which means that just to keep even with inflation, NINCDS needs an additional $35 million for Fiscal Year 1981. Nor is the President's request adequate to maintain our research training efforts which are vital and which must be maintained if we are to assure <u>quality</u> research.

The funding figure I support is $285 million--or $43 million more than last year's figure. This figure is supported also by the Epilepsy Foundation of America and by the Consortium Concerned with the Developmentally Disabled. I understand that you received testimony this morning from a representative of the Epilepsy Foundation focusing on funding for rehabilitative programs such as those authorized under the Rehabilitation Act as well as education, developmental disabilities, employment, and mental health programs. I would like to point out for the record, Mr. Chairman, that I endorse the funding recommendations made by the Epilepsy Foundation for rehabilitative programs, but I am focusing my statement this afternoon on NINCDS.

Again, the bulk of the $43 million increase I endorse for NINCDS is to allow the Institute to keep pace with inflation, to sustain current research activities, and to maintain current research training programs; and the remaining $8 million is to allow the Institute to move forward on special projects and initiatives which have been identified by the Epilepsy Commission and other commissions concerned with neurological diseases and disorders.

With your committee's fine assistance, Mr. Chairman, monies were approved last year for a sixth Comprehensive Epilepsy Center, and I am pleased to advise that NINCDS officials reported to me on Monday of this week that proposals for this Center have been received and are now under review. It is expected, I am advised, that an award for the Center will be announced by June 1.

I know that we face a very tight year economically and our budget priorities must be reviewed with a great deal of care. We need to support medical research and we need to insure our supply of trained researchers if we are to sustain our efforts at prevention and treatment so that fewer of our citizens will become incapacitated because of disease, injury or neurological disorders. Such incapacitation is a drain on our economy and on the taxpayers in terms of lost productivity and dependency on welfare programs for support. I am convinced that the dollars we spend on research and treatment are well-spent; they are an investment in our future--an investment in the productivity, the dignity, and the well-being of all of society.

Mr. Chairman, thank you for this opportunity to appear.

SCHOOL CONSTRUCTION FUNDS

Senator BURDICK. Mr. Chairman, I have a very meritorious case. I am here on behalf of a school district composed of Indians, but it is not on a reservation. They wanted to come and testify but didn't have any money, so they gave me testimony to submit to you which I am now so doing. I ask consent to put their letters in the record if I may.

This district has no tax base, a high Indian population, and gets no BIA construction funds. At the present time classes are held in six separate buildings, one condemned 25 years ago. I have a series of pictures here that will make you cry. One is a high school building that is known as the Butler Building. That is a steel building. That is their school. Those are just for the file, not the record. We had temperatures out there in Western North Dakota of 27 to 35 degrees below 0. The high school is on the priority list for section 815 funding. We are asking you give consideration to $80 million in the education budget for impact aid construction. I ask that you to give consideration to the attached testimony.

Senator MAGNUSON. There is $80 million in the budget.

Senator BURDICK. I want to make sure it stays there. [Laughter.]

[The statement follows:]

Statement of Senator Quentin N. Burdick

I am here to present testimony on behalf of several North Dakota constituents in support of the President's recommendations in the Department of Education budget for Impact Aid construction. $80 million has been requested for fiscal 1981.

My constituents had wanted to come to Washington to testify in person. The cost of such a trip was prohibitive for this poor, rural school district, however, and so I offered to present their testimony for them.

The testimony is from a school district comprised primarily of Indian land. Thus, the district has no tax base. The district has a high Indian population, but it is not a reservation. Thus, it gets no BIA construction funds. At the present time, classes are held in six separate buildings, one of which was condemned 25 years ago. Recently, when the temperature outside was -27, they could not get one of the buildings any warmer than 56 degrees, but they held classes anyway.

This school is high on the priority list for 815 funding. If the $80 million is approved, they will get their school in fiscal 1981. I submit the attached letters as testimony on their behalf, and I hope my colleagues on this subcommittee will give their needs most sympathetic consideration.

Thank you.

LETTERS FROM EIGHT MILE PUBLIC SCHOOL DISTRICT NO. 6, TRENTON, N. DAK.

February 28, 1980

Senator Quentin Burdick
Senate Office Building
Washington, D.C.

MAR 0 6 1980

Dear Senator Burdick:

Testimony in this letter is of urgent importance. We have no alternative course of action other than the federal government to solve the serious educational problem the Trenton community now faces. Without 874 Impact Aid funds, our school would have to cut about ten teachers. I am sure you are aware that we need 874 payments to help run our school.

The most desperate need right now is for a new addition to our present building that is very inadequate for the number of students we have. As I explained before and I will explain again, we need help and we need it now. Under the Public Law 815 in the President's budget, the Trenton School would receive funding to make this become a reality, but we need your support to fund this type of project. Public Law 815 has been very inadequstely funded in the past. I know we are not the only school suffering under these hardship conditions, but certainly Congress must know and should be informed

of the seriousness of inadequate facilities, energy costs, and the importance of educating Indian children equal to the standards of white children.

As an educational leader I would like for you to tell me how to accomplish this without adequate facilities. The present high school building has already been condemned by the state fire marshall. A man from the Denver office of 815 made an on-site visit two years ago and told me to have the school board condemn the building, which they did.

With the high cost of construction and because our tax base is so low, we could not even raise enough to pay the architect's fees. A steady increase in the Indian population of Trenton is making a serious problem much worse.

Our school population is on a very fast growth rate at the present time. In the next three years the problem is going to be much worse. The reasons are that approximately 80 new homes have been built in the town of Trenton itself, Impact of the Fort Union being restored and more federal employees will be employed at this facility, and young farmers are staying in farming the irrigated land. Also in our area we have an oil and coal boom going on, and we do have some families who are living in our community as a result of this. All of this has led to and will lead to worse crowded conditions than we already have.

At the present time we are holding school in six different buildings and just getting by. We have children attending a school which was condemned about 25 years ago. The 7th and 8th grades are in an old teacherage converted to a classroom. We are using a 14 x 70 trailer house. We are busing quite a few special education students to Williston. We have built three different additions for our present school.

Within five to seven years our school population will double in size, so instead of looking at 200-225 students, we are going to be dealing with 350-450 students. Because of the government land in our district and no evaluation because of it, our borrowing capacity from the State School Construction Fund is limited to about $200,000.00. The school we will need in five to seven years is a building that will adequately provide the children in this community an education equal to that in other communities. In order to do this, we have to have new facilities, and the costs are going up rapidly each year. Costs have more than doubled in the last five years from our original request. Our present school is just too small for 200 students. Just think of the problem if something is not done soon to help us when we reach the 400 student mark.

Our town and farming community are growing rapidly and will continue to grow. More Indian housing is planned for the community, and this is creating the biggest problem now as far as being able to handle the increase in students. Because of the vast amount of federal involvement in creating this problem, I feel our school deserves a higher priority for funding under Public Law 815.

In conclusion, in view of the serious energy crisis as far as heating fuel is concerned, our present school system is using 14 furnaces: 6 furnaces in the high school building and gym, 2 furnaces in the elementary building, 2 furnaces in the old elementary school which was condemned for use 25 years ago, 1 furnace for the 7th and 8th grade room, 2 furnaces for the school shop and bus garage, and 1 furnace for the 14 x 70 trailer house. Totaling all these utility and gas bills for operating these buildings, the price was in excess of $40,000 this past year. It will probably double this school year if prices continue to go up as they are predicted.

By building a new school that is well insulated and converting to coal heat, it will heat the whole building. This will save on energy and on the school budget. Many other aspects of the education program are needed, but the energy one is the problem giving us the most financial problems right now.

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If you need any other information, facts or figures, I would be happy to send them to you upon your request.

Sincerely,

Leary G. Getz, Superintendent

February 28, 1980

Senator Quentin R. Burdick
Unites States Senate
Committee on the Judiciary
Washington, D.C. 20510

Re: Trenton Eight Mile School District #6 Building Fund Request
P.L. 815

MAR 06 1980

Dear Senator Burdick:

This township has expressed many times before the concern it has about the local governmental problems presented it by the severe impact of the Department of Housing and Urban Development project in the township. However severe the impact is, the initial need for the units in the first place was and is unsurpassable. This does not surmise the governmental problems caused by growth and positive development. We are sure your offices must be aware of the increased oil activity in our area. This energy development, no matter the impact on the local communities, must be developed in this day of national fuel shortages. We are happy to do our part in this development. We understand this area will have over 100 separate seismograph companies seeking oil and gas in this area. In comparison to former years, this number of seismograph companies represents an increase of 75%. Drilling rigs have increased activities three fold during the past few years. Talk is of drilling test wells to over 30,000 feet seeking out the ever precious fuel source. This is all good, but we cannot forget the impact it is having again on our local governments.

Trenton Township is a unique form of government, perhaps the only grass roots unit in this area so concerned with human rights. To help improve the present conditions for our community, we participated in state government to amend a law to help offset the loss of the ever precious tax base. This government is working to seek out assistance in all areas, which brings to mind the deplorable education facilities our children are required to study under. These facilities amount to a total of five separate buildings, ranging from a trailer house, converted to classrooms, to an unheatable tin butler building incapable of being heated at the minimum 65 degrees on cold days. Children are forced to wear heavy jackets and uncomfortable clothing in a classroom setting, causing disturbances in our ever precious educational process. The school system is completely surrounded by rich school systems separated by elementary areas. This school district has a very low tax base that generates $60,000.00 for a school which is experiencing a rapid enrollment rise of well over 100%. The evaluation of the district is a little over $500,000.00 and a mill levy of 95 creating the tax revenue. The school district encompasses Corp of Engineers lands which has submarginally inundated 20,000 acres of prime irrigably lands; the housing projects are tax exempt as Federal law dictates; and Indian trust lands also remove a substantial amount of land off the tax rolls. With these thoughts in mind, how does a school system grow as the ever present need indicates. The classrooms were designed to hold a maximum of 23 students, however most classes far exceed that requirement two fold. Remodeling has been tried, but have you ever tried to remodel a tin building? The costs are outrageous if you are lucky enough to find a plan that would work. Yes, development is good especially in the area of energy and human rights, but how can you give your total to this great American society with facilities our future leaders are forced to be educated under when the

fault does not lie on anyone but progress itself. We must strongly urge your support and passage of the request for funding by Congress to help us create the facilities our childrens' children will be proud of. Most of all a process of education unsurpassed by no one if the setting is right and it will be right with the passage of the funding request. We have searched high and low and tried to fit in with various agencies as your office is well aware, but to no avail; disheartening denials always prevailed. Finally, Congress itself is our only alternative. Perhaps after 10 years of search, your colleagues and you will find it in your wisdom to grant this once in a lifetime request for a chance to help our children in their most precious American gift, a free education, security for the future.

Sincerely,

Tony Moran, Chairman

Lester Larson, Roadsoverseer

Louis Falcon, Supervisor

CHANGE OF CHAIR

Senator MAGNUSON. Hear, you can hear the next one. [Laughter.]

I have to go. Can you hear the next witness? I hear a lot of witnesses. [Laughter.]

Senator BURDICK. If I get the $80 million, I will hear anything.

Senator MAGNUSON. You can hear this stranger that came in out of the cold here.

Senator MELCHER. There are two items. First is Reye's Syndrome.

Senator MAGNUSON. Wait until the new chairman shows up.

Senator MELCHER. I will make him a cosponsor. [Laughter.]

Senator MAGNUSON. If any more stray Senators come in, you can hear them. [Laughter.]

REYE'S SYNDROME

Senator MELCHER. There are two items. The first is Reye's Syndrome. It's a disease of young people, generally below the age of 20. It's a condition which generally follows a viral disease, after the recovery from chicken pox or measles, and the aftermath results in brain disorder, liver malfunction, and intestinal problems. It quite often develops into a coma. When it does, most of those people die. Of all the people who are diagnosed as having Reye's Syndrome—though there is no reliable data—what data is available shows a mortality rate of 20 to 40 percent. The problem we have is that the syndrome wasn't identified until the last 15 or 18 years. It was first identified in Australia.

Now it's beginning to be recognized in this country. When I say "beginning," I don't want to treat it as brand new, but I am afraid a lot of young people who have Reye's Syndrome are not properly diagnosed. Early diagnosis is the key—the recovery rate is something like 75 to 80 percent. So it's extremely important that we pay more attention to this disease.

On February 28, 1980, I inserted in the Record a rather lengthy statement giving some of the current information that is available on this

disease. I would request that $500,000 in the next fiscal budget be designated and earmarked for a particular study of Reye's Syndrome. It will not be necessary that the total $500,000 be new money, because there is about $150,00 that has been spent during the past 2 or 3 years—maybe $200,000—by NIH on aspects of Rey's Syndrome. We are merely asking for an increase in that amount and some coordination of the research effort. Part of that coordination should be through the Communicable Disease Center in Atlanta with the idea of making it a reportable disease.

BROADENING CANCER RESEARCH

Second, on cancer research—perhaps your hearing this afternoon is not specifically for cancer research, or is it? I understand cancer came up this afternoon.

On cancer research, I would like to draw the committee's attention to the fact that while Congress has appropriated tons of money through the National Cancer Institute for the past several years, the results have been mighty slim. I personally want to draw the committee's attention to my opinion that the peer review system has not been very adequate and has not been successful in awarding or allotting grants through the National Cancer Institute. In reviewing grants that have been awarded during the past several years, it looks like a new form of incest, where if you have a grant during the past several years, you will probably get another grant. It's a sort of repetition, where peers look at each other, I think, with a bit too much of a closed mind. I would like to see it broadened.

One way I would like to see it broadened—though it's not a part of the overall NIH or NCI but is still a function of this committee, the full committee—I would like to see it broadened to include some money, about $10 million, earmarked for the Science and Education Administration in the Department of Agriculture for cancer research. I do that because one of the most profound breakthroughs in cancer has been through the Department of Agriculture. It's not very new. It has been used for years. It's a vaccine to prevent Marek's disease in poultry, which is actually a cancer. It has been successful.

RESEARCH ON ANIMAL CANCERS

I feel that we have not looked adequately, and have not made sufficient funding available for cancer research in naturally occurring cancers in animals. There is a valuable difference in cancer research where cancers are naturally occurring, in that those animals share the same environment that humans share. Whether it's dogs or cats, or to some extent cattle or poultry. They live with us in a natural way, and I feel that this aspect has been neglected by Congress in not adequately funding that type of cancer research.

I have been reading with some interest, though I haven't pursued it sufficiently, on what the future meaning might be of the use of the so-called product interferon. But if interferon proves to inhibit cancer in animals or in man, let me also point out that there is some basic research that shows that chorionic gonadatropin interferes with the de-

velopment of cancer. If that is the case, I would like that pursued through the Science and Education Administration in the Department of Agriculture, and more attention given to that possibility. Chorionic gonadatropin happens to be a hormone that there has been some basic research completed on by the Science and Education Administration. I think they are the most logical group to see whether it's use might interfere with the development of cancers that occur normally in animals. For that reason I suggest $10 million would be well spent.

Senator BURDICK. Now, Mr. Melcher, are you asking for $10 million of earmarking or $10 million added to the request?

Senator MELCHER. If I had my druthers, I would put $10 million into Science and Administration earmarked for that purpose, and reduce NCI by $10 million.

Senator BURDICK. That is a separate appropriation bill. In this bill we have over $1 billion, most of it for research.

Senator MELCHER. In NCI. For NCI, am I correct?

Senator BURDICK. Labor-HEW Subcommittee doesn't appropriate for Agriculture.

Senator MELCHER. The Full Appropriations Committee does.

Senator BURDICK. Yes, but not the Labor-HEW Subcommittee.

Senator MELCHER. I understand that. I bring it up because it will save me another trip.

Senator BURDICK. We thank you for your contribution.

Senator MELCHER. I will also draw it to the attention of Senator Eagleton.

[The following testimony, relevant to topics and programs discussed in public witness testimony on Wednesday afternoon, March 12, 1980, was submitted for the record:]

STATEMENT OF JORDAN U. GUTTERMAN, M.D., PROFESSOR OF MEDICINE, UNIVERSITY OF TEXAS SYSTEM CANCER CENTER, M. D. ANDERSON HOSPITAL AND TUMOR INSTITUTE

MR. CHAIRMAN: I am a professor of medicine at the University of Texas Cancer Center, M.D. Anderson Hospital and Tumor Institute, Houston, Texas. I am a board certified internist and oncologist with sub-specialty certification in Hematology. I have been involved for the last nine years in the clinical and laboratory investigation of immunological and chemotherapeutic agents for the treatment of human cancer. During the last 24 months, I have focused my clinical research on the nontoxic anti-viral and antitumor natural substance, interferon.

Interferon was discovered in 1957 as a natural anti-viral, hormone-like protein that is produced by most human cells. Interferon has been traced back in the evolutionary scale to fish and amphibians. Today, it is believed that interferon is the body's first line of defense against viral infections. Interferon's ability to slow down or stop the growth of cancer cells was discovered in 1962. Over the last 15 years, a tremendous amount of biological and chemical knowledge on interferon has been described in the scientific literature. Interferon has been shown to have potent antitumor effects in a variety of animal tumor models.

Since interferon works primarily in the species of origin, we must use interferon from human sources in order to treat human disease. There are at least three advanced breast cancer, and acute [illegible] in children.

The first study of interferon in cancer patients was carried out by Dr. Hans Strander in Stockholm, Sweden. Strander has shown that a group of 35 young adults with osteogenic sarcoma has had a significant increase in disease-free survival when treated with interferon for 18 months after surgery. Thus, 60% of the patients treated with surgery and interferon were alive and free of disease at five years compared to only 30% of historical control patients treated with surgery alone. At M.D. Anderson we initiated interferon treatment in patients with advanced breast cancer 24 months ago. The initial supply for 6 patients came from the National Cancer Institute. Three of the 6 patients with advanced recurrent breast cancer refractory to conventional treatment achieved a remission with interferon alone. These remissions have lasted up to one year. We treated the patients by a single intramuscular

injection once a day for two months and then three times a week. Through the generosity of a private foundation, we obtained additional quantities of interferon to extend our experience in breast cancer patients as well as in patients with lymphoma and multiple myeloma. Our total experience in these pilot trials is as follows. We have now achieved remissions in 9 of 19 patients with advanced refractory breast cancer. All of these patients had been treated previously with conventional modalities of treatment. Many were pre-terminal and interferon has certainly prolonged life in the responding patients. Five of 11 patients with malignant lymphoma have achieved remissions. Two of these responses were complete and very dramatic. One man who had been treated previously with all forms of chemotherapy was pre-terminal. He has achieved a remarkable complete remission and is now alive and well working in Louisiana almost 2 years later.

Five of 10 patients with multiple myeloma have achieved remission. Three of these responses were in patients refractory to chemotherapy. One remission was complete. Two patients are in remission for greater than 18 months on interferon. Dr. Strander in Sweden has achieved remissions in 4 of 4 patients with previously untreated multiple myeloma. Two of 4 patients had complete remissions that have lasted greater than 2 years. Dr. Merigan has described his experience in malignant lymphoma patients. Dr. Norwood Hill at the Wadley Institute in Dallas has produced his own leucocyte interferon to treat 5 young children with acute leukemia. Temporary remissions have been achieved in 3 patients. Dr. Habif at Columbia has achieved remissions in 1 of 2 breast cancer patients. Injection of interferon directly into tumor has produced regression in three malignant melanoma patients (Carter at Roswell Park) and 3 of 5 patients with breast cancer (Habif). We recently begun to study interferon in more common cancers such as cancer of the prostate, cancer of the colon and cancer of the ovary. We have documented remissions in all three types of patients but we have only treated 15 patients.

These results led the American Cancer Society to appropriate two million dollars in June 1978 to study interferon in patients with breast cancer, multiple myeloma, malignant lymphoma, and malignant melanoma. However, this money will permit the treatment of only 150 patients for 1 - 3 months each. Recently, the ACS appropriated an additional 3.6 million dollars for interferon research. This will allow us to begin evaluation of the other major

forms of cancer such as the three types of lung cancer, colon cancer, prostate cancer, bladder cancer, ovarian cancer, pancreas cancer, childhood cancers, and so forth. We also need money to begin controlled trials to determine if survival can be prolonged in those diseases in which evidence for anti-

primary types of interferon in the body. One is called leucocyte interferon which is produced by white blood cells. A related form of interferon is called lymphoblastoid. Another major type of interferon is called fibroblast which is produced by most of the tissue cells of the body. A third type of interferon is called immune interferon. This interferon is very potent in animals and potentiates the anti-viral and anti-cancer activity of leucocyte and fiberblast interferon. The production of interferon from these cells is a very expensive process. Thus, the amount of interferon available for clinical investigation is extremely limited and expensive. Although chemists are now working to identify the precise chemical structure (amino acid sequence) of pure interferon, until the structure is elucidated, interferon cannot be synthesized. Recent technical breakthroughs on amino acid sequencing as well as in recombinant DNA (cloning) hopefully will lead to a synthetic interferon in 3 to 5 years. Currently, we must rely on production of interferon by white blood cells or by cells in tissue culture. Almost all the world's supply of leucocyte interferon currently comes from the Finnish Red Cross in Helsinki under the director of Dr. Kari Cantell. The interferon used thus far in clinical trials is 0.1% pure. In the last year, at least 10 companies have begun to produce either leucocyte or fibroblast interferon in the United States. This material will soon be ready for clinical use.

There is now evidence that leucocyte interferon has anti-cancer activity in five malignancies. You have just heard of preliminary results in malignant lymphoma in work at Stanford. I will expand on our own experience at M.D. Anderson. We and other clinical investigators have evidence that interferon also has anti-cancer activity in osteogenic sarcoma (bone sarcoma), multiple myeloma (a tumor of the antibody producing cells of the bone marrow), advanced cancer acitivity is already present. But we still need an appropriation of

61 million dollars to develop production of all major types of interferon. We also need 10 million dollars to develop other nontoxic anti-cancer drugs. Currently, the cost per daily infection ranges from $75.00 - $150.00 per day, depending upon the dose used. However, as most patients on interferon do

not need hospitalization, the hospital costs are minimal compared with that required for chemotherpay.

Interferon opens up a new form of cancer treatment which is nontoxic. There is no nausea, no vomiting, no diarrhea, or the other side effects of chemotherapy. In addition, this material prevents viral infections in our patients. This is crucial since the majority of cancer patients die of infections, many of which are viral. As an anti-viral drug only it would be important to develop for cancer patients. We also need to see if interferon could prevent cancer in people at high risk.

There has always been a tremendous reluctance of granting bodies to finance work on the isolation of biological substances in their natural state. In addition, one need only to review the history of the development of a drug like penicillin in which long delays occurred despite the astonishing life-saving effects of this remarkable substance. Other natural substances which have found major roles in the treatment of human disease include insulin and cortisone.

The interferon we are now using is only 0.1% pure. Rapid progress on purification and potential synthesis of the pure interferon is occuring. We are hopeful that eventful use of pure interferon, which could be produced for a small fraction of the current cost, will be more effective than the current interferon. But we cannot wait for production of pure interferon since this may not occur for 2 - 3 years or even longer.

In interferon research we have an unusual situation in which basic research has proceeded far in advance of clinical results. This is unfortunate because preliminary clinical data strongly suggest that interferon can be of great help to patients with cancer. But we cannot administer it properly because there is not enough interferon available. There is no question in my mind that interferon will aid immensely to the therapeutic approach in some cancers. If we can organize the clinical investigation and support it properly, then we could make major progress in cancer treatment. It should be recalled that many millions of dollars of U.S. Federal funds were required to properly develop penicillin for clinical use.

Mr. Chairman, you and the members of the U.S. Senate have an opportunity that could eventually save the lives of hundreds of thousands of people in the U.S. and all over the world. Let us not waste any more time with this effort. The 385,000 patients who die every year cannot wait any longer for more progress. This natural nontoxic compound is active. Clinical research with interferon should open the door to the development of other natural nontoxic regulations of cancer growth.

Mr. Chairman, we urge you to appropriate the necessary funds to allow us to manufacture additional quantities of this novel nontoxic substance which appears to act totally different from conventional modalities of cancer treatment. Last year I testified on the antitumor effects of interferon. Although the Senate appropriated up to 39 million dollars for interferon, no material is yet available for clinical testing. We need your help in moving us toward our goals for successful treatment of cancer with nontoxic drugs.

I might add, Mr. Chairman, that practically all interferon work on patients is done at cancer centers. If and when interferon joins surgery, radiation and chemotherapy as a heavy weapon against cancer, then centers will do much of the educational work with physicians in related hospitals to spread the benefits of interferon. The trouble is that centers do not get enough money to do this work. This year we expect four cancer center core grants to go entirely unfunded, and centers lucky enough to receive funds will get only a portion of their peer review approved budgets. The Congress has given centers big responsibilities under the National Cancer Law, but centers need money to carry out these responsibilities.

I recommend that the Committee direct the National Cancer Institute to follow the recommendations of the peer review system in fiscal 1981 and fully fund all cancer center core grants at their approved levels--if need be, taking the money from the cancer control account. This is in line with a recommendation of the National Cancer Advisory Board. The two major cancer organizations in this country, the American Cancer Society and the Association of American Cancer Institutes, have endorsed this point of view.

Thank you.

PROPOSAL FOR THE CLINICAL EVALUATION OF INTERFERON

1. Which types of interferons should be tested now?

   Leucocyte
   Fibroblast
   Lymphoblastoid
   Immune

2. What are the estimated costs per million units for each type of interferon as of December 15, 1979?

Leucocyte	$20.00
Fibroblast	$50.00
Lymphoblastoid	$70.00
Immune	$50.00

3. What types of studies should be conducted?

   A. Efficacy studies (Phase II) with 4 types of interferon in the 15 major cancers.

   B. Controlled trials with leucocyte interferon in the four cancers in which antitumor efficacy has been demonstrated (breast cancer, multiple myeloma, non-Hodgkin's lymphoma, and osteogenic sarcoma).

4. How many total patients ideally should be tested in Phase II efficacy evaluation of the 15 major cancers?

Leucocyte	600
Fibroblast	600
Lymphoblastoid	600
Immune	600

5. How much of each type of interferon will be required for the Phase II efficacy studies?

Leucocyte	298 billion units
Fibroblast	298 billion units
Lymphoblastoid	298 billion units
Immune	298 billion units

6. What will be the cost for the Phase II studies?

Leucocyte	($20/million units)	= $ 5,960,000
Fibroblast	($50/million units)	= $14,900,000
Lymphoblastoid	($70/million units)	= $20,860,000
Immune	($50/million units)	= $14,900,000
	TOTAL	= $56,620,000

7. In addition, how many total patients should be tested with leucocyte interferon in controlled trials?

Breast cancer	75
Multiple myeloma	75
Malignant lymphoma	75
Osteogenic sarcoma	75

8. How much leucocyte interferon will be required for the controlled trials?

225 billion units

9. What will be the cost for the controlled trials?

$4,500,000

10. Summary total cost for Phase II studies and controlled trials:

A.	Phase II studies	
	1. Leucocyte	$ 5,960,000
	2. Fibroblast	$14,900,000
	3. Lymphoblastoid	$20,860,000
	4. Immune	$14,900,000
		$56,620,000
B.	Controlled trials	
	1. Breast cancer	
	2. Multiple myeloma	
	3. Malignant lymphoma	
	4. Osteogenic sarcoma	
		$ 4,500,000
	TOTAL COST	$61,120,000

STATEMENT OF ALVIN M. MAUER, M.D., ST. JUDE'S CHILDREN'S HOSPITAL, MEMPHIS, TENN.

Mr. Chairman, the testimony on the National Cancer Institute you have received in your fiscal 1981 appropriations hearings described research taking place for the most part in cancer centers; comprehensive cancer centers, community cancer centers, and specialized cancer centers, the latter devoted to a particular type, say, lung cancer.

It is important to realize that where the laboratories produce promising research ideas they can immediately probe these ideas, where appropriate, in human beings if the laboratories are in centers.

Most of the centers in the nation, in fact, have staffs devoted to basic, laboratory research on the cell, or on immune systems of the body, or some other fundamental life process, including the relationship between the impact of cancer and the patient's age.

Mr. Chairman, practically all interferon work on patients is done at cancer centers. If and when interferon, today's single most promising anticancer agent, joins surgery, radiation and chemotherapy as a heavy weapon against cancer, then centers will do much of the educational work with physicians and related hospitals to spread the benefits of interferon. The trouble is that centers don't get enough money to do this work. In fiscal 1980, we expect four center core grants to go entirely unfunded and centers lucky enough to get funds will get only a portion of their peer review approved budgets.

The law gives centers big responsibilities. But they need money to carry them out. I recommend that the Committee direct the National Cancer Institute to follow the recommendations of the peer review system in fiscal 1981 and fully fund all center core grants at their approved level, if need be, taking the money from the cancer control account. This is in line with a recommendation of the National Cancer Advisory Board.

To see how cancer centers carry out their statutory mandate, one could examine a study of the aging of the cell where experimentation on aged laboratory animals might take place. As you know, the processes of aging might be scanned within three or four years, maybe 10 to 15 years in certain species, so that we get important insights that would take 60 to 90 years in humans.

Once the laboratories produce the ideas which seem workable, other scien-

tist cadres in the centers can apply the knowledge to human patients. Sometimes a patient responds only after two or three different regimens are tried. But, in any case, patients in centers are the first patients to benefit from new ideas and new therapies.

The key factor in research in this entire center picture is the close intimacy of laboratory and clinical research with patient care; for the emotional stimulus to laboratory workers who see their ideas helping people; and from the feedback which physicians can give to the laboratories. Feedback can include comment on where therapy failed; or fast, full and meaningful evaluations of new drugs, new equipment, new procedures. One often sees a PhD specialist making rounds in a center with a physician where the PhD actually knows the chemistry of what is happening in the patient's body better than the physician. The physician, of course, is in charge of the patient and knows what that patient can stand in the way of toxicity and is better trained to measure the whole well-being of the patient.

Now that research has made it possible to save 30 to 40 percent of all cancer patients, we realize that the new technologies are vastly understaffed. We don't have enough people to do the important new things that help patients. Unfortunately, there is reason to believe that maybe only 75% of all patients in all types of care situations are getting the best that science can offer.

To remedy this situation, we are training people at most of the nation's 85 cancer centers and, again, what better place to train someone than where laboratory work and patient care take place together? There we have the emotional, the technical, and the administrative milieu in which to achieve real progress.

Since cancer research results from the National Cancer Plan can hardly have been decisive after only eight years of work--it takes up to 14 years just to evaluate in beagles whether birth control pills cause cancer--one would not expect yet to find a vast change in training. But we now have a survey which shows the following:

Among nurse oncologists, nurses who know the special needs of cancer patients, there has been an increase from 200 nurse oncologists in 1975 to 1,700 in 1979. Part of that is related to the formation of the Oncology Nurses Society, a development that took place since the advent of the National Cancer Plan.

In the medical oncologist category, the specialty physicians who know the best drug regimens, how to treat old people, there are 1,130 now, and in the pipe-

line enough to total 1,846 in 1980 and 3,165 in 1985. Gynecologic oncologists now number only 144, but those in training will change that total to 239 this year and 432 by 1985, a boost of 200%. Pediatric hematologist-oncologists now number 424 and there will be a 230% increase by 1985. Specialist surgical oncologists now number 1,220 and there will be 1,992, or 63% more by 1985.

One of the good things this means is that these specialties are being trained mostly in centers, exactly where the world's most advanced care procedures are being used. In contrast to many other students under academic training, these students graduate with the latest available knowledge, not outdated text-book information that must be followed by on-the-job training.

The National Cancer Institute is investing this year, some $10 million in schools of medicine, dentistry, osteopathy, and public health. Major hospitals affiliated with medical schools and specialized cancer institutions are training the physicians, dentists, and other care personnel at all skill levels needed for cancer detection, diagnosis, treatment, and rehabilitation. This is the heart of the nation's cancer manpower education program and it offers the medical students and would-be specialists the opportunity to choose cancer as a field of concentration.

Training focused directly on producing such researchers as have testified before you in these hearings, is budgeted at about $38 million by the President. With the kinds of results we are getting, my own judgment is that cancer centers and other institutions could easily absorb another $10 million in National Cancer Institute training and career awards. The record should show the need is urgent.

Most clinical trials of new therpaies are performed more in cancer centers than elsewhere in the medical care delivery system because the centers have a large enough flow of patients to select those needed in various categories to make the final statistical outcomes meaningful and comparable from one place to another. And if one trial proves successful, the immediate follow-up is duplication of that trial elsewhere by others, reducing possible personal bias, reducing possible chance factors' influence over outcomes. In an NCI-supported prostatic cancer study, there are 11 institutions at work. They talk each other's language. They are already standardized in their approaches by past cooperation. If we didn't have cancer centers now, we would have to embark on an immense effort to set up standardized treatment facilities so that these clinical trials could take place

productively. Even if a type of cancer is rare, so that no one center can be expected to come across sufficient numbers of patients with that cancer to make meaningful statements on therapeutic outcome comparisons, one treatment against another, still protocols can be developed so that many centers can pool information, making findings that no one center could make.

Mr. Chairman, cancer centers have been moving strongly into direct community work of exactly the sort recommended in every major cancer planning document since at least 1945. Here are some examples:

In the past five years, this UCLA center has built on the historical program of the American College of Surgeons' Commission on Cancer to help Southern California hospitals gain approval according to the College's carefully worked-out standards of what constitutes an adequate cancer program at a community hospital. When the University of Southern California Comprehensive Cancer Center began this work, only 30 hospitals in the area had approved programs. Last year, the total exceeded 70, and the work goes on. The center effort began with NCI seed money, won an implementation grant from NCI, and brings together many resources, both budget-supported and volunteered, to bear on this process of upgrading the care received by cancer patients in the hospitals where, by far, most of them appear first for treatment.

Typical of the way centers mount community aid projects, this UCLA program employs, usually fulltime, one or two center staff persons. But numerous institutions are involved in administering this upgrading effort.

As an example, the program has trained approximately 120 medical secretaries, nurses, and others in the operation of a tumor registry. It is from tumor registries that the nation learns facts about cancer incidence, treatment outcomes, adherence to standards, and much of the epidemiological data that gives direction to cancer detection and therapy programs.

The work of training has become so demanding that the center has needed to help East Los Angeles College to institute a two-year training program for preparing tumor registry personnel. Center administrators note that such training programs in various parts of the country are gradually producing sufficient practitioners so that an emerging occupational title is being identified with all the benefits that go with standardization of duties, easy transfer of skills, and appropriate development and validation of curricula.

At the Southern California center, a panel of specialists meets once a week to answer questions posed by practitioners who need special advice. The practitioners can present slides, pathology material, x-rays, or other diagnostic data to the consultants who aid in diagnosis, prescribe treatment, and who stand ready to assist with problems that arise in the couse treatment. The historical problem of jurisdiction over the patient, (who gets paid?) is solved by this center with a policy of leaving that entirely to the practitioner who seeks consultation. If he or she wants to turn the patient over to a consultant, appropriate arrangements can be made. If not, the consultant continues transfer of technology, the latest proven regimens, and the all-important diagnosis expertise while the patient remains in a community hospital or other facility selected by his personal physician. This technology transfer, consultation, and advice are provided by the panel without charge. Those on the panel serve without compensation. This pattern is duplicated in many respects by other cancer centers in the U.S.

In another educational activity, the Fred Hutchinson Cancer Research Center in Seattle administered an eight-week biology of cancer course designed to help both nonspecialist physicians and laymen. Family practice doctors were provided with information on carcinogenesis. Laymen were given rudiments of cancer biology to assist in their understanding of cancer facts and with the possibility that some of those attending the course will choose an occupation useful in cancer control or therapy. A number of young people attended and are expected to seek careers in oncology nursing or some other occupation such as those under training in Southern California programs already described.

Also, at the comprehensive cancer center in Seattle, a two-day course on oncolcgy nursing brought participants from throughout the State of Washington and from Montana, Idaho, Alaska, and Oregon. So great is the momentum of the cancer program, the new hope for success in treatment, and the acceptance by health care practitioners of the special burdens demanded by treatment of the second most important cause of death, that this course had 250 registrants before it was formally advertised.

Mr. Chairman, the Association of American Cancer Institutes recommends the "Bypass Budget" of $1.17 billion for the National Cancer Institute in fiscal 1981;

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the budget which went, under the law, directly from the National Cancer Institute to the President without being reduced by upper administrative levels in the Department of Health & Human Services. We recommend this budget because it represents the best thinking of the National Cancer Advisory Board, the National Cancer Institute staff, and the officers of our association. It is only slightly above a simple cost of living increase, which would be $1.135 billion.

Mr. Chairman, our association is in full agreement with you and other congressional leaders that the country this moment is in an economic crisis. That is not sensational talk, we agree with you--but a measured view of what is happening to our savings, our insurance, our bills for heating and other essentials. We know that past nations have foundered on the rocks of economic crisis.

It is not without consideration of this crisis that we submit a request for an NCI appropriation increase.

Rather, it is our calculation that for every $1.00 appropriated for NCI, a sum of $1.90 is returned to the U.S. Treasury in the form of personal income taxes paid by the persons whose lives have been extended by cancer therapy. (A table with the calculation is attached). Other forms of tax contribution by cancer survivors must be great, but have not been calculated.

These returns will certainly suffer if the National Cancer Program hesitates of falters as it must if momentum is not maintained. Thus, cutting the NCI appropriation could contribute to inflation, rather than fight it.

If it is argued that such small sums added to the Treasury are insignificant when one is seeking desperately to balance the budget, and when discretionary programs in the budget are forced to take an undue share of the cuts, then one must also recognize that the entire biomedical research budget of this nation is a tiny portion of the overall federal budget, $4.8 billion (NIH and Alcohol, Drug Abuse and Mental Health Administration) out of a total fiscal 1981 budget of $696 billion, or 0.69%.

In our justified haste to fight inflation, and this association has sufficient institutional managers daily involved in financial problems so that inflation is of extreme urgency to us, we must not fall into overenergetic, wrongly directed budget action which, in fact, will reduce national productivity, waste past investment, do damage to our institutions and our human resources.

Mr. Chairman, we feel this is a responsible budget. We feel it is entirely

in keeping with national objectives, not just the narrow objectives of the estab-
-lished biomedical research community.

One reason that we advocate this budget is that it would make approximately $90 million available for cancer center core grants. The original $66.4 million core grant allocation in fiscal 1980 proved too small so that years of investment in several centers ended with a cutoff of core grant funds, certainly damaging. Other peer review-recommended budget amounts were decreased for centers which did get grants. This is true institutional damage and disruptive. We strongly recommend to this Committee that report language direct the NCI to use as much of this $90 million as is necessary to fully fund at peer reviewed levels the core grants to all applicants receiving peer review approval.

Association of American Cancer Institutes
Proposed Fiscal 1981 Appropriations for National Cancer Institute

	Millions of Dollars	
	President's January Budget*	A.A.C.I. Proposed Budget*
Activity		
Research		
Cause & Prevention	$313	$343
Detection & Diagnosis	58	68
Treatment	318	364
Biology	143	165
Total Research	(833)	(939)
Resource Development		
Cancer Centers	68	85
Manpower	38	49
Construction	4	26
Total Resources	(110)	(160)
Cancer Control	65	70
TOTAL	$1,008	$1,170

*Rounded

STATEMENT OF ROBERT A. GEORGINE, PRESIDENT, BUILDING AND CONSTRUCTION TRADES DEPARTMENT, AFL-CIO

The Building and Construction Trades Deparment, AFL-CIO,, strongly urges the Appropriations Subcommittee to recommend the appropriation of the full FY 1981 budget request by the Occupational Safety and Health Administration. The amount of appropriation requested represents only a modest increase of at least this magnitude will be necessary for the agency to effectively carry out the purposes of the Occupational Safety and Health Act of 1970. A brief summary of the reasons for our support for upgrading OSHA's performance follows:

1. OSHA enforcement of its safety and health regulations is lagging badly because of an inadequate number of compliance officers. There is a critical shortage of safety officers in hazardous industries, such as construction, longshoring, grain storage and foundries. We fully support the recommendations of the OSHA task force on construction, including: improvement of the training program for OSHA construction inspections, and expedited issuance of citations for alleged violations that present an imminent danger.

2. American workers desperately need the further development of OSHA's "New Directions" compliance assistance program, which provides grants to organizations such as labor unions, employer associations and educational institutions to aid them in developing a capability for providing safety and health training and technical assistance to workers and employers. An educated work force and management will ensure the most effective compliance with the Occupational Safety and Health Act of 1970.

3. The basis of any effective regulatory policy is a reliable and accessible body of current information on which to base enforcement decisions. We believe that OSHA's data management capability must be upgraded and that a modern system capable of providing the data needed for planning and coordination could significantly improve OSHA's inspection and enforcement resources.

In establishing the Occupational Safety and Health Administration, Congress intended that the federal and state governments would set strict safety and health standards to control workplace hazards - and would impose stiff penalties on employers who failed to comply. Since then, the intentions of the OSHA Act have been systematically broken. In a spirit contrary to the original legislation, Congress, the courts, and the White House have all worked to tie OSHA's hands. The same business interests who have worked to cripple the agency now cite OSHA's lack of success as an argument for cutting it back even further.

The law was designed, in part, to cut the economic costs of job hazards. The direct cost to the economy of workplace injuries alone is more than $21 billion per year. For every dollar industry spends to meet OSHA standards, the public spends $11 to $15 for occupationally related medical costs. Ten times more work days are lost each year because of injuries than because of strikes. Under the OSHA law, the cost of providing safety and health on the job was supposed to finally be recognized as a normal cost of doing business in America, a cost to be borne by employers rather than by workers.

In 1977, it appeared that OSHA's effectiveness might be improved as President Carter appointed sincere, qualified professionals to direct the agency. But while the agency has cut away at red tape and succeeded in developing new health standards to protect cotton mill workers from "brown lung" disease, and other workers from benzene, arsenic and lead, employers have stepped up their attack. OSHA's budget has been held to less than 3 cents per worker - so that spending for prevention of hazards is less than 2 percent of the cost of workers compensation payments alone.

Responding to industry requests, some administration officials have begun to regularly second-guess the OSHA experts, forcing a severe weakening of some regulations. No OSHA health standards for toxic substances have been issued since November 1978. Even more important to construction workers is the fact that a standard to control workplace noise which was first drafted six years ago has still not been put into effect.

To ensure that the employer efforts to weaken OSHA are not successful, and to guarantee that all workers receive adequate protection under the law, the Building Trades Department feels that OSHA must be strengthened. Needed inspectors should be hired, standards developed, and training programs to help workers and employers plan a more active role in controlling hazards supported. The first step in strengthening the agency is to increase its appropriation for FY 1981. We are particularly concerned that the following OSHA program areas receive increased funding:

1. Enforcement

We believe that OSHA enforcement is weak because of the inadequate number of compliance officers. OSHA currently employs 1,522 inspectors and industrial hygienists who visit only 2 percent of America's workplaces each year. The shortage of inspectors is compounded with regard to the construction industry because few OSHA inspectors have experience in constuction.

Construction has an injury and illness rate that is among the highest for U.S. industries and is 60 percent higher than the national average for all occupations. We are pleased to note that OSHA has agreed to target construction safety problems by, among other steps, appointing 15 compliance officers with extensive experience in construction and offering them last year the first OSHA construction specific training course. The course was developed and taught by the OSHA construction task force with the assistance of the Building Trades Department.

We endorse the recommendations announced last month by the OSHA construction task force, calling for more inspections, particularly of high hazard activities, and for expedited issuance of citations for alleged violations that present an imminent danger. The task force also recommended establishment of a construction division in the Directorate of Federal Compliance Programs, development of a unified reporting system, and assurance that each area and regional office has a staff of compliance personnel with strong construction backgrounds.

The Building Trades Department urges OSHA to adopt these recommendations and asks this Sub-committee to recommend the appropriation of sufficient funds to ensure that these measures are carried out.

2. Training Grants

The number of construction workers killed and injured in the United States during the past several years has been extremely high. Construction workers lost more than 945,000 working days in 1978 as a result of occupational injuries alone. These statistics indicate that construction is one of the nation's most hazardous industries.

One of the prime reasons for the continued loss of human work potential in the construction industry is that appropriate information about safety and health has not been made available to those at the job-site who are in positions to take action to avert the effects of hazards.

OSHA's "New Directions" compliance assistance program attempts to meet this need for information in the workplace by providing grants to unions, employer associations and educational institutions to promote better understanding of their obligations and rights under the law, to foster voluntary compliance, and to stimulate activity to identify and eliminate safety and health hazards in the workplace.

Over the past four years under OSHA grants, the Building Trades Department has developed programs and trained over 500 labor and management members of the construction industry in hazard recognition and control; has participated in the development and modification of standards for the construction industry; has been instrumental in bringing labor and management together for the purpose of safety and health, training and education: has established a resource for construction safety and health information and educational material; and has produced media resources concerned with hazard identification and workplace risk assessment.

We believe that other recipients of OSHA "New Directions" grants have been equally effective in establishing local safety and health educational and technical assistance services. These programs, staffed by an estimated 325 safety specialists across the country, have a unique capacity to reach the millions of workers and employers which these organizations represent. The services range from newsletters, to classroom training, to the identification of specific workplace hazards.

The Building Trades Department supports the small budget increase requested for the "New Directions" grant program. It is our understanding that increased expenditures on education and training through this program, which represents only 6 percent of the agency's estimated budget for FY 1981, would be the most cost effective means of ensuring voluntary compliance with the Act. We are encouraged by OSHA's continued support of this kind of independent training activity, and we hope to see an expansion of the "New Directions" grant program in future years.

3. Management Information System

One further area in which a small budget increment could provide great benefits is that of Management Information Systems.

At present, OSHA has a computerized system to keep track of complaints, inspections, citations, penalties, etc. This is a valuable aid in a number of administrative and program planning tasks -- determining patterns of hazards and violations across industries, occupations and firms, pinpointing particular enforcement priorities monitoring the backlog of complaints, citations, assuring proper follow- up to complaints, citations, penalties, etc.; and generally providing an overall picture of OSHA enforcement activity.

The main problem with this arrangement seems to be one of the timeliness. The information system is presently computerized only at the Washington, D.C. headquarters. Reports must now be prepared by hand in the field and mailed to Washington on a monthly cycle for entry into the system. The result of this is a substantial time lag in reporting, sometimes longer than six weeks. Similarly, there is also a long lag involved when field personnel wish to make inquiries of the system regarding the pattern of hazards, status of complaints, etc.

It is our understanding that, from time to time, there have been proposals made within OSHA to install a system of on-line computer terminals in all areas and regional offices which would allow instantaneous interaction between field personnel and the management information system. The cost of this inovation is estimated at $1.2 million per year. Such a system would allow the continuous updating of the data base, eliminating the current long delays, and generally make the OSHA information system much more useful in targeting and tracking enforcement activity.

Such a network could also provide timely and accurate information on health hazards. The terminal network could easily be hooked into all existing data bases containing information on hazardous substances, etc., and could facilitate the exchange of information among field offices regarding unusual or unexpected problems which may arise. With such a system, a compliance officer faced with an unfamiliar hazardous substance or safety problem could instantly obtain the needed scientific and engineering data as well as information on how best to handle the problem.

In general, some of the most urgent tasks facing OSHA are to use scarce inspection and enforcement resources as efficiently as possible. This means that OSHA must identify the most important health and safety problems and target their resources to deal effectively with these problems. A modern system capable of rapidly providing the data needed for planning and coordination could help greatly in these tasks. For this reason, the Building Trades Department urges the subcommittee to inquire into the status of current Labor Department planning in this area and if appropriate, to seriously consider the addition of the approximate $1.2 million funds needed to implement the national computerized management information system.

4. Elimination of Current Restrictions

The Building Trades Department supports OSHA's proposal to eliminate most of the restrictions included in the appropriations language in 1980. We agree with the assessment that such restrictions cause some workers to be deprived of their full rights under the law and that they violate the principal of the Occupational Safety and Health Act - that every worker should have the right to safe and healthful working conditions. We would oppose any additional restrictions in appropriations language which unfairly eliminates workers in affected employments from the protection of the Act.

5. Conclusion

In brief, the Building Trades Department supports the budget increment requested for the OSHA appropriation for FY 1981. We believe that holding down the OSHA budget would prove to be more inflationary in the long run than substantially expanding it, which is necessary for effective enforcement of the Act. OSHA and the other federal safety and health agencies must be strengthened. Uncooperative employers must be forced to obey the law.

Only changes such as these will make OSHA a more effective tool to save lives. Many in our country - workers and their unions, health professionals, educators, and others - are concerned that the health and safety of workers will deteriorate as a result of budget limitations and employer pressures to weaken the Act.

We believe in our nation's promise to provide safety and health on the job. We think it's time that promise was kept.

STATEMENT OF ROBERT M. KOCH, PRESIDENT, NATIONAL LIMESTONE INSTITUTE, INC.

Purpose

1. To update the Subcommittee on the Mine Safety and Health Administration/ National Limestone Institute relationship.

2. To request inclusion in the FY 1981 Labor-HEW Appropriations Bill of language appearing in the FY 1980 Appropriations Bill as follows:

"Mine Safety and Health Administration

":Provided further, That none of the funds appropriated under this paragraph shall be obligated or expended to carry out section 115 of the Federal Mine Safety and Health Act of 1977 or to carry out that portion of section 104(g)(1) of such Act relating to the enforcement of any training requirement, with respect to shell dredging, or with respect to any sand, gravel, surface stone, surface clay, colloidal phosphate or surface limestone mine."

3. To request, further, that the above language be amended before inclusion in the FY 1981 Bill to delete the word "surface" wherever it appears.

For the record, Mr. Chairman, my name is Robert M. Koch, and I am President of the National Limestone Institute, Incorporated (NLI). NLI represents over 550 producers of limestone throughout the country. Limestone accounts for 74% of the crushed stone produced in this country, with crushed stone accounting for the highest total tonnage in the construction mineral group. There are approximately 3,600 limestone quarries located in 46 states (with about 100 of those being underground operations), and in 1978, these quarries produced over 785 million tons at a value of $2.01 billion. Our members account for more than 60% of the limestone produced in the United States which, in turn, is about 46% of the total crushed stone production, making us the largest aggregate association in the Nation.

Since passage of the Federal Mine Safety and Health Act in 1977, the National Limestone Institute's general philosophy and policy has been, as determined by our members through our Board of Directors, to work as closely as possible in a constructive manner with both MSHA and the Congressional Committees with legislative jurisdiction over MSHA to minimize or eliminate those areas in the law and its regulations that do not contribute to safety and health within our Industry and which have an undue economic impact on our members.
I am happy to say that this policy of ours has been fruitful in many areas, and that we are welcome within the offices of MSHA and those of the Senate and House Committees with jurisdiction over the law.

There have been disagreements as to the efficacy and applicability of various segments of the Act and its administrative regulations, but we are convinced that our policy of consultation and education, rather than confrontation, will continue to obtain the realistic and beneficial governmental role in the regulation of health and safety that Congress, MSHA, and our Industry desire.

In addition to our development and maintenance of a very fine working relationship with Assistant Secretary of Labor Bob Lagather and his associates, we have called our concerns to the attention of the Congress no less than two times in the past year -- once before Chairman Harrison Williams' Senate Committee on Labor and Human Resources, and once before Congressman Joseph Gaydos' House Subcommittee on Health and Safety. Complementing our testimony in the House, we also escorted Chairman Gaydos, other members of his Subcommittee and their staffs on a field trip to several surface and underground limestone operations in the State of Missouri last year to give each an "on-site" appreciation of the problems we have been discussing with them. Prior to that, of course, in 1978, we conducted Assistant Secretary Lagather on a similar tour of our members' operations in the Mid-West.

We continue to talk, almost on a weekly basis, with the top officials at MSHA and those here in the Congress. Currently, our most immediate area of concern and interest is the internal, MSHA review by Assistant Secretary Lagather of the MSHA Assessments Program. NLI has had a large amount of input into this review of the manner in which producers are cited and fined for infractions of the law and its regulations. We are hopeful that much of our Industry's problems with administration in this area will be resolved by mid-Summer. There is, too, a great interest in this area by the Congressional Committees with legislative jurisdiction. In that regard, I would encourage all the members of this Subcommittee to read the reactions of Chairman Gaydos' Subcommittee to Assistant Secretary Lagather's formal testimony on October 30, 1979.

What I hope I am conveying, Mr. Chairman, is that our members are, through NLI, attempting as best we can to work constructively with those in government to mold a health and safety program we can all live with. This has taken time, and it will continue to demand more time and effort from all of us.

In our working with MSHA on training, for example, several MSHA policy changes in this area have occurred due to our input -- and the training program has become much more realistic and common-sense oriented without compromising its basic intent. But more needs to be done. Much of our concern is based on the statutory, rather than regulatory, strictures in the Act itself.

The National Limestone Institute could not agree more with the philosophy that the real key to health and safety -- the non-engineering key -- is sufficient training of the individual employed in the workplace. We have testified in that manner in every instance we have appeared before the Congress. We like to believe, too, that we practice what we preach. It is simply -- and we are firmly convinced of this after having tried to view the matter in every other light conceivable -- that certain provisions of Section 115 of the Act and the regulations promulgated pursuant to Section 115 are inapplicable to the crushed stone industry -- both surface and underground. These inapplicabilities are in the areas of inflexible minimum hourly requirements, course requirements, the extent of training required, and the form in which the training is to be given -- a regimen that requires an unnecessary expenditure of time and money by operators who, for the most part, are small.

Even after passage last year of the current language contained in the Appropriations Bill prohibiting MSHA from enforcing the Act's training requirements, we exhorted our members -- on several occasions, in writing and orally -- to live up to the spirit of Section 115 of the Act in every way -- and, we believe they have done so. We believe, as do our members, that it is to their own humanitarian, legal, and financial interests to train as exhaustively as is practical the individuals they hire.

We believe that experience over this past year has indicated that MSHA's inability to enforce Section 115 of the Act has neither been (1) a deterent to the formulation and administration by producers of effective training programs, nor (2) deleterious to those employed within our Industry. In other words, MSHAs inability to enforce has not made any difference.

We ask that you retain this language as first enacted last year -- with one amendment.

We respectfully submit that last year's language should be broadened to include underground limestone operations.

I think it was put as succinctly as it can be by Assistant Secretary of Labor Lagather, himself, after his tour of both surface and underground operations in the Mid-West in 1978 (a tour which we conducted), when he said that underground limestone quarrying was nothing more "than surface limestone mining, underground." With very few exceptions, there is no difference. Underground limestone quarrying bears absolutely no relationship to deep-shaft coal mining, for instance. The Mine Safety and Health Administration will soon take note of this when it promulgates its regulations for underground mine rescue teams. After a great deal of NLI input, we are told that the proposed rule will recognize our concerns -- and for this, we are happy and thankful. We would hope that the members of this Subcommittee would recognize, too, the difference between coal and non-coal mining in underground situations, and broaden the Appropriations language relative to training by striking the word "surface" wherever it appears in last year's language.

And finally, while the adequate training of employees at a quarry site is one of the keys to safety in the workplace, we believe that it necessarily follows that the education of and assistance to management is also an intergral complement. MSHA has authority to assist in this area through Section 502 of the Act, and MSHA has significantly increased its activity in this area in recent months. Again, however, we believe more could be done -- an even greater commitment of MSHA man-hours and materials can be devoted to educating and assisting management in the self-regulation and -policing of safety and health at their operations.

This has been our main contention all along -- people in our Industry believe in health and safety, and, given the proper tools and encouragement, rather than Draconian directives, they will respond, their employees will respond, and the end goal toward which we are all working will be achieved.

We appreciate this opportunity to discuss with you where we have been, where we are, and, hopefully, where we are going in the future. The National Limestone Institute will continue to work, in every way it can, with MSHA and with the Congress to promote our mutual interests. There is absolutely no difference of opinion between us on these goals -- only in how to obtain them. And, these differences have been and continue to be resolved through the constructively critical, working relationship we have built together since the Act's implementation.

I appreciate being able to discuss these differences with this Subcommittee, in the hope that it can help us with stop-gap assistance until all our differences are resolved.

Statement of the National Congress of American Indians

The National Congress of American Indians is vitally concerned with the level of the budget request for the Administration for Native Americans (ANA) contained in the Department of Health and Human Services Budget for 1981. The Fiscal Year 1981 request for the program authorized by Title VIII of the Community Services Act of 1974 and administered by ANA is $33.8 million. This would continue a static funding pattern for a sixth consecutive year, inhibit the delivery of badly needed services to reservation and urban Indian communities and be contrary to the Congressionally determined goal of Self-sufficiency for Indian people. A significant increase in the ANA program level for FY 81 is desperately needed. The Administration's request for FY 81 of $33.8 million is totally inadequate.

The National Congress of American Indians recommends to your Committee

that it consider a $10 million increase in ANA's budget in 1981, bringing the total to $43.8 million.

An increase of $5.5 million is justified simply on the basis of the increase in the cost of living that has occured since FY 74. The additional $4.5 million we recommend, over and above the increase necessary to adjust for inflation, would permit a modest expansion in the programs aimed at assisting tribal governments and urban Indian programs.

The ANA budget has not risen significantly for the last seven years. In FY 75, the budget for the Office of Native American Programs (ONAP), ANA's predecessor agency, was $32 million. In FY 76, the program level went up slightly to $33 million. It has remained at that level every year until 1980 when an additional $800,000 increase was authorized. The funds were primarily used to assist the Hawaiian Natives. For FY 80, the appropriation is $33.8 million.

Despite an increase in the overall cost of doing business over this seven year period of over 41%, the ANA budget has increased just 5.6%.

Translated into dollar terms, this means that the ANA budget should have gone up $17 million between 1975 and 1979 just to keep up with inflation, a modest rate of 7%. Instead it went up only $1 million over the 1975-1979 period, with another increase of just $800,000 for 1980.

Inflation has not been the only factor pressing on ANA's budget. When Congress rewrote the authorization legislation for the ANA program mid-way through FY 75, it required the agency to extend its financial assistance to an additional group of native people--Native Hawaiians. This single act added some 150,000 people to ANA's service population in Hawaii alone. Some estimates indicate that upwards of 150,000 are eligible for services on the mainland. ANA has funded native Hawaiian programs in the Islands. All this happened without any significant addition to ANA's budget.

ANA also has reached out to serve other previously unserved groups of Indian people. Extending services to formerly ignored Indians in the eastern states has been a growing ANA priority. In addition, ANA initiated an urban Indian effort serving 81 groups and extended services to previously unserved Indians in Oklahoma. Special projects providing protection for tribal rights and improving the economic base on reservations have also been ANA concerns. All this has had to happen without any significant addition to ANA's budget.

ANA has recently projected a new effort that is designed to assist those tribes with energy resources. This will involve efforts to better enable those tribes to manage their resources.

In fact, the number of ANA funded programs has risen from 168 in FY 74 to 219 in FY 77--all without any significant addition to the agency's budget.

The Administration for Native Americans in the Office of Human Development Services is charged with promoting social and economic self-sufficiency for American Indians, Alaskan Natives, and Hawaiian Natives. Financial Assistance is provided for Native American community projects, research, evaluation, technical assistance and training. A major emphasis is assisting Native American groups to use both federal and non-federal resources to achieve locally determined goals. Funding priority is given to projects that strengthen local Native American institutions and show promise of furthering social and economic self-sufficiency. The particular needs, resources and culture of the specific Native American communities, are considered in this priority. In all ANA projects and activities, priority is given to those projects which will be completed, are self-sufficient, or supported by other resources.

In fulfilling its legislative mandate to promote economic and social self-sufficiency for American Indians, the Administration for Native Americans provides financial assistance to American Indian groups through direct grants, contracts and inter-agency agreements. The grant support enables them to build and strengthen their local institutions of government. Where gaps exist in local administrative and financial management or other skills, the Administration for Native Americans provides training and technical assistance through contracts with Native American technical assistance providers and inter-agency agreements with other federal resources. Increasing the capacity of tribal governments and community organizations to deal with their needs requires a multi-faceted approach that is sensitive to the diversities in potential and stages of development among the tribes and groups. The Administration for Native Americans' plan provides for flexible and comprehensive support to American Indian communities.

For projects on Indian reservations, the Administration for Native Americans efforts are directed toward strengthening the executive functions of the governing bodies of Indian tribes. A primary function of ANA is their advocacy on behalf of tribal governments. ANA has been charged with developing

Department of Health, Education and Welfare policy that recognizes the sovereignty of the tribal governments. Further, ANA has attempted to implement federal policies within HEW such as subsection 25 CFR 31a.2,[1] that provides for tribal consultation and P.L. 93-638, the Self-Determination and Education Assistance Act. A principal activity is the creation of a planning and development clearinghouse capacity for Indian tribes. The Office of Management and Budget (OMB) regulations require that Indian tribes with an established coordination mechanism be provided with the opportunity for review of financial assistance applications in the same manner as States and area-wide clearinghouses. While Indian tribes have this opportunity, the fundamental and essential work of developing tribal mechanisms for coordinating the activities of tribal departments, divisions, enterprises and entities has been without support. The thrust of this effort is to coordinate the fragmented projects and programs on Indian reservations by assisting tribes in developing a local system and mechanism for coordination and comprehensive planning. A related aspect of this initiative is to provide tribes with the capacity for establishing a merit employment system and implementing affirmative employment ordinances that encompass Indian Preference and Indian Self-Determination, both Congressionally mandated efforts.

Additional funding is needed to provide support to the tribal governments so that they can better develop a comprehensive management program for their tribal resources.

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[1] From the FEDERAL REGISTER for Tuesday, October 9, 1979, p. 58099, Part 5 DOI/BIA Indian Education Policies and Transfer of Functions, Rules and Regulations.

Subsection 25 CFR 31a.2-Definitions:

(g) "Consultation" means conferring process with tribes, Alaska Native entities, and tribal organizations on a periodic and systematic basis in which the Bureau and Department officials listen to and give effect, to the extent they can, to the views of these entities.

(n) "Indian Organization"

(r) "Tribal Organization"

Subsection 25 CFR 31a.4-Policies:

In carrying out its education mission the Assistant Secretary for Indian Affairs through the Director shall: (a) Policy making. (1) Assure that no new policy shall be established nor any existing policy changed or modified without consultation with affected tribes and Alaska Native government entities. (2) Be guided in policy formulation and funding priorities, including the proposing and awarding of contracts and grants, by periodic and systematic consultation with governing bodies of tribes and Alaska Native entities.

Influencing the non-Native American institutions and developing coherent, responsive services for American Indians is the program direction for urban Indian and off-reservation programs. These programs provide vitally needed advocacy for Indian concerns to all levels of government with responsibilities for serving all their citizens. ANA provides core funding to these programs which provides them with funds to support core administration funds--salaries of staff that oversee the programs and leverage the other funding sources, office space, community outreach programs and other expenses that make possible for the urban Indian centers to be the base for many service delivery activities.

Additional appropriations are needed that will allow ANA to expand its urban effort and that will enable the urban centers to better advocate and co-ordinate social services for Indians that reside off-reservation.

The Department of Health Human Services appears to ignore the needs of the American Indian people served by the Administration for Native Americans. But the Congress, in establishing the Administration for Native Americans, has defined the goal for the ANA program and for Indian projects in a most appropriate way--the attainment of economic and social self-sufficiency for American Indians and Alaskan Natives. This would allow our people to take greater control of their resources and would provide the opportunity for the Indian people to join in those decisions that affect their lives. This will be truely Self—Determination.

All we ask is that we again be permitted to step forward toward that goal.

Statement of the D.C. Media Task Force

The D.C. Media Task Force is a 7-year old local(D.C.) media advocacy organzation whose mandate it is to act as an industry watchdog in telecommunications--to assure that Black employment and programming needs are met. To that end, the Task Force has been invo ed in numerous local and national hearings, station negotiations and license challenges.

We are submitting this testimony to be inserted in the Congressional Record as a critical review of the Corporation for Public Broadcasting and to make certain recommendations to Congress regarding the Corporation.

STATEMENT OF PROBLEM

Public Telecommunications was created in order to serve the public interest in a way commercial television could not. Because Public television has no advertising or ratings to respond to, it has free license to present innovative and creative programming for the millions of Americans who pay for it through their tax dollars . CPB, established by Congress in 1967, is the Federal body which administers funds to public telecommunications entities.

However, in the thirteen years of its existence, public television has evolved into another "old boy" network where the wealthiest and most powerful stations influence much of what is produced.

This network is strongly tied to the top-heavy management of the Corporation for Public Broadcasting (CPB). Together, consciously or unconsciously, their actions result in the exclusion of the independent/minority producers--ironically those who can make a tremendous contribution to the creative and high-quality programming demanded of public television. Although CPB is making some effort to include independents their efforts have not been strong, or we think, sincere enough to begin to deal with independents sufficiently. After thirteen years of public telecommunications, the independents still find themselves knocking on CPB's and PBS's doors only to be thrown a few crumbs--then fighting for those, while well-known producers (who qualify as independents under CPB's present definition of "independent") still get most of the available opportunities and resources. This situation has two results: it restricts the diversity of programming and it allows CPB to keep asking for more and more money to serve the independent and minority interests to whom they are still largely unresponsive.

As those who control the purse-strings of this corporation, there are problems the members of Congress need to be aware of before appropriating more money to CPB.

THE CORPORATION'S STATEMENT

In his recent testimony before the sub-committee, Robben Fleming, President of CPB, listed four priorities as justification for more money: direct support to local stations program services, extension of service and new telecommunication services. The performance of CPB and their apparent

attititude toward these "priorities" leave much to be desired in at least two of these categories:

1. Direct Station Support. "Public television and radio stations are today reaching increasing numbers of people with a variety of services not otherwise available."[1] This support for local stations comes in the form of CSG's (Community Service Grants) and a variety of training grants. These grants, Mr. Fleming calls, "unrestricted," yet, in reality, CPB has been known to set arbitrary eligibility standards (such as, five full-time paid staff members, a certain percentage of matching funds, etc.) which along with the general administrative confusion has prevented the well-intended funds from reaching those who really need them. In other words, the small stations which are under staffed or cannot raise much money, are virtually shut out of the process and receive a very nominal amount of money, if any, while the large, well-endowed stations receive hundreds of thousands of dollars.[2] Even more ironic, this inequity results in the small stations, usually closer to their communities (by economic necessity) getting considerably less money than the less-responsive big stations who get a lot of money for "community service."

Program Services. This is the most controversial category because it includes the provisions made for independent producers.

In his testimony, Fleming describes this program as one designed to "stimulate innovative programs with wide appeal and support from the creative producing talent with which the country is so amply provided."[3] He then goes on to discuss the qualifications of the one man, Lewis Freedman, who will be responsible for dispensing these funds.

The objection here is not to Mr. Freedman, but that it is the impossible for one person, no matter how qualified,to fairly decide who will get money and who will not. Moreover, CPB's alternative--to let stations decide who gets money--usually ends up with the most-favored or well-known producers get more work (as they fall under the loosely defined term of "independent" producer, which could include anyone from a home movie producer to Norman Lear) while that talented, unfamiliar majority of producers get very little work. Despite the numerous calls for peer review panels to disburse independents' fund money, CPB has yet to incorporate this procedure or explain why it refuses to do so.

Secondly, the Corporation for Public Broadcasting has never said exactly how much money will be available for independents, other than to remark that a "substantial amount will be devoted to that area.

Specifying the exact amount of money to go to independents is critical to understanding the extent of CPB's commitment to the independents. We are not satisfied with Fleming's vague rhetoric about the amount of money allocated to independents, and the Congress shouldn't be either.

Furthermore, the terms of funding agreements are not spelled out until it is close to the time of production. Many independents have found that stations exercise unnecessary and excessive editorial control.

More than mere oversites on CPB's part, these considerations must be resolved before any more money is handed out. CPB must be accountable in its administration of policies before asking the Congress or the people of this country to give money on the assumption that it will be properly spent.

SOLUTIONS

The answer to CPB's administrative problems is not to give it more money. While we're not encouraging Congress to deny Fleming's fiscal request Congress should thoroughly investigate precisely how past monies have been administered.

Many groups of media advocates, independents, public interest groups, and concerned individuals have proposed a number of what we think are creative solutions. CPB has yet to respond to these proposals and has not shown any real policy shift in its administrative policy.

Coordinator for the National task Force on Public Broadcasting, Lawrence Hall, submitted a response to CPB's policy statement on independent producers. He recommended that the policy be "totally scrapped."[4] Fleming then asked Hall to create a structure which could be used to disburse programming funds. Hall submitted a set of well-thought out guidelines which included a peer review panel.[5] Judging from Mr. Fleming's most recent testimony, these suggestions have never been duly considered (if not totally ignored).

Moreover, in 1978 the Task Force on Minorities in Public Broadcasting submitted a report to CPB ("A Formula for Change"). This report contained a very scientific, detailed and comprehensive analysis of the status of minorities in public broadcasting and generated a list of recommendations to remedy what it found to be grossly inadequate abuses in the industry. CPB agreed to follow these recommendations. But, on a follow up meeting

with CPB one year later, the Task Force was shocked to discover that the Corporation had not acted on a single recommendation.

Finally, a three-day conference, sponsored by the Rockefeller Foundation, was held last summer in New York City to formulate policy guidelines for independents in public broadcasting. Some of the brightest, most knowledgeable and competent people in the industry were invited and came up with a number of fresh approaches to the problem of independents which were later published as "Working Papers."[7] Again, none of these ideas were reflected in any of CPB's policies.

It is not that the Corporation for Public Broadcasting has not received enough solid, practicale approaches to resolving the ticklish situation of the independent producer, but for one reason or another, it has consistently failed to follow up on them.

It is now up to Congress to demand that the Corporation be specific in its structure and plans for independents and minorities and spell out exactly how and where money will be spent in these areas, before any more money is approved for CPB. Specifically, we recommend:

1. The amount of money to be designated for each of the four categories mentioned be clearly and precisely allocated.

2. That CPB mandate a definite structure for stations to disburse money for independent producers which includes peer review panels made up of those people listed as ascertainment sources in the station's files, representatives from the local independent producer community and station personnel.

3. That the terms and conditions of production contracts be spelled out before funds are disbursed.

4. That the station not exercise any direct editorial control of a product, but defer to the review panel to judge controversial productions.

5. That an oversite committee, made up of those identified organizations and individuals--outside of, but knowledgeable about the industry--be created by Congress to present an annual report on the responsiveness and progress of the Corporation of Public Broadcasting. This committee should testify whenever CPB testifies and should weigh heavily in the consideration of appropriations for the Corporation.

The recommendations, we feel, are the beginning of a workable and amicable framework to ease the tensions between the two most vital components of industry--independents and corporate management.

Because it is clear that CPB is not willing to structure itself to better serve the people Fleming says the Corporation serves. It is left up to Congress to carry out this task.

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The industry is supporting the rich and powerful stations at the expense of the less-endowed but talented individuals public television is supposed to serve. Congress is their last hope.

Congress should be wary of those who ask for money in the name of minorities or "disadvantaged" groups--especially when those benefits fail to reach those who need them most.

Finally, minorities, women and children are as American as you are, and that together, they comprise close to two-thirds of the population. It is time to stop thinking of these as "special interests," and think in terms of pursuing those policies and practices which would have them deeply interwoven into the fabric of public telecommunications.

FOOTNOTES

1. "Statement of Robben Fleming Before the Sub-Committee on Labor, Health Education and Welfare of the Senate Appropriations Committee." February 28, 1980.

2. Case in point: Last year, Washington's WETA-FM received some $80,000 in CSG money while listner-sponsored WPFW was to receive $29,000 in CSG money. The latter was then told that it had to have 5 full-time paid staff people. It was later told that it didn't have to have 5 full-time paid staff persons and is still waiting for its money. Figures tend to show this situation to be more the rule than the exception.

3. Opus cited, see footnote 1.

4. Lawrence Hall, "Response to CPB's Initial Draft Policy Statement on Independent Producers." November 7, 1979.

5. Lawrence Hall, "Recommendations Regarding the Establishment of Structures for the Disbursement of Program Funding Commissioned at the National Level by the Corporation of Public Broadcasting." Prepared on behalf of the National Task Force on Public Broadcasting. May 1979.

6. A Formula for Change: A Report of the Task Force on Minorities in Public Broadcasting. November 1978, Corporation for Public Broadcasting.

7. Working Papers: Independent Television Makers and Public Communications Policy. December 1979. The Rockefeller Foundation.

SUBCOMMITTEE RECESS

Senator BURDICK. Subcommittee will stand in recess until 12:45 tomorrow, our last date for public witness testimony.

[Whereupon, at 4:10 p.m., Wednesday, March 12, the subcommittee was recessed, to reconvene at 12:45 p.m., on Thursday, March 13.]

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1981

THURSDAY, MARCH 13, 1980

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

The subcommittee met at 12:45 p.m. in room S–128, the Capitol, Hon. Lowell P. Weicker, Jr., presiding.

PUBLIC WITNESSES

STATEMENTS OF:
SHELDON REIN, SCHIZOPHRENIA ASSOCIATION OF LOUISVILLE
DR. MELVIN SABSHIN, AMERICAN PSYCHIATRIC ASSOCIATION AND AMERICAN ACADEMY OF CHILD PSYCHIATRY
RODOLFO B. SANCHEZ, NATIONAL COALITION OF HISPANIC MENTAL HEALTH AND HUMAN SERVICES ORGANIZATION
DR. DAVID SANDLER, NATIONAL COUNCIL OF COMMUNITY MENTAL HEALTH CENTERS

INTRODUCTION

Senator WEICKER. The subcommittee will come to order. Public witness testimony on health and education programs will be heard this afternoon. There are so many groups, that I would request that everyone stay within the 15-minute limit.

MENTAL HEALTH PANEL

The first panel that we have before us in the area of mental health is with Mr. Sheldon Rein of the Schizophrenia Association of Louisville; Dr. Melvin Sabshin of the American Psychiatric Association, American Academy of Child Psychiatry; Mr. Rodolfo Sanchez of the National Coalition of Hispanic Mental Health and Human Services Organization; and Dr. David Sandler of the National Council of Community Mental Health Centers.

Gentlemen, it's a pleasure to have you here, and you may proceed in any way that you decide among yourselves.

Follow the order that's on the list. And I repeat, just so that we set the pattern, the total amount of time allotted is 15 minutes, so as long as you all understand that, go right ahead.

SCHIZOPHRENIA

Mr. REIN. Mr. Chairman, my name is Sheldon Rein. I come from Louisville, Ky. I appreciate the opportunity to discuss with you one of our least understood and most disabling illnesses.

I represent the Schizophrenia Association of Louisville. We are an affiliate of the National Alliance of the Mentally Ill, representing 100 groups nationwide.

Our groups consist of family and friends of persons ill with schizophrenia. Those ill are intelligent persons. During active phases, symptoms include withdrawal, suspicion, disordered thinking, auditory hallucinations, and an inability to separate fantasy from reality. They become lonely, without friends, fearful, and unable to work.

According to National Institute of Mental Health studies, 2 million Americans are ill with schizophrenia. Half of the Nation's psychiatric patients suffer from schizophrenia. Onset is typically between the ages of 15 and 30, and can result in a lifetime disability. Incapacitation ocurs at a time when most young people are developing career and vocational skills.

Only 15 to 40 percent of individuals with schizophrenia can work. The rest subsist on welfare. In 1975, the American Psychiatric Association published a study reporting costs ranging from $11 to $19 billion per year for hospitalization, treatment, welfare, and lost productivity.

The economic and human costs are staggering. Schizophrenia is a major illness and needs to be recognized as such.

There are two important topics that I wish to briefly emphasize:

SCHIZOPHRENIA RESEARCH

First, the need to elevate the level of research to determine cause and improve treatment. The cause is unknown, but is believed by most researchers to be biochemical. Present recognized treatment with tranquilizer drugs has not changed in 25 years. The drugs only temporarily relieve symptoms, but do not cure. The drugs may cause severe side effects with long-term use, and in some chronic cases bring no relief.

Studies have estimated 600,000 annual episodes requiring hospitalization. The failure of present-day treatment is evidenced by the patient rehospitalization rate of 70 percent. If treatments do not improve, then another 1 million Americans during the next 25 years will become disabled with this illness, and you will be requested to fund ever-increasing amounts for welfare and prisons.

The National Institute of Mental Health in 1980 funded $17.3 million in schizophrenia-related research. Comparative research funding for other major illnesses was cancer, $693 million; heart and circulatory disease, $290 million.

The President's budget for fiscal year 1981 allots $18.6 million for schizophrenia research. This represents an 8-percent increase over the $17.3 million funded in fiscal year 1980, but is insufficient to cover inflation.

I come before this committee to request that you elevate the level of research and that you declare a war on schizophrenia, comparable to the war you declared a few years ago on cancer.

DEINSTITUTIONALIZATION PROBLEMS

The second topic I wish to discuss is a crisis in housing our mentally ill. In 1955, the State hospitals were the primary locations in caring for the Nation's sickest psychiatric patients. At that time the hospital census reached a peak of 560,000. A shift in philosophy occurred which took chronic patients out of the hospital and placed them in the community, so that the State hospitals now have a patient census of 170,000.

This shift is referred to as deinstitutionalization. Large numbers of patients have been dumped into inadequate settings, such as nursing homes, board-and-care homes, single-occupancy hotels; and some wander the streets, are picked up by the police, and end up in prisons.

The patients lack medical treatment and social rehabilitation. Two new syndromes have developed: "falling between the cracks," and the "revolving door."

The former indicates a total lack of aftercare, and the latter a failure of present treatment methods.

In Kentucky, the schizophrenia treatment program is a disgrace and a tragedy; and in most States, with precious few exceptions, the situation is the same. Deinstitutionalized patients needing housing are placed in board-and-care homes. These are private residences where patients are supported by Federal and State grants amounting to $10 per day per patient. The $10 is supposed to cover food and housing and pay the operator a profit. The $10 is insufficient to maintain care required for minimum human dignity.

The result is that patients live in substandard and sometimes filthy rooms, are overmedicated, without supervision, and fed an inadequate diet.

The deinstitutionalization process should be suspended until proper housing, rehabilitation, and followup services are in place. Community mental health centers are not sufficient because patients do not know about the facilities, have no transportation, and the facilities are only open a few hours a day.

We need transitional housing facilities where patients sufficiently well to live semi-independently can reside with minimum supervision.

I appreciate the opportunity of speaking to you.

[The statement follows:]

STATEMENT OF SHELDON M. REIN

I appreciate the opportunity to discuss with you one of our least understood and most disabling illnesses. I represent the Schizophrenia Association of Louisville. We are an affiliate of the National Alliance of the Mentally Ill (NAMI) representing 100 groups nationwide. Our groups consist of family and friends of persons ill with schizophrenia.

Those ill are intelligent. During active phases, symptoms include withdrawal, suspicion, disordered thinking, auditory hallucinations, and an inability to separate fantasy from reality. They become lonely without friends, fearful, and unable to work.

According to NIMH studies, two million Americans are ill with schizophrenia. Half of the nation's psychiatric patients suffer from schizophrenia. Onset is typically between the ages of 15 and 30 and can result in a life time disability. Incapacitation occurs when most young people are developing career and vocational skills. Only 15 to 40% can work, the rest subsist on welfare. In 1975 the American Psychiatric Association published a study reporting costs ranging from $11 to 19 billion per year for hospitalization, treatment, welfare, and lost productivity. The economic and human costs are staggering. Schizophrenia is a major illness and needs to be recognized as such.

There are two important topics that I wish to briefly emphasize: First- The need to elevate the level of research to determine cause and improve treatment. The cause is unknown but is believed by most researchers to be biochemical. Present recognized treatment with tranquillizer drugs has not changed in 25 years. The drugs only temporarily relieve symptoms but do not cure. The drugs may cause severe side effects with long term use, and in some chronic cases bring no relief. Studies have estimated 600,000 annual episodes requiring hospitalization. The failure of present day treatments is evidenced by patient rehospitalization rate of 70%. If treatments do not improve then another 1 million Americans during the next 25 years

will become disabled with this illness, and you will be requested to fund ever increasing amounts for welfare and prisons.

The NIMH funded in 1980 $17.3 million in schizophrenia related research. Comparative research for other major illnesses was cancer $693 million, and heart and circulatory disease $290 million. The President's budget for FY 81 allots $18.6 million for schizophrenia research. This represents an 8% increase over the $17.3 million funded in FY 80, but is insufficient to cover inflation. I come before this Committee to request that you elevate the level of research and that you declare a war on schizophrenia comparable to the war you declared a few years ago on cancer.

Prominent scientists have identified a number of areas that are either underexplored or unexplored.

1. Research in biological causes and pharmocological treatments have fallen off in relation to inflation.
2. Initial studies on treatments combining a supportive environment with minimal medication have been promising. More work needs to be done to determine what supportive environments and what medications work with what patients.
3. Treatment based upon diet, allergies, and metabolic imbalances warrants exploration with a demonstration project. A California physician reports success in treating medication side effects with the mineral manganese. This treatment warrants funding for replication studies.

The second topic I wish to discuss is the crisis in housing our mentally ill. In 1955 the State hospitals were the primary locations in caring for the nations sickest psychiatric patients. At that time the hospital census reached a peak of 560,000. A shift in philosophy occurred which took chronic patients out of the hospital and placed them in the community so that today the State hospitals have a patient census of 170,000. This shift is referred to as deinstitutionalization.

Large numbers of patients have been dumped into inadequate settings,

such as nursing homes, board and care homes, single occupancy hotels; and some wander the streets, are picked up by the police and end up in prisons. The patients lack medical treatment and social rehabilitation. Two new syndromes have developed: falling between the cracks, and the revolving door. The former indicates a total lack of aftercare and the latter the failure of present treatment methods.

In Kentucky, the program is a disgrace and a tragedy; and in most states, with precious few exceptions, the condition is the same. Deinstitutionalized patients needing housing are placed in board and care homes. These are private residences where patients are supported by Federal and State grants amounting to $10 per day per patient. The $10 is supposed to cover food, and housing and pay the operator a profit. The $10 is insufficient to maintain minimum human dignity. The result is that patients live in substandard and sometimes filthy rooms, are overmedicated, without supervision, and fed an inadaquate diet.

The deinstitutionalization process should be suspended until proper housing, rehabilitation, and follow up services are in place. Community mental health centers are not sufficient because patients do not know about the facilities, have no transportation, and the facilities are only open a few hours a day. We need transitional housing facilities where patients sufficiently well to live semi-independently can reside with minimum supervision.

I appreciate the opportunity of speaking to you today.

PSYCHIATRY AND CLINICAL RESEARCH

Senator WEICKER. Let me state at this time that the full text of the various statements will be included in the record, and that will go for each witness appearing before the committee. Again I would only suggest, due to limitations of time and appearance of each witness, that everybody understands the limitation of 15 minutes per panel.

Next we have Dr. Melvin Sabshin of the American Psychiatric Association and American Academy of Child Psychiatry.

Dr. SABSHIN. Thank you, Senator Weicker.

I will be brief, and I am pleased that my prepared text will be included in the written record.

I am here representing five organizations: The American Psychiatric Association; two training groups, the American Association of Chair-

men of Departments of Psychiatry, the American Association of Directors of Psychiatric Residency Training; and two groups dealing with special problem areas, the American Academy of Child Psychiatry, and the American Society for Adolescent Psychiatry.

What I am here to do today is to urge this committee to continue in its efforts. I congratulate this subcommittee for its past activities in support of clinical and research training. You have been a force of conscience in this country by taking action in the past, and I hope you will continue in that important direction.

There is a major need to support personnel in the field of psychiatric care, and this subcommittee, as I said, has been a force for that.

FUNDING RECOMMENDATIONS

The organizations that I represent ask you to go beyond the administration recommendation of the $90.354 million to $129 million for clinical and research training—$98.5 million for clinical training, and $31 million for research training in the field of psychiatry and mental health generally.

Senator Weicker, I was in your home State just 2 weeks ago. I gave the Clifford Beard lecture at Yale. I am sure you know about Clifford Beard, but for those who don't, Clifford Beard was a great American from the State of Connecticut. He was the forerunner of the mental health association of today, the developer of the mental hygiene committee. The Clifford Beard Center exists in Yale, and Beard was a man who became psychiatrically ill himself, who was a force in the 1920's and 1930's for a union of psychiatry and the general public in improving the care of the mentally ill in this country. We owe him a great debt, and the major part of my talk at Yale, Senator, was that it's time for a new Clifford Beard, for a new linkage of psychiatry with the public and with allies in other mental health disciplines to deal with some of the same issues and forces that came up in the 1920's and the 1930's.

There was an effort during this administration by the President, the President's wife, and the President's Commission on Mental Health.

PSYCHIATRIC TRAINING

It has come up with some recommendations that are very positive. I want to focus on one part of that total recommendation: Where are we going to get the manpower to do the job that we want to accomplish?

As I say, your subcommittee has been a positive force, but there is a shortage of psychiatrists and other mental health personnel, a severe shortage in this country. When Drs. Klerman and Pardes appeared before this subcommittee, they acknowledged that shortage existed. There are forces within the administration that constrain a response, however. It's been your subcommittee that's opened up that question and led to the acknowledgement that these severe shortages do exist.

Every such study has indicated the presence of shortage of mental health personnel, including psychiatrists. We are going to have a much more severe problem in this country unless something is done dramatically to alter the pattern of training. We plead with you to pay attention to this matter.

There is a need for increased psychiatrists to deal with the very poignant problems of children, and let me add that in the field of child psychiatry; the shortage that affects the rest of the population is enhanced. Untreated children who are mentally ill later burden psychiatric personnel who deal with the problems of the elderly, with the problems of minorities with mental illnesses, and with people with chronic mental illness. And here in my testimony I am emphasizing serious mental illness. I am not emphasizing those borderline problems, those problems of improving capacity to cope, those areas of improving people's lifestyle. I am talking about the needs for personnel in dealing with serious mental disorders, and that's the area where there is an opportunity for a modest improvement.

I am here, sir, to ask for your support, and the subcommittee's support, to reverse the shortage trend, to see what can be done to have increased personnel in these areas; increased personnel which, if supported, will be offset by decreased use of the rest of the health care system.

I recognize the severe problems facing this subcommittee, and the country as a whole, in dealing with the economic issues and inflation in this country. But I am saying to you that I believe a modest improvement in personnel can be offset in reduction of costs in other parts of the health care system.

And talking about psychiatrists, I hope that the image of psychiatrists in this room is generally positive; indeed, I believe it is so in this country. You should be aware that I am talking about a profession that is heavily engaged in the public delivery of care. Psychiatry is the lowest paid medical specialty. We need—in part, because of its public involvement—we need an effort to increase the number of psychiatrists and other mental health personnel.

I say to you that your subcommittee has been the Nation's conscience in this regard. Please continue in that role and support the increased number of personnel.

Thank you, sir.

Senator WEICKER. Thank you very much, Dr. Sabshin.

I have, just before we get to Mr. Sanchez, I have questions for Dr. Sabshin which I'd appreciate that he respond to for the record.

Dr. SABSHIN. Yes, sir. I'd be happy to.

[The statement and information follow:]

STATEMENT OF DR. MELVIN SABSHIN

Mr. Chairman, members of the Subcommittee, I am Dr. Melvin Sabshin, Medical Director of the American Psychiatric Association, a medical specialty society representing over 25,000 psychiatrists nationwide. I am pleased to appear before the Subcommittee not only to address the American Psychiatric Association's particular concerns, but also those of the American Academy of Child Psychiatry (a nationwide organization of over 2,300 doctors of medicine who have completed two years additional training in child psychiatry), the American Association of Chairmen of Departments of Psychiatry (a national association representing over 125 academic departments of psychiatry in this nation's medical schools), the American Association of Directors of Psychiatric Residency Training (the organization representing over 90 percent of the more than 200 psychiatric residency training programs in the nation) and the American Society for Adolescent Psychiatry (a national organization of 1,700 psychiatrists who specialize in adolescent psychiatry) regarding the President's proposed FY 1981 appropriations for the Alcohol, Drug Abuse and Mental Health Administration of the Department of Health and Human Services.

While our interests in the HHS appropriation for FY 1981 are wide-ranging, from capitation funding for medical education, including the National Health Service Corps scholarships, to a deep and abiding commitment to research into the causes and treatment of major mental illness, I will restrict our statement to NIMH clinical and research manpower training funds, since I know many of these other issues will be discussed by other panel members.

Before I analyze the President's proposed funding level and our appropriations recommendations to the Committee, I want the Committee to know how very much aware we are of your concern for expenditure cutbacks and efforts to balance the budget. We share the national concern about the need to provide an effective response to America's inflation problem. Yet, at the same time, we think it important to recognize that any cutbacks, or the President's hold-the-line budget, in the funding of clinical and research manpower training not only fail to address the problems of inflation, but also leave the American people with a host of unfulfilled promises for providing improved, cost-effective care for those suffering from mental illness.

It is essential that the Committee recognize that the overwhelming evidence of reduced length of stay in hospitals for the treatment of mental illness and the documented cost savings effect of timely treatment for mental illness are the direct result of research breakthroughs in drug research and treatment techniques. Moreover, all the sound and fury regarding mental health service legislation initiatives will signify nothing unless there are trained personnel to provide the treatment mandated under such programs.

To put the issue of the cost effectiveness of receiving mental health care into perspective, the Committee should realize that I am speaking of as many as 20 to 32 million citizens of this country whom the President's Commission on Mental Health has identified as in need of treatment for mental illness. We are speaking of two million individuals who have been or would

be diagnosed as schizophrenic; two million who suffer from profound depressive disorders; more than one million with organic psychoses of toxic or neurologic origin and other permanent disabling mental conditions. More than twenty-five percent of those elderly persons diagnosed as "senile" actually have a diagnosable, treatable and often reversible mental disorder and need not be forgotten or written off by society as lost. As many as 8.8 million children in this country suffer from some emotional disorder, and of those children, only ten percent receive treatment from the existing health system or through the social, corrective and welfare systems.

In speaking of the need for a greater number of trained psychiatrists, made possible through increased training funds, I wish to emphasize that we are speaking of professionals who treat mental illness rather than deal with the health/happiness/achievement of potential/social welfare continuum. We are speaking of individuals -- psychiatrists -- who I might note are the lowest paid medical specialists but who can render treatments as agressive as many life-saving physical health care techniques, not serving solely to expand consciousness or raise the awareness of the general public.

The initial costs to train psychiatrists, as well as psychologists, psychiatric social workers and psychiatric nurses, will be offset in the future by the reduction in overall health care costs. The prompt provision of treatment for mental illness has demonstrated cost effective results.

A recent paper, "Mental Health Services and Medical Utilization," noted that the likely influence of psychotherapy on the reduction of medical utilization may be in the magnitude of 14 percent. Another study, "Impact of Alcohol, Drug Abuse and Mental Health Treatment on Medical Care" reported that 12 of 13 studies reviewed found that psychotherapy was followed by reductions in medical utilization ranging from 5 to 85 percent, with a median reduction of 20 percent. Studies which bear out such a prediction include:

1) Group Health Association of Washington indicated that patients treated by mental health providers reduced their non-psychiatric physician usage within the HMO by 30.7 percent in the year after referral for mental health care compared to the previous year. Use of laboratory and x-ray services declined by 29.8 percent.
2) The Kaiser Plan in northern California estimated that the subsequent savings for each patient receiving psychiatric treatment were on the order of $250 per year.
3) Blue Cross of Western Pennsylvania assessed the medical/surgical utilization of a group of subscribers who used a psychotherapy outpatient benefit in community mental health centers with a comparison group of subscribers for whom such services were not made available. The findings showed that the medical/surgical utilization rate was reduced significantly for the group which used the psychiatric benefits. The monthly cost per

patient for medical services was more than halved -- dropping from $16.47 to $7.06.

4) In Texas, a longitudinal study (1973-1977) demonstrated that access to needed treatment for mental illness resulted in a reduction in mean length of stay of over-65 patients in inpatient facilities from 111 days to 53 days. This halving of hospital stays resulted in a cost reduction of more than $1.1 million.

Such positive effects, in both human and economic terms, will be seriously curtailed, if not eliminated all together, if sufficient numbers of qualified psychiatrists and other mental health personnel are not trained to provide critically needed mental health services.

Our particular concern with respect to the ADAMHA budget, and one we know is shared by the other three core mental health disciplines -- psychology, psychiatric social work and psychiatric nursing, and shared by this Committee, evidenced by its report of last year, is clinical and research manpower training funds within the National Institute of Mental Health. We commend this Committee's initiative in seeking answers to "determine where changes should be made to deal with the shortage of mental health professionals" and "how the shortage can be reduced or eliminated over the next five years and the amount of money it will take to do this."

The President has recommended a funding level of $90,354,000 for clinical and research manpower training. This represents an effective cut of $17.59 million in clinical training alone from the sums appropriated by Congress for FY 1980 (taking into account the impact of inflation and the OMB mandated new 15 percent passthrough to existing stipended students).

The APA, AACP, AACDP, AADPRT and ASAP, and indeed the Coalition for Health Funding (a national organization representing over 50 major health-related organizations), urge the Committee to revise that figure upward to $129,500,000 -- $98.5 million for clinical manpower training and $31 million for research training.

One of the key recommendations of the President's Commission on Mental Health and the special task force to implement such recommendations was to "increase the number of psychiatrists in training and to incorporate mental health concepts into training programs for other health care specialists." Such recommendation was carried through in FY 1980 only by the redirection of existing NIMH funds. If the President's budget -- identical to that appropriated last year -- holds, there will be grave concerns for FY 1981 and what it portends for the future.

The NIMH manpower system is the key to providing quality mental health care to the 20-32 million Americans identified as in need of such services. It represents the trained professional resources vital to the mental health of our nation -- a matter of increased importance as the otherwise available foreign medical graduate (FMG) is lost as the result of PL 94-484.

Indeed, Dr. Gerald Klerman, Administrator of ADAMHA, when recently appearing before your Subcommittee noted "we do acknowledge there is a shortage in one of the fields, psychiatry." You may recall that Dr. Klerman estimated the shortage of psychiatrists as ranging from 10,000 to 60,000 during your and the House Subcommittee hearings. During the course of the latter hearings, he noted "In some cases, like psychiatry, as Dr. Pardes indicated, there is an indication that there is an absolute shortage of some magnitude, the estimates ranging from 10,000 to as high as 60,000."

Moreover, in responding to your 1980 appropriations hearing for ADAMHA, Dr. Herbert Pardes, Director of the National Institute of Mental Health, submitted a report to the Committee which stated in its conclusion that "(I)f the nation is to maintain the same ratio of professionals to clients as existed in 1975, we will - in 1980 - require an additional 10,100 psychiatrists, 6,600 psychologists, 4,400 psychiatric social workers, and 3,400 psychiatric nurses. The demand is caused primarily by a rising utilization rate." For child psychiatry, a subspecialty of 3,000 serving 40% of this nation's population, the situation is equally grave.

Mr. Chairman, I ask that the full text of his letter and attachments be included in the hearing record.

Further, the manpower system must develop strategies to offset the loss of FMGs who primarily serve in our nation's state and local mental hospitals. As you know and as is noted above, the number of FMGs in the country has diminished sharply as the result of PL 94-484 which cut off the availability of such graduates. This means we will have to replace as many as 50 percent of the psychiatrists and other physicians who staff state mental hospitals since they are FMGs. Moreover, since there is already a shortage of psychiatrists in these settings, the conditions will worsen as fewer FMGs are allowed to immigrate. Last year, for example, we know the Committee received information that the shortfall in State and county mental hospitals totalled over 3,200 psychiatric positions. FMGs comprise 39 percent of all psychiatric residencies in 1974-75. However, subsequent to the implementation of PL 94-484, the number of FMG first-year psychiatry residents dropped by 36 percent in just one year.

Just last year, Time magazine noted that in part as the result of the FMG drain, only 4-5 percent of medical school graduates go into psychiatry versus 12 percent in 1970. In part, this is also due to the segregation of psychiatry from other medical specialties within PL 94-484, and until such segregation is eliminated, the NIMH clinical and research manpower training programs mark the only major means of assuring an adequate supply of psychiatrists.

The NIMH training programs not only service the four core disciplines in the mental health field, but provide training for para-professionals and those whose ultimate goal is research. Moreover, the system trains the primary care physician and general medical student, not only to refer individuls they believe to be suffering from mental illness for appropriate treatment, but also to detect, diagnose and manage such illnesses

within the physical health care setting. Such is a bridge-building mechanism, highlighted in the President's Commission on Mental Helath report, and concurred in by this Committee since it "earmarked" through redirection $2.4 million dollars for such an initiative in the FY 1980 appropriations. It is designed, in part to relieve the strain on the small number of mental health professionals, and strengthen and improve the means of meeting the needs of the mentally ill throughout the nation. Such training further can help eliminate the fear, stigma and misunderstanding of mental illness and its tratment which have regrettably kept many individuals who could be helped from seeking treatment.

There is a need for training support for researchers in the mental health field. The mental health systems in this country cannot continue to be effective without continued production of a stable core of mental health researchers. Because of inflation, of static or lessening university involvement in research support, and states' inability or unwillingness to support higher education, it is not possible for states and universities to replace losses in Federal support for research training in the mental health area. Research training must go hand-in-hand with manpower development -- responding to the special research questions about the young, the old and minorities, responding to the special needs of the terminally ill and their families, the physically handicapped. The research community, too, must encouarage minorities to join its ranks. The increase above the President's hold-the-line budget for research training in 1981 which we recommend (from $18,691,000 to $31 million) will provide the funds to train individuals who will answer these questions.

The President has recommended that clinical manpower training appropriations for FY 1981 be held at the same level as were appropriated in FY 1980. Such recommendation:

* reflects a real dollar retrenchment from White House and Congressional concern and involvement in the area of mental health over the past several years;
* disregards the recommendations of the President's Commission on Mental Health report, the Task Force on Personnel report, and the Report of the Task Force to implement the recommendations of the Commission;
* ignores last year's compelling data which attest to a serious manpower shortage, not just psychiatry, but across all mental health disciplines;
* contradicts this Committee's mandate that means of reducing or eliminating the shortfall in mental health professionals through programs and funds must be established and implemented.

Without psychiatrists and other qualified personnel, it will be impossible to meet the mental health needs of the unserved and underserved Americans in need of mental health care, the very old and very young and the minorities in our nation.

As noted earlier, the evidence is in that we can provide relief for many of those diagnosed as senile. We can provide therapeutic intervention for the elderly which can assure that rather than being inappropriately, expensively and tragically "warehoused," they may be able to live cost-effectively and comfortably at home, retaining their dignity and productivity, both hallmark objectives of the Older Americans Act.

We know further that with adequate and appropriately trained personnel, we can help treat the estimated five million under the age of 25 who have a definable developmental disturbance requiring immediate care, and further reach the additional five million who also need help but somewhat less urgently. Today, services are available for only about 5 percent of these children. Moreover, there are over 60,000 children and adolescents in the state hospital system and thousands more in other systems including juvenile justice, special education, and social service systems who are in need of mental health care.

Further, our minority populations have special problems. Cultural and linguistic differences make treatment difficult. It therefore becomes critical to assure that individuals are trained both to the special needs of minority populations and that members of such minority populations are encouraged to become trained, practicing members of the psychiatric, psychological, social work and nursing professions. Twenty-four years ago there were five Black psychiatrists in this nation. Today, there are over 550. Moreover, there are over 1300 psychiatrists of whom we know who speak Spanish and either have Spanish surnames, were born in Spanish-speaking countries or have a strong Hispanic affinity. We have begun to respond but admittedly, a great deal more must be done to make expectations a reality for the millions of suffering minority Americans.

However, if the President's budget for clinical manpower training is adopted, we must expect that the result will simply be that existing funds will be shifted -- moving dollars from one target population to another, sacrificing one for the other, pitting one against the other.

Ever mindful of the need for fiscal austerity, we believe our recommendation of $129,500,000 charts a course between the need for fiscal restraint and the need to provide services to those Americans lease able to help themselves. The added funding in both clinical and research manpower training will provide specific impetus to the NIMH-identified critical needs: (1) increasing training in primary care providing training in mental health principles and skills to medical students, nurses and others; (2) increasing training of minorities professionals as well as individuals ultimately providing services to minorities; and (3) providing an increase in all programs which will permit special emphasis to be placed on meeting the needs of the chronically mentally ill, children, youth, and the aged.

Without adequately trained personnel to meet the mental health needs of our nation, we become poorer - losing able, contributing members of our society to mental illness simply because qualified, trained personnel are not available to provide treatment, rehabilitation, and direction back to the mainstream of society.

On behalf of the APA, AACP, AACDP, AADPRT and ASAP, we urge you adopt a funding level of $129,500,000 for NIMH clinical and research manpower training, with $98,500,000 for clinical training and $31,000,000 for research training.

LETTER FROM DR. MELVIN SABSHIN

March 17, 1980

The Honorable
Lowell Weicker
313 Russell Senate Office Building
United States Senate
Washington, D.C. 20510

Dear Senator Weicker:

I am grateful for the opportunity to have appeared before the Labor/HEW Appropriations Subcommittee hearing which you chaired to express the concerns of the American Psychiatric Association, the American Academy of Child Psychiatry, the American Association of Chairmen of Departments of Psychiatry, the American Society of Adolescent Psychiatrists and the American Association of Director of Psychiatric Residency Training regarding the FY 1981 appropriation for NIMH clinical and research manpower training.

The following is our response to your written questions which we request to be made part of the hearing record.

QUESTION: During the Administration's ADAMHA testimony, Mr. Miller suggested that "it doesn't necessarily follow that it is a federal responsibility to make it up," even if ADAMHA data conclusively documented the psychiatric and other mental health personnel shortage about which this Committee expressed concern. Would you care to respond? How do you justify your increased funding request as Congress and the President are seeking to balance the budget?

RESPONSE: As prior reported NIMH data have indicated, we are confident that the ADAMHA data will continue to reveal and conclusively document the severe shortage of psychiatrists and other mental health professionals, and believe where there are such shortages there is a concomitant Federal responsibility to provide appropriate financial support for psychiatric and other mental health personnel clinical training and thus enable the nation to meet the needs of its mentally ill.

The reasons are twofold. First, there is a well-established history that psychiatrists provide treatment for mental illness within the public sector throughout the United States. Public service practice in state mental institutions and treatment facilities for the mentally ill is essentially fixed-income, salaried employment. If we are to maintain such a continuing commitment by psychiatry (and the other mental health professions) to provide public sector service, there is a Federal responsibility to help train such individuals. As you may know, psychiatry is the lowest paid medical specialty, due in part to the nature of psychiatric practice -- spending more time with each patient than other physicians. A variety of data from a Medical Economics survey show that psychiatrists have a net income significantly less than the average medical specialist and that their incomes are far less than the astronomical sums usually assumed to be the incomes of psychiatrists.

Another underlying reason for the low financial position of psychiatrists is, as indicated, public sector service. Of the 27,500 psychiatrists in the United States, over fifty percent are full-time public service providers, whether, as previously noted, in clinics, state mental hospitals, CMHCs or

other public facilities. If part-time is included, some 70 percent of the nation's psychiatrists are involved in public sector service.

Second, the Federal government has pledged itself to helping to alter the continuing, frightening impression created by the threat or reality of mental illness, indicated by the report of the President's Commission on Mental Health. That report specifically notes "If our goal is to make available high quality mental health care to all Americans, there must be specialists who can meet the needs of the individual living in a rural area or smaller town, the child with a severe learning disability, the troubled adolescent, the disturbed person who cannot speak English well, the young adult with a chronic mental disability, and the depressed older person. We do not have enough such specialists today."

The Commission continues that the Federal responsibility toward meeting the needs of the above-mentioned populations will "require a stable and adequate budget" and recommends that "funding for clinical and service manpower and training programs of the NIMH (should) be increased to $85 million in FY 1980, and in subsequent years be adjusted annually for inflation."

Without Federal support, the treatment provided to those millions of Americans suffering from profound mental disturbances will be curtailed; the commitment to public sector service will be reduced; and the ability to provide quality treatment will be diminished.

To respond specifically to the issue of why increase the funding as this Administration and Congress are attempting to balance the budget, I believe it critical to point out that the cost of training adequate numbers of psychiatrists and other mental health personnel is offset by the increased productivity of millions of Americans who will receive treatment from such individuals. Estimates of the loss of productivity range as high as $31 billion. NIMH estimated the indirect cost of mental illness at nearly $20 billion, noting that indirect costs are the "income or income-equivalent losses which result from deaths due to mental illness, total disability due to mental illness, and the loss of productive time to those individuals who are institutionalized or who utilize outpatient therapy for mental illness."

As I noted in my written testimony submitted to the Subcommittee, we are speaking of as many as 20 to 32 million citizens of this country; two million individuals who have been or would be diagnosed as schizophrenic; two million who suffer from profound depressive disorders; more than one million with organic psychoses of toxic or neurologic origin and other permanent disabling mental conditions. These are many millions of individuals who could, with treatment, contribute to the productivity of our nation.

Just as the Government recognizes it is important to spend funds to assure energy self-sufficiency and savings in the future, I believe it is equally important for the Federal government to continue to invest in the training of psychiatrists and our other mental health professionals, so those now suffering from mental illness may receive appropriate treatment and become producing, active, contributing members of our workforce in the future.

QUESTION: Why has there been a decline over the past number of years in enrollment in psychiatric residency programs across the nation? Is NIMH funding related to such trend? What efforts are being undertaken by the APA and other organizations on whose behalf you appear today to respond to the apparent problem of lack of interest in psychiatry as a medical specialty?

RESPONSE: The decline in enrollment in psychiatric residency programs across the nation has its basis in a series of decisions made at the Federal level as well as the status of psychiatry as a low-paying specialty as noted above. Some of these decisions directly relate to funding, others relate to Federal initiatives to train certain types of practitioners.

In 1970-71, a total of 11 percent of American medical school graduates entered psychiatry. By 1975-76, this number dropped to 4 percent, and by 1978-79, to 3.6 percent. In part, the decrease in the number of American trained psychiatry residents is due to the national emphasis on primary care. Title VII of the Public Health Service Act encourages medical schools to recruit and train

students interested in primary care and consequently has the effect of discouraging recruitment of students into psychiatry and maintenance or expansion of academic psychiatry residency positions.

The above-mentioned problems result directly from the redirection of Federal efforts in P.L. 94-484. However, there is also a direct correlation between the dwindling numbers of American Medical Graduates (AMGs) choosing psychiatry as a specialty and the shrinking sums appropriated to NIMH for clinical manpower training. Such training funds were at their height in 1970-71, and the downward spiral of numbers of psychiatric residencies directly parallels the decline of Federal dollars to the NIMH clinical training program. The real dollar value of the sums recommended by the President for training for FY 1981 is less than half of what it was in 1970, with the cost of education rising at the same time.

The APA is making efforts to help reverse the trend in numbers of medical students entering psychiatry, both through working with Congress and with other organizations within the health care community.

We have made a determined effort to provide better information to Congress about the critical need for greater numbers of trained psychiatrists. This effort resulted in Congress amending the National Health Service Corps deferral for service payback of scholarships to extend beyond three years and thus to permit students to choose psychiatry (with a four-year residency) as a specialty and complete such residency before payback. We have seen the Mental Health Systems Act recognize through Congressional funding that psychiatry is a medical shortage specialty, and manpower extension legislation (S. 2375) recently introduced also contains such designation of psychiatry as a medical shortage specialty.

Within the APA and in conjunction with other organizations, we have taken other steps to meet the shortfall of psychiatrists. A working agreement was developed between the National Association of State Mental Health Program Directors and the American Association of Chairmen of Departments of Psychiatry to develop coordinated efforts between the academic community and the state mental health delivery system, consistent with each state's mental health plan, to train manpower to deliver services to psychiatrically underserved areas. The APA sponsors an APA/NIMH Minority Fellowship program, specifically designed to attract increased numbers of minorities into the field of psychiatry to meet the identified need of minority and other populations. A similar effort is now underway with respect to geriatric psychiatrists.

QUESTION: What is the relationship between the Health Professions Educational Assistance Act (P.L. 94-484) and the NIMH clinical and research manpower training programs? Both programs provide funds to train medical professionals. Is such funding duplicative?

RESPONSE: The Health Professions Educational Assistance Act provides medical students with their primary perception of the Congressional view of what is an appropriate Federal response to medical education and, as noted from the shortcomings of such Act with respect to psychiatry, there has been a need for NIMH training programs to provide the mechanism for funding support for psychiatry. However, the downward trend in the availability of NIMH clinical manpower training funds has resulted in the diminution in the numbers of psychiatrists being trained. The Health Professions Educational Assistance Act and NIMH training programs are not duplicative since their thrusts are entirely different. P.L. 94-484 provides capitation money, basic institutional support to medical schools. It provides students scholarships under the National Health Service Corps to medical students, not residents, with a service payback to be paid after the residency is completed. Moreover, there is no authority to provide funds for residency training under HPEA for psychiatric residency training. Such residency training authority is the NIMH clinical training program.

QUESTION: Your testimony addresses breakthroughs in mental illness treatment and research and speaks about both as cost-effective. What details can you provide us which indicate that treatment of mental illness can have a cost-savings effect?

RESPONSE: In addition to those studies cited in the testimony submitted to the Subcommittee, I believe the appended series of studies compiled and summarized by NIMH provides an overview of the growing data regarding the cost effectiveness of treatment for mental illness. As mentioned in response to an earlier question, there is a long-term savings with respect to productivity resultant from treatment of individuals suffering from mental illness. As much as 54 percent of the cost associated with mental illness results from loss of productivity, lost income, dependence on the social welfare system, etc.

Data continue to be accumulated which attest to the cost efficiency of treatment of mental illness. As the result of breakthroughs in treatment techniques, the average length of stay in acute-care facilities (both general hospitals and private psychiatric hospitals) has decreased from an average stay of as many as 25 days ten years ago, to an average stay of 14 to 17 days. This reduction of approximately 8 days in length of hospital stay has a demonstrable fiscal outcome. For example, there are over 600,000 admissions in general hospitals for short-term acute care for the treatment of mental illness. Thus today we have a reduction of over 4,800,000 hospital days (which would have been utilized 10 years ago) at an average cost of $200 per day in the hospital. The savings realized totals over $950 million annually. Such figure does not include the numbers of individuals treated in private psychiatric or other short-term acute care facilities. Consequently, the cost savings to be realized solely from reduced hospital days is more than a billion dollars annually.

Moreover, the NIMH Biometry Division has determined that expenditures per episode of mental illness have not increased, despite an increase in the absolute numbers of both inpatient and outpatient episodes of treatment for mental disturbances. Such stability comes at the same time as other hospital and physician costs have not remained as constant, and may be directly attributed to both the reduced length of stay in hospitalization and the availability of effective, short-term intervention for those requiring outpatient care.

The cost of providing treatment for mental illness is therefore declining. At the same time, the costs are themselves offset twice, once by the reduction of other health care costs resulting from access to mental illness treatment (as cited in the studies in my written testimony) and once again by the return of countless numbers of our citizens in crisis to health and productivity as tax-paying citizens, with its positive "ripple-effect" on the economy.

I trust the foregoing is helpful, and if there is any additional information you require, please let me know.

Sincerely,

Melvin Sabshin, M.D.

Melvin Sabshin, M.D.
Medical Director

HISPANIC AND MINORITY MENTAL HEALTH CARE

Mr. SANCHEZ. I also will submit my entire statement for the record, but for the sake of brevity will summarize for you.

I am Rodolfo Sanchez, the national executive director for COSSMHO. COSSMHO is the coalition that represents 5 national Hispanic organizations and 223 agencies that provide direct services to 33 States, which includes your State of Connecticut.

In any proposed consideration of reduced spending as part of the inflation fight, we urge no reduction in health and human services programs, especially those needed by Hispanic and other minority communities.

Such cuts not only would not result in any significant decline in the inflation rate, according to most economists, but also would extract a terrible toll among people least able to afford to absorb losses.

I would also like to comment that I know that you have a difficult

task before you, sir, and within the next 3 or 6 months, maybe you will be making decisions regarding which group do we listen to. I hope that none of us here today, my colleagues sitting here with me and many others around the country, do not fall into making the mistake of asking you to take it away from one group but not to take it away from us.

I honestly think that we have to look realistically as to what is feasible in our country today, and we have to make some sacrifices, but I don't think it should be the poor people who do not have the power and who are not well organized and who do not have the financial means to defend themselves.

We should look at existing programs and see where we can shift the moneys, as well as, you know, to decrease—let's look at shifting.

SERVICES AND RESEARCH IN ADAMHA

In the areas of research, we support increases sought for research budgets in all three Institutes. In National Institute on Mental Health, the three Hispanic-oriented research and development centers should be continued and expanded because they have proved to be invaluable resources to our communities. The expertise they provide is otherwise unavailable. Further, at least one additional center should be initiated to intensify the focus on Hispanic populations in the Southeast.

National Institute on Drug Abuse and National Institute on Alcoholism and Alcohol Abuse should initiate a clearly identifiable effort to fund the development of Hispanic research capacity, similar to that already underway at NIMH.

In particular, NIDA should target studies by Hispanic investigators on the severity of problems of heroin, polydrug abuse, and inhalant abuse among Hispanics. The latter two are especially critical among our youth.

In the area of services, we support increases sought for community mental health and alcohol abuse services targeted to minority and other high-risk populations. Due to the current recognized underutilization of these services by Hispanics, it is vital that new funds be used, or existing funds be shifted to significantly expand efforts to develop culturally/linguistically appropriate programs for our communities, thus helping reduce or eliminate existing barriers.

Increases or reallocations should be provided for the drug abuse treatment services program for the same compelling reasons as the above; namely, greater investment by NIDA in the development of programs and services in appropriate language and cultural contexts.

In the area of training, I could not agree more with Dr. Sabshin's comment that we need psychiatrists. The Hispanic community will probably number as the largest minority in this country, and we have a devastatingly low number of psychiatrists. We need Hispanic psychiatrists, we need clinical social workers, psychologists, et cetera.

Overall, the proposed budget seeks a level of effort that is in no way commensurate with the severe need to increase the number of qualified Hispanic and other minority mental health personnel. The agency should report on this deficiency.

Successful model programs should be expanded, such as the NIMH minority fellowship program. I don't even know if you are aware of that program, but presently NIMH funds professional organizations such as the American Psychiatric, American Psychological, American Sociological, and American Nurses Associations, and that has been a tremendous way of increasing the number of minorities, as well as developing a good relationship between minority organizations and the professional organizations.

The new ADAMHA program, minority access to research centers, which began modestly this year should be closely monitored so that support for it can be adjusted accordingly.

In Hispanic employment, sir, adequate funds and slots should be provided to rectify ADAMHA's record as one of the poorest agencies with regard to Hispanic underrepresentation. The present employment by ADAMHA of Hispanics is .45—less than one-half of 1 percent. NIDA and NIAAA should be required to improve their performance in this regard immediately.

Thank you very much, sir.

Senator WEICKER. Thank you, Mr. Sanchez.

[The statement follows:]

STATEMENT OF RODOLFO B. SANCHEZ

I am Rodolfo Sanchez, the National Executive Director of the National Coalition of Hispanic Mental Health and Human Services Organizations (COSSMHO). I am submitting these remarks on behalf of our nationwide membership network and the Hispanic communities they serve.

The programs and funding of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) have a direct impact on the day-to-day work of the COSSMHO network. This network includes community-based service agencies, national organizations, and professionals working to meet the mental health, drug and alcohol abuse, and human service needs of Mexican American, Puerto Rican, Cuban, and Latino communities in over 175 cities in 30 states, the District of Columbia, and Puerto Rico.

As you recommend appropriations for ADAMHA and specify the purposes for which these funds are to be spent, we request that you consider the following concerns of Hispanic American communities. Many of our concerns are also shared by other ethnic and racial minorities in this country.

I realize that at this time you are hearing a chorus of concerned voices reacting to the prospect of cuts in spending in programs they consider vital. No one wants inflation to spiral upward, but if cuts are to be made as part of an effort to reverse this trend, few want the cuts to come in their area of interest.

As you well know, inflation is particularly devastating to Hispanic and other minority communities. The cruel irony is that our communities have disproportionately less of the goods and services and opportunities available in this country and yet we lose disproportionately more through the ravages of inflation.

Any proposed solution or cure must not worsen the social and economic crisis already assailing our communities. We urge both the Congress and the Administration not to reduce those health and human service programs especially needed by Hispanic and other minority communities. Such cuts not only would not result in any significant decline in the inflation rate, according to most economists, but also would exact a terrible toll among the very people who can least afford to absorb the losses.

As is noted in the fourth annual report by the Department of Health and Human Services to the Congress and the President, minorities -- including Hispanics -- still have poorer health care, higher death rates, lower life expectancy, and a lower sense of health and well-being than whites. Can we seriously consider any

abatement of effort to correct these inequities? In fact, do these conditions not warrant just the opposite -- an intensified initiative, on the part of both public and private sectors, to reverse the human suffering and loss involved?

Hispanics and other minorities have been encouraged by the emphasis given to our needs and concerns in the Report of the President's Commission on Mental Health. Implementation of the recommendations of the Commission has yet to have a significant impact on our communities. If this is delayed or diluted, the psychological impact will be severe -- it will halt or retard the shift from confrontation to cooperation between our communities and the agencies mandated to assist the underserved, and it will revive or reinforce the age-old suspicion that our needs and aspirations are readily expendable when times get rough. There is much wisdom in the saying that a dream deferred is, in truth, a dream denied. That is the message that will be conveyed, regardless of the words used.

With regard to the ADAMHA budget originally submitted to this subcommittee, we support the increases sought for research in all three Institutes and for expanded community mental health and alcohol abuse services targeted on minority and high-risk populations.

We welcome the priority given to prevention and its focus on families, children, youth, women, and the elderly, in accord with Congressional directives and the Report of the President's Commission on Mental Health. The ADAMHA Institutes should devote serious attention to the consensus among Hispanic practitioners that the most effective prevention strategies addressing our concerns are those that incorporate a community-based, family-oriented approach, in contrast to narrower approaches that target isolated groups of individuals. This is especially important in reaching the large numbers of our youth who are not in school, but are still within our communities.

Research on Hispanic mental health and substance abuse is among our highest priorities. The knowledge base applicable to all Hispanic communities -- Mexican American, Puerto Rican, Cuban, and Latino -- is still at a developing stage in terms of demographics, epidemiology, and treatment and prevention differentials. We urge expansion of the three Hispanic-oriented R&D centers supported by the National Institute of Mental Health. These three centers are invaluable resources for our communities. Further, at least one additional center should be started to intensify the focus on Hispanic populations in the Southeast. Hispanic research in substance abuse areas should receive increased funding from NIDA and NIAAA -- it is particularly important for these Institutes to initiate a clearly identifiable effort to fund the development of Hispanic research capacity, similar to that already underway at NIMH. In parti-

cular, given reports from the field, NIDA should direct its attention to the severity of problems of heroin, polydrug abuse, and inhalant abuse among Hispanics -- with the latter two problems especially critical among our youth.

Service fund increases in community mental health and alcohol abuse are important to our communities. The budget announces that these are to be directed toward needs of minority and other high-risk populations. In light of the current recognized under-utilization of these services by Hispanics, it is essential that new service funds be used to expand efforts to develop culturally/linguistically appropriate services for our communities, thus helping reduce or eliminate existing barriers. Although a level budget is proposed for drug abuse treatment services, we believe that increases should be made here for the same compelling reasons -- namely, our communities require greater investment in the development of programs and services in appropriate language and cultural contexts.

With regard to training, the ADAMHA budget proposes a level of effort that in no way is commensurate with the severe need to increase the number of qualified Hispanic and other minority mental health personnel. The underrepresentation of Hispanics and other minorities in the mental health professions is clearly a major national problem, one that directly relates to improvements needed in Hispanic and other minority accessibility to quality services. Yet the response to this problem on the part of federal officials and the professional associations has not been matched to its urgency, magnitude, and severity. It has, for example, never evoked the spirited ardor and advocacy with which federal agencies and the associations have approached the Congress on the question of the personnel shortage in psychiatry. For this reason, we must appeal to you to exercise continuing leadership in monitoring and conducting oversight on the federal effort in minority mental health training, as well as in providing funding increases necessary to enable us to advance.

Clinical and research training in all the core mental health disciplines -- psychiatry, psychology, social work, and psychiatric nursing -- remains a major Hispanic priority. In these professions today, Hispanics account for little more than 0.5% of the work force; among graduate students preparing for practice in these professions, Hispanics comprise only 2% or less of the total, with the sole exception of social work where Hispanics make up about 4% of the enrolled graduate students.

Successful model programs already in operation should be continued and expanded, such as the NIMH Minority Fellowship Program and the NIDA Minority Internship Program. Due to inadequate funding levels, these have been able to support only a small pro-

portion of the reported qualified Hispanic and other minority applicants. The new effort -- ADAMHA's Minority Access to Research Careers (MARC) program -- which begins modestly this fiscal year should be closely monitored so that support for it can be adjusted accordingly in coming years.

Overall, the ADAMHA training budget raises several questions:

-- How can the agency hope to achieve its stated goals of targeting more specialized services and research on underserved populations, including Hispanics and other minorities, if there is no significant increase in training the kinds of specialists, including Hispanics and other minorities, required to deliver these services and conduct related research?

-- Even if the agency proposes to shift support to minority training within the confines of a no-growth budget, how much do minorities really gain when the dollars thus shifted actually buy much less in the market today? For example, if the agency increases stipends to accommodate rising costs but seeks no new funds, will the result not be fewer trainees in coming years?

-- Why does the agency, in presenting to you its progress in minority training, never discuss the significance of these efforts in relation to the scope and dimensions of the minority personnel shortages?

In calling for continued federal leadership in personnel training, we recognize that other entities should share in the responsibility of contributing resources and programs to help increase the Hispanic and other minority personnel pool. In particular, colleges, universities, and professional associations receiving federal dollars should be more accountable for equal opportunity and affirmative action efforts in recruiting, training, and retaining students and in hiring and promoting faculty.

The final concern we ask you to address is our urgent need to increase the number of qualified Hispanics actively involved in developing, implementing, and evaluating ADAMHA policies and programs. Adequate funds and slots should be provided to rectify the scandalous underrepresentation of Hispanics that has persisted throughout ADAMHA for years.

According to Department figures, ADAMHA today has the lowest percentage of Hispanic professionals employed in any Public Health Service agency -- 0.45%, roughly the same as was reported in 1978. Within ADAMHA, NIDA and NIAAA have the worst records -- NIDA has no Hispanic in a permanent, full-time career position; NIAAA has only three. In light of the lack of Hispanic input in these two Institutes, we

believe that both should be instructed to report -- in realistic, non-cosmetic ways -- how effective their service, research, and training programming is in addressing the concerns that our communities have repeatedly raised with them, how much more needs to be done, and how the Institutes can do it expeditiously.

In the Regional Offices, Hispanic underrepresentation is a recurring problem -- Region II (New York), III (Philadelphia), VII (Kansas City), and X (Seattle) have no Hispanics assigned to mental health, drug and alcohol abuse concerns. Yet these are regions with significant concentrations of Hispanic populations.

It is our position that the lack of Hispanic representation and participation throughout ADAMHA is more than a pattern of continuing discrimination. Even worse, it impedes vital efforts to improve program quality and service accessibility for our communities. Our communities continue to be underserved in large part because policy and programs are not congruent with our needs and concerns, because they are too often administered and evaluated without attention to our special circumstances, and because they are not subject to Hispanic monitoring and oversight throughout the planning and implementation process.

Thank you for your consideration of these pressing issues facing Hispanic Americans as you deliberate directions for ADAMHA's budget.

COMMUNITY MENTAL HEALTH CENTERS

Senator WEICKER. Dr. Sandler of the National Council of Community Mental Health Centers.

Dr. SANDLER. Thank you, Senator. Our organization, the National Council of Community Mental Health Centers, represents providers of mental health services at the community level. Our membership includes over 650 community mental health programs, as well as over 100 other agencies providing mental health services.

Senator, we certainly appreciate the support which you have given to our program in the past, and especially for your recent cosponsorship of the Javits amendment to the Child Health Assessment Act.

This amendment will expand mental health coverage for children and include community mental health centers services for children.

Passage of this amendment will go a long way in ending discrimination against mental health services which often appears in legislation.

We have been hearing a lot about budget cuts lately, and I certainly hope that this Congress will take a look at the specific programs and examine them very carefully on a case-by-case basis, and really phase out those which are ineffective, rather than make any across-the-board cut.

The community mental health center program has undergone intensive scrutiny lately, first by the President's Commission on Mental Health, and recently by the General Accounting Office, and as a result

both studies have reported favorably on the community mental health center program, and both have urged for its expansion.

The facts are very clear that the institutionalized populations, large expenses, and sometimes even mental institutions have been reduced significantly since the beginning of the community mental health center program.

At the moment, however, about 50 percent of the mental health services in this country are covered by the community mental health center.

In Connecticut, for example, there are 22 mental health service areas; yet only 5 have a comprehensive community mental health center.

From what I understand, approximately 8 to 10 communities in Connecticut are in the process of starting a community mental health center, and funds are going to be needed. Federal funds are going to be needed to help them get started and to assist in our national goal of coverage in every area of the country.

BUDGET RECOMMENDATION

I would just like to make one brief point, and that concerns inflation. I think Congress really has to recognize that has to be a factor in determining program costs, and particularly our continuation costs—how much money is needed to continue operations.

In fiscal year 1980, for example, NIH only asked Congress for $214.5 million for continuation of grants. And now it appears that we actually need $247.5 million to continue the centers. Now this is a difference of $33 million which will result in a nationwide reduction of mental health services at a time when the Presidential Commission on mental health has determined that there is a great lack of mental health services in this country.

Now our specific recommendations for community mental health appropriations are contained in the written statement which will be submitted for the record.

Thank you.

[The statement follows:]

STATEMENT OF DR. DAVID SANDLER

RECOGNIZING THE NECESSITY TO RESPOND TO THE UNMET NEEDS OF THE MENTALLY ILL IN THIS COUNTRY, PRESIDENT CARTER FORMED A PRESIDENTIAL COMMISSION TO ANALYZE OUR MENTAL HEALTH SYSTEM WITHIN ONE MONTH AFTER COMING TO OFFICE. AFTER A ONE YEAR STUDY, THE PRESIDENT'S COMMISSION REPORTED THAT A SUBSTANTIAL NUMBER OF AMERICANS DO NOT HAVE ACCESS TO MENTAL HEALTH CARE. THIS IS ESPECIALLY TRUE FOR THOSE WHO LIVE IN RURAL AREAS, SMALL TOWNS, AND POORER SECTIONS OF OUR LARGE URBAN AREAS.

THE STUDY CONCLUDED THAT THE NATION NEEDED TO DEVOTE GREATER HUMAN AND FISCAL RESOURCES TO MENTAL HEALTH. THE 12 PERCENT OF GENERAL HEALTH EXPENDITURES WHICH IS DEVOTED TO MENTAL HEALTH WAS FOUND NOT TO BE COMMENSURATE WITH THE MAGNITUDE OF THE PROBLEM. THE COMMISSION ALSO RECOGNIZED THAT MOST OF THE MENTAL HEALTH DOLLARS ARE BEING SPENT IN LARGE STATE INSTITUTIONS AND IN NURSING HOMES,AND CONCLUDED THAT THERE IS A URGENT NEED TO FURTHER DEVELOP COMMUNITY BASED SERVICES. THE COMMISSION RECOMMENDED THAT THIS COUNTRY CONTINUE TO DEVELOP A NATIONAL NETWORK OF HIGH QUALITY, COMPREHENSIVE, COMMUNITY MENTAL HEALTH SERVICES.

ON FEBRUARY 3, 1963, PRESIDENT JOHN KENNEDY REQUESTED CONGRESS' HELP IN PROVIDING HUMANE TREATMENT FOR THE MENTALLY AFFLICTED AND SET THIS NATION ON A COURSE TO REMEDY CENTURIES OF NEGLECT. AS A DIRECT RESULT OF PRESIDENT KENNEDY'S INITIATIVE. THE FEDERAL GOVERNMENT HAS ALREADY MADE AN INVESTMENT OF OVER $1.5 BILLION IN CREATING OVER 700 COMMUNITY MENTAL HEALTH CENTERS THROUGHOUT THE UNITED STATES AND ITS TERRITORIES. BASICALLY, WE ARE ASKING THIS COMMITTEE TO CONTINUE THIS PROGRAM WHICH BEGAN 17 YEARS AGO AND EXPAND IT TO ENSURE GREATER ACCESS FOR THOSE THAT HAVE BEEN UNDERSERVED IN THE PAST. DESPITE THE LIMITED RESOURCES WHICH THIS COUNTRY IS FACED WITH, WE ARE PLEASED THAT THE PRESIDENT'S BUDGET ASKS FOR AN INCREASE IN MENTAL HEALTH FUNDING.

IT IS UNFORTUNATE, HOWEVER, THAT THE ADMINISTRATION'S BUDGET FOR FY'81 IS BASED ON THE IMMEDIATE PASSAGE OF THE MENTAL HEALTH SYSTEMS ACT, S.1177. THIS ACT HAS YET TO BE CONSIDERED BY THE LABOR AND HUMAN RESOURCES COMMITTEE. NEVERTHELESS, THE CHANGES MADE BY THE HEALTH AND SCIENTIFIC RESEARCH SUBCOMMITTEE, WILL CONTINUE THE PRESENT COMMUNITY MENTAL HEALTH CENTER PROGRAM THROUGHOUT FY'81, AND WILL NOT PUT THE NEW PROGRAM INTO EFFECT UNTIL FY'82. CONSEQUENTLY, WE URGE THIS COMMITTEE TO BASE FUNDING ON THE COMMUNITY MENTAL HEALTH PROGRAM AS IT NOW EXISTS. LAST YEAR, WE WERE IN THE SAME SITUATION AND THIS COMMITTEE

CHOSE THE PROPER COURSE OF ACTION. THIS YEAR WE ARE AGAIN HOPEFUL THAT REALITY WILL PREVAIL OVER FANTASY.

IN 1975, CONGRESS OVERRODE A PRESIDENTIAL VETO AND PASSED PUBLIC LAW 94-63 TO CONTINUE THE COMMUNITY MENTAL HEALTH PROGRAM. THE PREAMBLE TO THAT LAW STATES: "THE CONGRESS FINDS THAT COMMUNITY MENTAL HEALTH CARE IS THE MOST EFFECTIVE AND HUMANE FORM OF CARE FOR A MAJORITY OF MENTALLY ILL INDIVIDUALS". IF THE TREND TOWARD DEINSTITUTIONALIZATION AND THE THE HUMANE TREATMENT OF THE MENTALLY ILL IS TO CONTINUE, THIS COMMITTEE MUST BE PREPARED TO APPROPRIATE THE NECESSARY FUNDS TO CONTINUE THE COMMUNITY PROGRAM.

FOR FY'81, WE MAKE THE FOLLOWING RECOMMENDATIONS FOR THE COMMUNITY MENTAL HEALTH CENTER PROGRAM:

NEW OPERATIONS GRANTS - $42,000,000 - CURRENTLY, ALMOST ONE HALF OF THE MENTAL HEALTH SERVICE AREAS IN THIS COUNTRY STILL DO NOT HAVE A COMMUNITY MENTAL HEALTH CENTER. WE ARE FAR BEHIND IN MEETING OUR GOAL OF ESTABLISHING A NATIONAL NETWORK OF COMMUNITY MENTAL HEALTH CENTERS. AT THE PRESENT, THERE ARE THIRTEEN APPROVED/ UNFUNDED INITIAL OPERATIONS GRANTS WHICH REQUIRE $13.7 MILLION. BY THE END OF FY'80, THIS BACKLOG WILL INCREASE.

CONTINUATIONS FOR OPERATIONS, STAFFING, AND CHILDREN - $297,400,000 - IN THE PAST, WE HAVE RELIED ON THE FIGURES PROPOSED BY THE NATIONAL INSTITUTE OF MENTAL HEALTH IN MAKING OUR REQUEST TO CONGRESS REGARDING CONTINUATION LEVELS. HISTORICALLY, HOWEVER, THEIR ESTIMATES HAVE BEEN TOO LOW AND THEY HAD TO TAKE MONEY FROM OTHER SOURCES TO CONTINUE EXISTING PROGRAMS. ALTHOUGH WE CONDONE THIS PRACTICE, CONGRESS SHOULD CLOSELY EXAMININE THE FIGURE IT RECEIVES FROM NIMH IN THIS AREA. CONSEQUENTLY, OUR RECOMMENDATION IS 5% HIGHER THAN WHAT THE ADMINISTRATION HAS REQUESTED.

CONSULTATION AND EDUCATION - $20,000,000 - THESE FUNDS PROVIDE PREVENTIVE AND EARLY INTERVENTION SERVICES TO PUBLIC AGENCIES SUCH AS SCHOOLS AND POLICE. CURRENTLY, THERE ARE 62 APPROVED/UNFUNDED C & E GRANTS WHICH REQUIRE $7.7 MILLION. APPROXIMATELY $9.3 MILLION IS NEEDED TO CONTINUE EXISTING C & E PROGRAMS.

FINANCIAL DISTRESS - $25,000,000 - AT THE END OF THE 8 YEAR FEDERAL OPERATIONS GRANT, SOME COMMUNITY MENTAL HEALTH CENTERS ARE STILL UNABLE TO ACHIEVE TOTAL SELF-SUFFICIENCY. THIS IS DUE TO THE FAILURE OF STATE GOVERNMENTS TO TRANSFER

FUNDS USED FOR INSTITUTIONAL CARE TO COMMUNITY CARE AS WELL AS THE INELIGIBILITY OF COMMUNITY MENTAL HEALTH CENTERS TO QUALIFY FOR MEDICARE AND OTHER THIRD PARTY REIMBURSEMENT PROGRAMS. CURRENTLY, THERE ARE 43 APPROVED/UNFUNDED DISTRESS GRANTS WHICH REQUIRE $13.9 MILLION.

PLANNING GRANTS - $1,000,000 - THESE ONE YEAR GRANTS ENABLE COMMUNITIES TO DETERMINE UNMET MENTAL HEALTH NEEDS, SET PRIORITIES, AND DESIGN APPROPRIATE SERVICES. CURRENTLY, THERE ARE 19 APPROVED/UNFUNDED PLANNING GRANTS WHICH REQUIRE $1,059,000.

CONVERSION GRANTS - $2,000,000 - COMMUNITY MENTAL HEALTH CENTERS HAVING MET MINIMUM FEDERAL REQUIREMENTS TO PROVIDE A BASIC CORE OF COMMUNITY MENTAL HEALTH SERVICES MAY APPLY FOR A CONVERSION GRANT TO OFFER MORE COMPREHENSIVE SERVICES NEEDED IN THE COMMUNITY. CURRENTLY, THERE ARE 5 APPROVED/UNFUNDED CONVERSION GRANTS WHICH REQUIRE $1.4 MILLION.

IN ADDITION TO THE COMMUNITY MENTAL HEALTH PROGRAM, WE WOULD LIKE TO MAKE THE FOLLOWING RECOMMENDATIONS FOR FUNDING UNDER THE PUBLIC HEALTH SERVICES ACT:

THE COMMUNITY SUPPORT PROGRAM - $33,400,000 - THIS PROGRAM IS A SERVICES DEVELOPMENT PROGRAM TO ASSIST STATES AND LOCALITIES IN PLANNING, DEVELOPING, AND IMPLEMENTING DEINSTITUTIONALIZATION PROGRAMS FOR THE MENTALLY ILL. INCREASED FEDERAL SUPPORT OF THIS PROGRAM IS NEEDED TO CONTINUE EFFORTS TO ADDRESS THE COMPLEX INTERAGENCY AND INTER-GOVERNMENTAL NATURE OF PROBLEMS OF THE LONG TERM MENTALLY DISABLED IN THE COMMUNITY.

MOST IN NEED PROGRAM - $10,000,000 - PUBLIC PRESSURE HAS RESULTED IN THE ESTABLISHMENT OF AN OFFICE OF PREVENTION AT NIMH. FUNDING IS NEEDED TO SUPPORT THIS OFFICE AND PROVIDE FOR SPECIFIC GRANTS.

FORMULA GRANTS FOR MENTAL HEALTH SERVICES & PLANNING, SECTION 314 (G) - $25,000,000 - PRIOR TO FY'80, FORMULA GRANTS WERE AWARDED TO STATES UNDER SECTION 314 (D) OF THE PUBLIC HEALTH SERVICE ACT TO ASSIST IN MEETING THE COSTS OF PROVIDING PUBLIC HEALTH AND MENTAL HEALTH SERVICES. 314 (D) REQUIRED THAT AT LEAST 15% OF EACH STATE'S ALLOTMENT OF 314 (D) BE SET ASIDE FOR MENTAL HEALTH ACTIVITIES. EFFECTIVE IN FY'80, CONGRESS ELIMINATED THE REQUIREMENT FOR A MINIMUM SET ASIDE FOR MENTAL HEALTH, ENACTING A NEW PROGRAM UNDER 314 (G) OF THE SAME ACT TO SUPPORT FORMULA GRANTS TO STATE MENTAL AUTHORITIES FOR SERVICES AND PLANNING.

THE PRESIDENT'S FY'80 BUDGET REQUEST TO CONGRESS DID NOT INCLUDE FUNDS FOR THIS REVISED MENTAL HEALTH FORMULA GRANT PROGRAM. INSTEAD THE ADMINISTRATION PROPOSED TO CONSOLIDATE THE PROGRAM WITH ALCOHOL AND DRUG ABUSE FORMULA GRANTS TO STATES. THIS LEGISLATIVE PROPOSAL, WAS NOT ENACTED. 314 (G) WAS NOT INCLUDED UNDER THE 1980 CONTINUING RESOLUTION OF CONGRESS IN SPITE OF ADMINISTRATION SUPPORT FOR THE

PURPOSE OF THE PROGRAM. THE ADMINISTRATION HAS NOT REQUESTED SUPPLEMENTAL APPROPRIATIONS FOR THE PROGRAM TO DATE.

314 (D) FUNDS HAVE BEEN REALLOCATED TO OTHER PUBLIC HEALTH FUNCTIONS EXPECTING THAT 314 (G) WOULD COVER MENTAL HEALTH FORMULA GRANTS PREVIOUSLY IN 314 (D). THIS HAS NOT HAPPENED. IN THE ABSENCE OF A SUPPLEMENTAL APPROPRIATION, NO MONEY WILL BE AVAILABLE FOR MENTAL HEALTH FORMULA GRANTS IN FY'80. THIS IN SPITE OF THE FACT THAT WITH THE HEALTH PLANNING ACT AMENDMENTS OF 1979, STATE MENTAL HEALTH AUTHORITIES HAVE AN INCREASED RESPONSIBILITY FOR MENTAL HEALTH PLANNING.

WE RECOMMEND A MINIMUM OF $13,700,000 TO FUND 314 (G) IN FY'80 AND NO LESS THAN $25,000,000 IN FY'81.

LINKAGE OF COMMUNITY MENTAL HEALTH CENTERS TO COMMUNITY HEALTH CENTERS - $11,500,000 - THE LINKAGE PROGRAM WAS DEVELOPED TO RESPOND TO THE NEED TO HAVE INDIVIDUALS WITH MENTAL HEALTH TRAINING PLACED IN COMMUNITY HEALTH CENTERS. NIMH AND THE BUREAU OF COMMUNITY HEALTH SERVICES HAVE MADE SOME INTERNAL RESOURCE ALLOCATIONS TO FUND THIS PROGRAM IN FY'79 AND FY'80.

OUR RECOMMENDATION OF $11,500,000 WILL FUND 232 LINKAGE GRANTS PROVIDING MENTAL HEALTH PERSONNEL IN COMMUNITY HEALTH CENTERS AROUND THE COUNTRY. RESEARCH HAS DEMONSTRATED THAT MENTAL HEALTH PROBLEMS OFTEN ACCOMPANY OR EVEN UNDERLY PHYSICAL SYMPTOMS. PROVIDING COMMUNITY HEALTH CENTERS WITH INDIVIDUALS TRAINED TO RECOGNIZE AND TREAT MENTAL ILLNESS HELPS PROVIDE THE MOST APPROPRIATE COST AND EFFECTIVE CARE FOR PRESENTING PROBLEMS.

THE COMMUNITY MENTAL HEALTH PROGRAM IS THE ONE PROGRAM WHICH THE CONGRESS AND NATION CAN BE PROUD. HERE, FEDERAL MONEY HAS BEEN USED WISELY, AND ALTERNATIVE FUNDING HAS BEEN SOUGHT TO RELIEVE THE FEDERAL GOVERNMENT OF THE ENTIRE BURDEN OF SUPPORT. CURRENTLY, FEDERAL GRANTS CONSIST OF ONLY 27% OF THE BUDGETS FOR FEDERALLY FUNDED CMHCs. MOREOVER, OVER 100 CENTERS WHICH UTILIZED FEDERAL FUNDS TO GET STARTED NOW OPERATE WITHOUT ADDITIONAL FEDERAL GRANTS. CONSEQUENTLY, AN EXCELLENT WORKING RELATIONSHIP HAS DEVELOPED BETWEEN LOCALITIES AND THE FEDERAL GOVERNMENT. NO LONGER DO COMMUNITIES HAVE TO BE TOTALLY DEPENDENT ON STATE MENTAL HEALTH SYSTEMS WHICH ARE OFTEN INSENSITIVE TO THEIR NEEDS AND UNRESPONSIVE TO THEIR PROBLEMS.

THE COMMUNTIY MENTAL HEALTH PROGRAM WHICH WAS STARTED BY PRESIDENT KENNEDY IN 1963 IS JUST BARELY HALF COMPLETE. WE NEED THE ASSISTANCE OF THIS CONGRESS TO KEEP THE PROGRAM GOING UNTIL ADEQUATE MENTAL HEALTH CARE IS AVAILABLE TO ALL AMERICANS. DESPITE THE PRESIDENTIAL VETOES AND IMPOUNDMENTS OF THE PAST, THE COMMUNITY PROGRAM HAS STAYED ALIVE BECAUSE OF CONGRESS' CONCERN, COMMITMENT

AND DEDICATION TO THE TREATMENT OF THE MENTALLY ILL IN UNCONFINED COMMUNITY SETTINGS. WE THANK YOU FOR YOUR CONTINUED SUPPORT AND REAFFIRM OUR DESIRE TO WORK WITH CONGRESS TO EXPAND THE COMMUNTIY NETWORK, SO THAT ALL AMERICANS, REGARDLESS OF THEIR FINANCIAL STATUS, WILL HAVE ACCESS TO COMMUNITY MENTAL HEALTH FACILITIES.

SUMMARY

COMMUNITY MENTAL HEALTH CENTER PROGRAM:

NEW OPERATIONS	$ 42,000,000
CONTINUATIONS	297,400,000
C & E	20,000,000
DISTRESS	25,000,000
PLANNING	1,000,000
CONVERSION	2,000,000

OTHER PROGRAMS:

C S P	33,400,000
MOST IN NEED	10,000,000
PREVENTION	10,000,000
314 (G)	25,000,000 AND
SUPPLEMENTAL FOR FY'80	13,700,000

COMMENTS ON BUDGET PROBLEMS

Senator WEICKER. Dr. Sandler, thank you very much.

I would like to make several observations in response to your testimony and also to what I am sure will be the testimony to follow.

I would say that at the present time the Congress of the United States and the President of the United States are in a near state of panic, relative to how to, one, handle their own elections; two, handle the economy.

What this has resulted in is a posture that encompasses the concept that inflation will be fought best by balancing this budget. But there is one caveat: By balancing the budget to the extent that everything will be cut, except defense. .

Point No. 2: There has been a total disregard for the fact that this inflation has been primarily fueled by the lack of an energy policy. My memory is not so short—it goes back to the first Arab world embargo of 1974. After 6 years of doing nothing, of 6 years of not demanding sacrifice of the American people in the sense of the use of their auto-

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mobile, the sense of additional production and in the sense of development of alternate source of transportation, nothing has been done.

And I suppose what's surprising to me and a few of my colleagues—not many—is that the cost to fight this battle against inflation is going to be exacted in terms of human coinage, rather than gasoline and the sacred American automobile.

The other aspect of the budget fight that bothers me has been suggested by those of you on the panel, and that is that in this effort to give a semblance of balancing the budget of 1981, huge costs are going to be incurred in future years. In other words, the lack of an energy policy, is going to pass the bill on to future generations—our children.

This kind of action now is going to pass the bill on to our children, and there will be a price to pay. Yesterday in my subcommittee hearings on the Federal Bureau of Investigation, the Director had made it very plain that he would comply, he would cut the budget in his agency, but there was no doubt about the fact that what was being cut would have to be funded 2, 3, and 4 years hence at a considerably higher cost.

Well, there's no question in my mind that the price to be paid in terms of our children, in terms of mental health, in terms of education, in terms of vocational training, is going to be enormous—in order to give, as I say, the semblance in this election year of 1980 of a balanced budget.

So let's understand that there will be no savings in cost over the long run. Maybe a few of us are older and will avoid paying the bill. Maybe a few politicians will avoid paying the bill for purposes of this election.

But, I, for one—and, as I've said, there are a few of my colleagues—and you correctly identified this as one of the standout committees in the sense of its devotion to conscience and to the human condition—plan to fight to the extent that what we are talking about here are the investments made in this Nation which indeed bring us back to greater economic strength. And for whatever temporary political purposes, for whatever purposes, to defend a lack of courage, these are not reasons enough to go ahead and cut the budget in the context of the panic that seems to pervade both these Halls and the White House.

REPRESENTING AMERICAN DEMANDS

Which brings me to the last point, as I mentioned yesterday, Congress is no more than a reflection of the American people. This is a representative democracy. I always chide those who like to refer to, "What are you Congressmen or Senators doing about it? What is Washington doing about it?"

Well, Washington is going to do no more and no less than what the American people demand, and this idea that we can divide and sort of appeal as a separate body here, either in the sense of achievement or failure is ridiculous. The failure of the individuals down here personally or institutionally are conceptual. They are the failures of the American people, and the successes, the successes of the American people. And in that regard, I would hope that each one of you addresses your constituents and asks them to speak up. Ask them to speak up.

I, for one, have felt for years that the American people have been willing to engage in sacrifice on the energy front, but that's not reflected here in the Congress, because the people don't make themselves heard. And if we're going to have some priorities in this country—and I think you do represent a portion of those priorities—then your constituency has to speak up.

It's not enough, in other words, just to admit to the fact that a few powerful men are going to go ahead and make the determinations regardless of what the people say. I suppose the best example I can give, and it's almost taking up my 15 minutes—and it will be the last time I speak today, because the rest of the time I will be listening—I remember for a long period of time how it was very fashionable to blame the lack of movement in the civil rights areas on a few Southern Senators.

It wasn't a few Southern Senators. Nobody could block that concept and that right, once the American people insisted that their representatives go ahead and embody it in their actions down here in Washington. When they did, the Congress acted. It was an easy way out, a scapegoat, to blame it on a few Southern Senators, when we now know it was Northern Senators, Southern Senators, Western Senators, and Eastern Senators.

So what I'm saying to you is if you think that this is in the grips of some mysterious element or it has a preordained conclusion that you're all going to be wiped out by these budget cuts, my answer to you is you will be wiped out if you don't speak up. And if you do, and the rest of this Nation speaks up, as to what is important, then, believe me, it will be the desires of the country and not the desires of a few persons who want to be reelected in the year 1980 that's going to predominate.

But if you don't speak up, then the election comes first, and the human beings come second.

With those comments which, as I said, are pretty much addressed to everything that's going to happen here today, I thank you very much for your observations. We will do the best we can on your behalf, and thank you for taking your time.

We will next hear from the witnesses on drug abuse and alcoholism, and in this regard we have from the Department of Public Health of the State of Michigan, Mr. Kenneth Eaton; and Project Return Foundation, Inc., Mr. Edmund Menken. Is that correct?

All right, the floor is yours. You can proceed in any way you deem appropriate.

Drug Abuse and Alcoholism

STATEMENTS OF:

KENNETH EATON, DEPARTMENT OF PUBLIC HEALTH, STATE OF MICHIGAN

EDMUND MENKEN, PROJECT RETURN FOUNDATION, INC.

Mr. Eaton. Mr. Chairman, thank you very much. I am here not only in my State official capacity, but as the legislative committee chairman for the National Association of State Alcohol and Drug Abuse Directors.

We do have a fuller statement that we would appreciate submitting

for the record. With your permission, I would proceed to summarize our points.

There are 10,000 million-plus American people, Mr. Chairman, who suffer from the problems of alcoholism and drug abuse, and they seldom get opportunities to speak for themselves. I volunteer to speak in their behalf, and there are some important issues that we should all face in that sense.

TREATMENT SERVICES COST SAVINGS

They don't need to suffer nearly as much tragedy as they do. I won't dwell on the human impact of these problems, because I know that this committee has considered them very carefully in each of the past several years; but rather in this time of economic stress, and especially considering the remarks you made so very fluently, Senator, I would like to concentrate for a few moments on some of the economic implications. That apparently is the climate in which we must deal with many of these issues.

Let me get to the bottom line first. The appropriation of public funds for the treatment and prevention of alcoholism and drug abuse is not going to add to inflation. There is no sensibility to thinking that restricting or withholding funds for these purposes is going to help reduce inflation.

In fact, a very brief review of the facts leads to a completely opposite conclusion. These problems create an enormous—an estimated $53 billion—economic drain from our Nation's economy every year.

Most of that, over half of it, is in the form of lost productivity on the job all by itself. The rest of it is in a variety of different losses.

In the State of Michigan, this cost amounts to about $1.5 billion a year related to alcoholism, and about $500 million a year for drug abuse. This has been recognized for some time, but not well enough.

In 1970, the Federal Government began with a very modest effort to deal with these problems. Using the tools of treatment, research, training, prevention activities as our major weapons, the cornerstone of this effort was a close Federal-State partnership.

FEDERAL-STATE PARTNERSHIP

I'd like to describe some differences that it has made. I would also like to bring to your attention some concerns about this Federal-State partnership, especially some that are reflected in the budget proposal you are now considering.

At the beginning of this decade, the States were very minor partners in this effort, contributing less than 10 percent of the total funds for alcoholism and drug abuse problems. They were relatively loosely organized, fairly ill-equipped from a legislative point of view; but in less than a decade, 7 or 8 short years, the States have multiplied their appropriation many, many times to the point where the States' contribution to fighting these problems far exceeds the contribution now of the Federal Government.

In alcoholism, the States provide almost four times more than the Federal Government does; and in drug abuse, the contribution is

somewhat equal. All the States in this interim have updated their legislation to follow the Federal pattern.

Following the leadership of the Federal Government, 26 States decriminalized public intoxication. Every one of the States has designated a single State agency to work with Federal agencies and the Federal Government toward the achievement of national objectives.

Look for a moment at the Federal effort in this same decade. Frankly, I cannot point to great pride in it. Beyond that initial effort, Mr. Chairman, the Federal funds, frankly, have not even kept pace with the inflationary costs of ongoing services that are being administered throughout the country.

Repeatedly, the Federal partner has passed the buck to other levels of government. Here is the reality—10 years ago the Federal Government formed a partnership to treat and prevent alcoholism and drug abuse. In that partnership it included itself, the States, localities, and the private sector.

The conscriptive partners are holding up their end of that bargain. The private sector is increasingly active. States, as I have mentioned, have increased their appropriations, cleaned up their legislation; localities are making good contributions. In our State, it's about a third of the grand total that is appropriated by local units of government.

Only the initiator, the Federal Government, is now dragging its feet and declining to assume its continuing share of the responsibility. This neglect is hurting. It's emptying the coffers of other levels of government, discouraging the private sector, and it's frankly making all of us somewhat weary from attempting to work with a seemingly unwilling and ambivalent partner.

BUDGET CONSIDERATIONS

We do have a full analysis of the budget, so I won't go into the details of some of our concerns, but I would point out, Mr. Chairman, that in Public Laws 96–180 and 96–181, recently enacted by the Congress, there were some very clear signals concerning the directions the Congress wished the Federal alcohol and drug abuse programs to take.

Authorization levels for some portions of both programs were in fact reduced from previous years. This was based upon a very careful examination by the House and by the Senate about service needs, and it resulted in authorization levels which I think were realistic, and which I think the Congress intended to be sought in the appropriations process.

And yet, the budget proposal you are now considering further decreases the Federal responsibility in maintaining these programs, rather than picking up the slack. Not only, as you were suggesting, is the Congress being given a fiscal meat axe by a panicked and a desperate Office of Management and Budget; but perhaps even more importantly, this budget proposal fails completely to recognize the economic viability of these programs, and I would like to make two or three points in that particular respect, by giving you some examples in our own State.

MICHIGAN ALCOHOL AND DRUG ABUSE PROGRAMS

In the State of Michigan, our program is funded by about $45 million of Federal, State, and local funds. Approximately $12 million of that comes from the Federal Government.

Mr. Chairman, more than 50 percent of all of our treatment clients are unemployed at the time they are admitted. This represents in Michigan between 10 and 50 percent of all the unemployed people in our State.

Among the clients, there is a 22-percent decrease in the unemployment rate after treatment is completed. The programs in this one State alone return 40 people, week in and week out, to the active work force. There is a 37-percent increase in personal income after treatment which, Mr. Chairman, is an average of $2800 per client.

I'm making this point for a very special reason. It costs only about $700 per client to provide this treatment. We provide or we spend about $45 million in total, to remind you again.

This results then in a $56 million increase in personal income alone among those who are receiving services. And, Mr. Chairman, I would like to point out that the Federal Government is a prime beneficiary of this increase in personal income. In the form of income and social security taxes alone, the Federal Government takes back 20 to 30 percent, or roughly $11 to $15 million of this increased personal income generated by the programs operated in the State of Michigan. So you invest about $12 million, and just in the income tax increases alone, you get back every single dollar.

That seems to me like a very good investment. At the State level, it's equally sensible. About $2.5 million of this increased personal income is returned to our State treasury in the form of State tax revenues. About $3.8 million is saved because of reductions in unemployment benefits.

About 5 percent of our clients resolve their legal problems. We take them out of the criminal justice system; a great savings there. We no longer send people for public intoxication to our criminal justice system as a result of our partnership. We are now taking care of these people in health care facilities; an enormous savings involved there.

NEED TO SUPPORT ALCOHOL AND DRUG ABUSE PROGRAMS

I could continue, Mr. Chairman, with case after case and example after example of the economic and human benefits of these programs. I could explain it in great detail, and I think that you would agree with me.

Quite frankly, there is one thing that I cannot explain, and that is why the Federal Government has been and apparently is inclined still to be so timid about making more of these kinds of investments. They are so sensible.

Even if Members in the Congress or the Federal Government do not subscribe to my personal human value system—and I feel very strongly about that—even if only counted in dollars and cents, this is one of the most sensible programs the Federal Government has ever invested money in.

This reminds me of a commercial. Maybe you've seen it on television. A mechanic is holding up an oil filter, stating that a customer has just spent $600 on engine repairs because he failed to change the oil filter when the oil was changed in his car. The final line of that commercial, you might recall, is, "You can pay me now or you can pay me later."

Mr. Chairman, that's about what we face in alcoholism and drug abuse. We can invest now or we can pay more later, and there is no question in my mind that we will pay more later.

We are already paying for our past neglect. We have a budget proposal pending before the Congress which I believe is penny wise and pound foolish. Every dollar, in summary, invested in alcoholism and drug abuse treatment is returned directly in the form of increased tax revenues. At least $2 additional are returned in the form of decreased government expenses, increased economic productivity, and other forms.

We are already paying, as I suggested, Mr. Chairman, for our past neglect. We can't continue to bear either the human suffering or the $53 billion annual drain to our gross annual product and our economy.

We can alleviate the human problems. We can deal with the economic problems. Only our will as a people is going to need to be stronger in order to do this. But failure now to make these limited investments will assuredly mean reduced tax revenues in the future, increased welfare and criminal justice costs, as well as more unnecessary human suffering.

I ask and plead, therefore, Mr. Chairman, for you to appropriate funds as previously authorized by the Congress. It was well thought out and highly defensible.

Thank you.

Senator WEICKER. Just one question. The $53 billion drain on our gross national product, what does that represent?

Mr. EATON. About half of that is lost economic productivity; that is absenteeism on the job, or related to people who have alcohol and drug abuse problems. Much of it is related to excessive health care costs which are about three times as frequent among alcoholics and drug addicts; that is for everything—hospitalization, treatment of other health problems—which is excessive.

It also includes factors for decreased tax revenues, for unemployment benefits, and very exorbitant series of disability claims under insurance as provided by employers because of alcoholism and drug abuse.

There are seven or eight categories. We will be happy to provide details for you.

Senator WEICKER. I'd like to have the details supplied for the committee.

I think it would certainly seem fair to me, though, if we are talking about inflation, there is $53 billion, in other words, just gone to waste.

Mr. EATON. Lost.

Senator WEICKER. Lost.

Mr. EATON. A very minor portion of that represents an expenditure of funds that are actually used in a purposeful attempt to ameliorate the problems. But that's probably less than 2 percent of that total.

[The statement follows:]

STATEMENT OF KENNETH EATON

Mr. Chairman, and members of the Committee, I thank you for the opportunity to appear before you today concerning the proposed fiscal year 1981 budget for the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse. I am appearing in my capacity not only as State official for Michigan but also as the chairman of the legislative committee of the National Association of State Alcohol and Drug Abuse Directors. In addition to my summary comments today, I respectfully request that I may be permitted to submit a more detailed statement for the record. Of course, I will be happy to answer any questions that you have.

I speak on behalf of ten million Americans and their families whose lives are damaged by alcoholism or drug problems. It is not necessary to recount this human suffering. All of us have observed it at one time or another among our friends, associates or family members. With adequate and proper treatment much of this suffering can be avoided. I urge that this Approrpiations Committee carefully consider the human impact of this pending decision.

In this time of economic stress there are other important factors to consider that are not so readily apparent in our daily lives. They are ones of economics, inflation and national productivity. Let me get to the bottom line first. The appropriation of public funds for the treatment and prevention of alcoholism and drug abuse does not add to inflation. Therefore, restricting or withholding public funds for this purpose will not help to reduce inflation. A brief review of the facts leads to the opposite conclusion.

Alcoholism and drug abuse problems constitute an enormous drain to the economy of this country every year. $25 billion is lost annually in the form of lost productivity alone. In Michigan, these figures are conservatively estimated to be

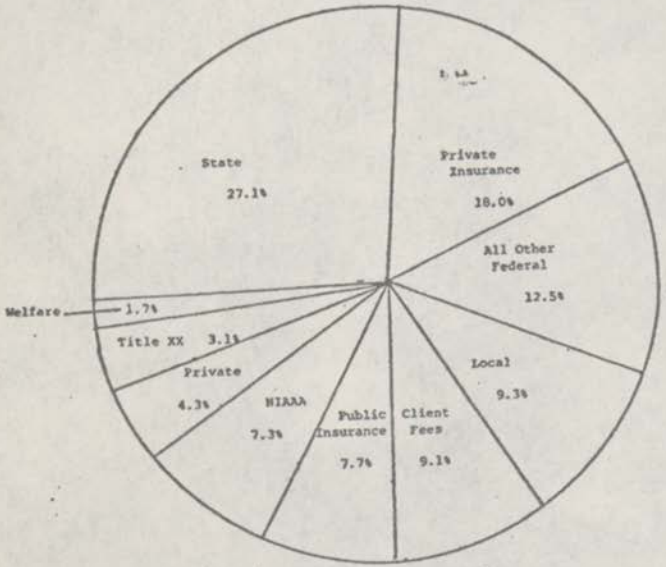
$1.5 billion for alcohol problems and $420 million for drug abuse.

In 1970 the Federal government began with modest efforts to deal with alcoholism and drug abuse as health problems. Using treatment, research, training and prevention as our major weapons the cornerstone of this Federal initiative was the development of a close Federal-State partnership. Has it made a difference? Yes, without a doubt.

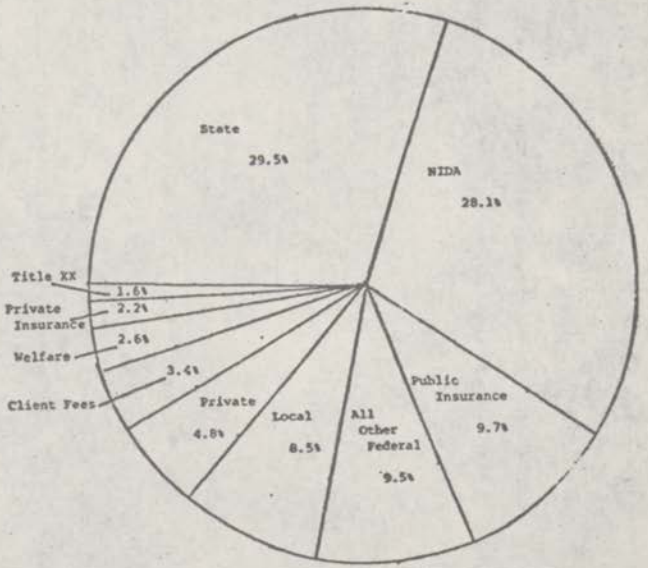
But allow me to bring to your attention some concerns about the Federal-State partnership in alcoholism and drug abuse. At the beginning the States were minor partners contributing less than 10 percent of the money, loosely organized and legislatively ill-equipped. In less than a decade the States, have increased appropriations of their own revenue for alcoholism and drug abuse many times, to the point where the States' contribution to fighting these problems far exceeds the contribution of the Federal government. This relationship is shown for fiscal year 1979 alone in the following two charts:

1979 FUNDING SOURCES

ALCOHOLISM TREATMENT



DRUG ABUSE TREATMENT



In addition to increasing their appropriations, all the States have updated their legislation to follow the Federal pattern. Twenty-six of them have decriminalized public intoxification in response to strong Federal leadership, and all the States have designated Single State Agencies for alcoholism and drug abuse to work with Federal government toward the achievement of our national objectives.

What about the Federal effort in this same decade? Frankly, the continuing Federal effort is not a very proud one. Beyond the initial efforts, Federal funds have not even kept pace with the inflationary cost of on-going services. Repeatedly the Federal partner has passed the buck to other levels of government. Here is the reality. Ten years ago the Federal government formed a partnership to treat and prevent alcoholism and drug abuse, which included itself, the States, localities, and the private sector. The conscriptive partners are holding up their end of the partnership. Only the initiator, the Federal government is dragging its feet and declining to assume its continuing share of responsibility. This neglect is emptying the coffers of other levels of government, discouraging the private sector and making us all weary from attempting to work with a seemingly unwilling, ambivalent senior partner.

In Public Laws 96-180 and 181, the Congress clearly gave the Administration several signals concerning the directions Congress wished Federal alcohol and drug abuse programs to take. Authorization levels for some portions of both programs were reduced because members of this chamber especially felt that authorization levels should be realistic ones and that full funding at the authorized levels should be sought. Both measures explicitly recognized the major role which the State alcohol and drug agencies have to play in our national, publicly funded and managed system for providing prevention and rehabilitation services in the alcohol and drug abuse fields. The important role of the voluntary sector was also explicitly recog-

nized by the Congress. The Congress gave explicit direction to Single State agencies for alcohol and drug abuse that technical assistance be provided to businesses and organized labor to assist in developing occupational programs in both areas. In addition, other new priority groups were explicitly included in the legislation for the first time.

And yet, the budget proposal you are now considering further decreases the Federal responsibility in maintaining these programs. Not only has the Congress been given a fiscal meat ax by a desperate Office of Management and Budget, but the President's budget unfortunately fails completely to recognize these important additions which the Congress made to priorities for alcohol and drug abuse programs.

In the budget as proposed by the President for FY 81, formula grant programs for both alcohol and drug abuse are cut by 10.3 percent. The Administration's budget justifications submitted to the Congress for these cuts are very weak, and the documents submitted concerning NIAAA's formula program states that the increases in the community programs line can be used to offset the cuts in the formula grant program. Unfortunately such offsetting totally ignores what Congress established as additional priorities for the States to address in the formula grant spending.

For NIDA's formula grant program the Administration offered the budget justification that increased spending in prevention under community programs would offset the cut. The Administration chose conveniently to ignore the fact that the increased prevention funding came at the expense of providing minimal increases for treatment to meet the the ever inflating cost in providing adequate treatment services, and to provide treatment efforts to meet needs caused by new influxes of heroin from the unstable regions of Western Asia which are now being seen throughout the Eastern part of the United States.

The Administration's budget justifications for the formula grant cuts also ignore the fact that other parts of the budget justifications are replete with references to States being expected to assume increasing responsibilities in the area of managing and monitoring the treatment services program and in the area of training. Unfortunately for both NIAAA and NIDA the training budget is also cut as well.

Thus, the President's budget ignores the clearly expressed wish of the Congress that States assume in their formula grant programs additional responsibilities, but ignores the long-standing Administration policy of promoting increased responsibilities for the States in areas in which a Federal-State partnership in providing treatment services , prevention services, and training for para-professional counselors have been developing. The small and long overdue increases for community programs in the alcoholism field do not offset the formual grant cuts, nor does the shifting of funds that would have provided for the inflating cost of treatment to prevention offset the drug abuse formula grant cut. Therefore, I urge the Congress to fund at the full authorized level both these programs, $65 million for the alcohol program and $45 million for the drug abuse program. For both these programs these increases will be the first in five years.

It is important to note that these formula grant programs are not programs which support State bureaucrats and which provide for only planning and administrative costs. Both formula grant programs provide implementation of the State plans which are required. The money is spent for treatment services, prevention services, for rehabilitation, for developing coordination with other health social services as well as for the actual planning and administration of the programs.

In FY 78 the alcoholism formula program money was spent by the States in the following ways:

Treatment and Rehabilitation	60%	Administration	3%
Intervention	10%	Research and Evaluation	3%
Prevention	8%	Training	3%
Planning	13%		

In FY 1979, the drug abuse formula grant money was spent by the States in the following ways:

Treatment and Rehabilitation	45%	Planning	15.2%
Prevention	24.3%	Training	4.3%
Administration	3.4%	Criminal Justice	2.4%
Research and Evaluation	3.2%	Management Information	2.2%

Formula grant cuts will mean reduction in all these programs and, for alcoholism will mean that States which have passed and begun implementation of legislation to decriminalize public drunkeness also will lose additional dollars, since the Federal grants to encourage implementation of that program are tied to formula grant programs. Thus, the States which have chosen to follow Congressional encouragement to decriminalize public drunkeness, to provide treatment rather than incarceration for individuals find that the Federal promise to assist them is one which seems to be shrinking. This change in the promise is in spite of the fact that not only is it more humane and more appropriate to treat these individuals rather than jail them, but also can be done at a much smaller social cost. Thus, the Administration's policy is extremely short-sighted in economic terms.

The Federal budget presented by President Carter to the Congress in June of this year for Fiscal 81 recognizes Federal responsibilities in the research areas. As I have already mentioned, a long overdue increase is also provided for the community programs in the alcoholism field. I am happy to say that I support this increase but urge that you fund at the fully authorized level of $115 million.

Another area of the President's budget clearly which does not recognize the Federal responsibility for both the alcohol and the drug abuse programs is training, which was singled out for a cut. In the mental health area, the training budget was cut

by almost 20 percent without any adjustments for inflation. For drug abuse the cut in training was 12 percent after last year's cut of more than 13 percent again without adjustments for inflation. I urge that Congress continue the training budgets for NIAAA and for NIDA at FY 80 levels in FY 81. To restore these amounts would cost the Federal government $2.4 million. This small investment would insure that other State and local funds will also be used for training and would repay the cost of the investment many times over.

The community services programs of the National Institute on Drug Abuse are unfortunately not provided with an increase in the President's original budget proposal for FY 81, even though the Congress explicitly directed that 10% of these funds be set aside for prevention activities. I request that the President's request for $161 million be increased to $185 million, the total amount authorized. This increase would allow the National Institute on Drug Abuse to spend $18.5 million for prevention, allow for modest inflationary increases in the cost of providing treatment services and for maintenance of the service at needed levels, and would allow a continuation at needed levels in other community treatment and rehabilitation programs. Needed increases would be those mandated by Congress in the prevention level and that made for inflation for the treatment services program. It is clearly the Federal responsibility to provide funding for these areas.

The myopic approach to saving money demonstrated by the President's budget should be evaluated in view of the economic benefits of providing alcoholism and drug abuse services. In Michigan our program is funded by about $45 million of Federal, State and local funds. Approximately $12 million are Federal funds. More than 50% of all our treatment clients are unemployed at admission - this represents between 10 - 15% of all the unemployed people in our State. Among the clients there is a 22% decrease in the unemployment rate after treatment. The

programs in this one State return 40 people per week to the active workforce. There is a 37% increase in personal income which is an average increase of $2,800 per client. It costs about $700 per client to provide these services. Here is the bottom line. We spend about $45 million per year. This results in a $56 million increase in personal income among those who receive services. Mr. Chairman, the Federal government is the prime beneficiary of this increase in personal income. In the form of income in social security taxes you take back 20-30% ($11.2 - $16.8 million) of this increased personal income. Indeed the Federal government provides about $12 million to our Statewide program and gets most of that, or more, back in the form of increased tax revenue alone.

At the State level, about $2.5 million of this increased personal income is returned in the form of State tax revenue. Additionally, an estimated $3.8 million is saved in the form of reduced unemployment benefits. Approximately 5% of our treatment clients resolved their legal problems and were removed from the State's court system caseload, creating another substantial savings to the State. I could continue with a fuller explanation of other economic benefits which include increased productivity and a diminished use of unemployment, disability benefits, welfare and other publicly funded crises services. One thing I can not explain is why the U.S. Congress has been so timid about making more of these kinds of investments.

In closing I would like to say that the President's budget for NIAAA and NIDA as requested for FY 81 reminds me especially in the State formula grant portion of a commercial which you may have seen recently on television. A mechanic is holding an oil filter and stating that a customer of his just spent $600 on engine repairs because he failed to change the oil filter when the oil was changed. The final line of the commercial is "you can pay me now or you can pay me later."

Given the rapidly escalating social cost of alcoholism and drug abuse, the Administration's budget proposal is "penny-wise and pound foolish."

Every dollars invested in alcoholism and drug treatment is returned directly in the form of increased tax revenues. At least two additional dollars are returned in the form of decreased government expenses and increased economic productivity. Mr. Chairman we are already paying for our past neglect and we cannot continue to bear a $53 billion annual drain to the economy. We must alleviate unnecessary human suffering. Failure to make these limited investments now will mean reduced tax revenues, increased welfare and criminal justice costs as well as human suffering, I therefore ask you to make the appropriate changes in the President's budget.

Again, I thank you for the opportunity to appear for you and will be happy to provide answers to any questions which you may have.

PROJECT RETURN

Senator WEICKER. All right. Is this Mr. Menken? Is that right?
Mr. MENKEN. Yes, I'm Menken.
Senator WEICKER. You go right ahead, Mr. Menken.
Mr. MENKEN. Thank you very much, Senator.
I would just like to open my comments by saying that I couldn't be more pleased with the fact that you're the one who is chairing this hearing today.
Mr. Eaton has made a very strong case which I personally subscribe to. As well, he referred to a constituency which I am representing, which is not merely the Project Return Foundation, one of the largest rehabilitation treatment centers in the country, but also the Therapeutic Communities of America, which is the only advocate existing that speaks for the drug abuse and alcoholism treatment programs exclusively nationwide.
I want to begin my comments, and I will keep them brief. There is prepared testimony that we are pleased will be in the record.

HEROIN EPIDEMIC

In 1970, and you were around then, and I know you recall, this Nation suffered one of its most devastating social and health problems in the form of a heroin epidemic that claimed at least, at least, 700,000 victims nationwide to heroin addiction. In New York City alone, 700 people died from it in 1970.

I would call your attention to a report that was prepared by the Drug Enforcement Administration Office of Intelligence, dated November 29, 1979. Here is a copy for you. It's called Operation Cerberus.

I would first comment on the fact that that report was prepared just a couple of weeks after the hostages were taken in Iran. It's a short consolidation of a larger report, and it ends up with a kind of an optimism that soon became a point of absurdity.

There was an expectation in that document, after they spoke about some very hard and significant data, that diplomatic channels would be able to handle the drug trafficking problem in Afghanistan and in Iran.

It has become obvious since, that that is no longer the case. We have no diplomatic recourse.

The 1970 epidemic was created by, according to that report, 80 tons of opium harvested out of Turkey. We are currently facing the prospects of an epidemic in this country as a result of a crop of opium approximated at 1,600 tons coming from Iran, Pakistan, and Afghanistan. Those are the DEA's figures.

A good portion of that opium is consumed in those countries right there at home, contrary to popular opinion and the fact that drug addiction and drug use is against the Islamic law. Each of those nations, considerably smaller than the United States, has at this moment larger addict populations.

It's been well reported and well documented, and the media has been carrying it quite heavily in the past several months that Europe has been deluged with a heroin epidemic. West Germany, where we have the major concentration of American troops in Europe, is reeking with an epidemic.

We have begun to see the first wave of this epidemic in this country. In 1 year alone, from December 1978 to December 1979, in the New York metropolitan area, including southern Connecticut, there was an 89-percent increase in hospital emergency visits associated with heroin overdose.

That figure can be checked with the New York State Division of Substance Abuse Services.

There was an increase from 1978 to 1979 alone of 77 percent of deaths related to drugs. Unfortunately, New York, which suffers from a very severe fiscal crisis, doesn't keep a categorical, specific record any more. It hasn't recorded for 2 years who has died from a heroin overdose as opposed to other kinds of narcotism.

What we are talking about is a problem that very likely will go nationwide. We are talking about a crop of opium that is uncontrollable at this point that has completely saturated the European market, according to DEA officials, Department of Justice officials, the Assistant Secretary of State for International Narcotics Matters. We are looking in the face of what could be the most devastating heroin epidemic this country has ever seen.

FUNDING CUTBACK PROTESTS

While this is all going on, the National Institute on Drug Abuse just recently informed the States that 11,000 treatment slots have to be cut

by 1981. We find that totally incomprehensible, and much in line with Mr. Eaton's comments, the most absurd form of fiscal constraint that could ever be taken.

We are talking dollars, we are talking taxes, but we are talking, most importantly, about human life. You made reference a little while ago in your statement to the concept of what our children will have to inherit if we make the wrong decisions today.

Part of that question, I think, should be related to how many children will have died before that as a result of the same ignorance.

I won't overburden you except to say that we fully subscribe to the concept of representative government. We believe that people must, in fact, approach their representatives, their elected officials, and urge them to do something.

I brought with me some representatives of our programs who have been out in the streets in the communities of only one part of the country. The rest will follow.

We have a quarter of a million signatures of taxpaying Americans on these petitions contained in six boxes. We want to deliver these to you with our compliments. That is the beginning of a flow that we expect will be running for many months until there is action.

I want to inform you as to what else we are engaging in. The city of New York, the model I am describing, is being replicated all over the United States. The city of New York will be entertaining next week a resolution which will first condemn the current Federal posture in relation to this threatened epidemic, and then will demand of the Federal Government swift intermediate action.

The New York State Legislature will be entertaining the same resolution. We will contact, and have been contacting, every known media representative in our local areas. That includes Connecticut, and we'll attempt through the national religious community to get every priest, every minister, and every rabbi in this country to request of their congregations over the next several weeks that they in turn flood the White House and the Congress with their sentiments and a demand for action.

Penny wise and pound foolish, as Mr. Eaton said, is a soft way of saying that we are inviting a kind of genocide to occur. We've got to act. We need it. The job can be done, but I don't think you or any one of your colleagues would want to turn to any one of these people and say, "You are one of the 11,000 people who has to leave treatment."

They're our children just as well as yours are.

Thank you.

Senator WEICKER. Mr. Menken, thank you, and Mr. Eaton, you also, for your very eloquent presentations.

Also I'd like to thank all of your friends that came here with you to make the point.

Mr. MENKEN. They're in the process of trying to get their minds together right now.

Senator WEICKER. These petitions are great, but you make sure that your people get out and vote. You know that in 1978, only 35 percent—35 percent of this country voted. There's no majority rule around here at all. And if only a fraction of these people get out there and

evince their priorities at election time, then we're going to get to the business that you so eloquently set before this committee.

Make no mistake about it, it's the most important investment that we make. As you say, if none of us had a human care in the world, and I think that we all do, if you just want to put it on a dollars-and-cents basis, it comes out in the black, not the red.

Mr. MENKEN. One final point, if I might, Senator. It seems that two exceptions have been made in current Federal policy. One that you referred to; that being the national security relative to the Persian Gulf problems.

The energy problem has also been bolstered. That also relates to the Persian Gulf. I would like to make our Government aware of the fact that the third, and perhaps in a sense the most critical, problem from the standpoint of the potential for the loss of human life which may be greater than the other two prices put together, also emanates from the Persian Gulf.

We've got to understand that it's all a fabric, and we've got to deal with it that way.

Senator WEICKER. Thank you both very much. Thank all of you also for coming here today. We appreciate it very much.

[The statement follows:]

STATEMENT OF EDMUND MENKEN

Mr. Chairman, members of this prestigious body, I am grateful for the opportunity to appear before you today.

My name is Ed Menken, and I am President of the Project Return Foundation, a voluntary, non-profit, New York City based human services agency providing a wide range of comprehensive health and social services to substance abusers, battered women, senior citizens and foster children. Project Return operates with a $5 million a year budget under various Federal, State and City contracts, and among our many activities is one of the largest publicly funded drug free treatment and rehabilitation programs in the United States. I am also a member of Therapeutic Communities of America, a national organization representing 302 drug abuse treatment centers throughout the country, caring for over 12 thousand clients, with a combined funding base of nearly $62 million.

I have come here today to discuss a matter of grave concern to me, to thousands of my colleagues in the field of substance abuse and to millions of parents throughout this nation.

As a body charged with the responsibility of appropriating revenues to serve the best interests of all the people of this land, I think it urgent that recent developments be brought to your attention which should be vital to your conclusions concerning funds for the National Institute on Drug Abuse.

There is a time bomb ticking away in our midst that is about to explode, causing misery and human destruction throughout America.

Hard evidence, from both public and private sources, clearly points to the fact that we should be preparing for another heroin epidemic, the likes of which have never been seen before in this country. Let me acquaint you with some facts....

After the disappearance of the French Connection in the early 1970s, the relative impact of crop subsidy programs and joint international enforcement efforts resulted in a temporary leveling off of the heroin supply to the United States. The "Golden Triangle" (Burma, Thailand and

Laos) continued to produce significant quantities of raw opium, but the primary source of heroin smuggling into this country became Mexico. The purity of the heroin decreased while the price increased, but the problem continued to escalate. Then the phenomenon of polydrug abuse emerged and the age of the typical drug abuser dropped significantly. The ravages of drug abuse spread from the ghettos of America and struck the suburban middle class.

It was then the mid-seventies and public attention was focused on the problem. The federal government responded for a time, but the interest turned out to be short-lived. Eventually, media coverage moved away from the issue and other matters captured our concern. As a nation, we began to act as though the problem had gone away and the consequence to that complacency is that we are now on the threshold of a new national disaster. Like a huge deadly monster rearing up out of the sea, the "Golden Crescent" has emerged - that volatile part of the world encompassing Pakistan, Afghanistan and Iran. The fact is that the largest opium crops ever known are now being cultivated in that area.

Prior to the recent crises in Iran and Afghanistan, our government was able to estimate, with reasonable accuracy, that that sector was producing about 200 tons of raw opium annually. Since the crisis, however, the conservative guesstimate is that a minimum of 1,000 metric tons are being produced,[1] but it could, in fact, be closer to 2,000 tons. So, the "Golden Crescent" has now become the dominant source of raw opium production, and together with the still active "Golden Triangle" and Mexican Connections, we have a situation of global heroin manufacture and distribution which is unprecedented in human history.

For nearly two years, there have been reports of a major heroin epidemic developing in Europe. Countries which never before experienced a drug problem of any serious magnitude are beset by an influx of white heroin of excellent quality and increased availability. Among the nations most seriously threatened is West Germany, where, not incidentally, the majority of American troops in Europe are stationed. According to Erich Rebscher, Chief of Intelligence for the Narcotics Division of the Federal German Police, "Heroin in Germany is so

plentiful and so potent that (they've) had 595 overdose deaths, almost twice the American total in 1979, although (they) have only one fourth the population."[2]

Mathea Falco, United States Assistant Secretary of State for International Narcotics Matters, recently told the House Select Committee on Narcotics Abuse and Control that a "sudden increase in availability of mid-east heroin over the last few years has brought a heroin epidemic to Europe in greater proportions than exists in the United States." She then said that, "The exposure of our military forces in Europe to this new supply is an indicator of the threat faced at home."[3]

David Anderson, the highest ranking American diplomat in West Berlin, further underscored the dilemma by noting that "the drug epidemic was posing a threat not only to young Europeans and United States troops stationed in Europe, but to Western society as a whole."[4]

What has been occurring in that part of the world should have received greater attention in this country, for it wasn't just happening in Germany. At Heathrow Airport, outside of London, there were at least 30 arrests in the latter part of 1979 alone, with over 16 kilos of high grade white heroin being seized. At the Bulgarian-Yugoslav border, 54.5 kilos of heroin and 20 kilos of morphine base were confiscated by Yugoslav police. And Greek authorities seized 42.6 kilos of heroin and 13.5 kilos of morphine base along the Greek-Turkish border.[5] Officials agree that the origin of all this new heroin and morphine base was the "Golden Crescent."

Indeed, these events were worthy of much greater attention. All over Europe reports of a flood of high-grade heroin should have signaled the inevitable for us here at home. Several of our own enforcement officials predicted what was to come, but our legislators and elected executives apparently took little heed. John Warner, the United States Drug Enforcement Administration Regional Director for Europe and the Middle East, warned that, "Since Europe is clearly saturated, all the new laboratories being set up and the tremendous increases in the flow of heroin to Europe demonstrates that a major drive is being prepared for Middle East heroin to take over the American market."[6] And Peter Bensinger, head of the DEA, added to the prophesy by stating, "All of Western Europe is overflowing with Middle East

heroin and our intelligence strongly indicates that we can expect larger amounts to hit the United States in the new year."[7]

Well, the prophesy was more than prophesy. Fifty-three pounds of 90 percent pure heroin was recently confiscated at Kennedy Airport in New York. The street value of that haul was over $40 million.[8] In Washington, D.C. -- right here in the nation's capital -- $32 million worth of heroin was seized just a few weeks ago, along with three men, two of them Iranians.[9] A DEA official said that an investigation into this drug smuggling episode was continuing and that the seizure was not an isolated incident.[10]

According to John W. Fallon, DEA Regional Director for the New York Area, 48 percent of all heroin confiscated in New York in 1979 had been traced to the Middle East and Asia, compared to 13 percent a few years ago. Fallon stated, "Much of it comes from the 'Golden Crescent', rural areas of Western Asia where political instability has allowed (the) unhindered cultivation of poppies. Our intelligence efforts here and in cooperation with European law enforcement agencies has led us to expect such an upsurge in heroin trafficking."[11] And DEA Chief Bensinger painted the picture with an even broader stroke by informing us that up to 800 kilos (1,760 lbs.) of heroin seized by federal agents in 1979 alone came from the mideast region.[12]

But our lawmakers weren't reading or weren't hearing or weren't listening.

We are indeed seeing the first wave of a new and worse epidemic than ever before. It is spreading far and it is spreading rapidly. The U.S. Journal of Drug and Alcohol Dependence reports that "Persian" heroin "appears to be heralding significant increases in West Coast drug use."[13] What is uniquely frightening about the California situation is that the "Persian" heroin being seen out there is not only of a higher concentration, but it appears to have been basified so that it can be smoked rather than injected.[14] This means that tens of thousands of young people who reject the idea of an intravenous high, but indulge quite comfortably with smoking marijuana, may be quite susceptible to a new but devastating euphoria. Smoking heroin is, in fact, the preferred method of ingestion in places like Hong Kong, and while a great many folks may believe that this method is less dangerous than injection, nothing could be further from the truth.

If the West Coast continues to be the trendsetter for youth as it has been in the past, then, with respect to this matter, the cost in human life could be incalculable.

If I sound like the prophet of doom, it's because I have come from the front lines, from the trenches. Back in New York and all along the East Coast, drug treatment facilities are at or over their capacities. I am hearing from my colleagues all over the country and the story is the same everywhere. We have an epidemic on our hands! How can we make our leaders understand this? What must we do to have your help and support?

Barely two months ago, the House Subcommittee on Health and the Environment, chaired by Rep. Waxman of California, effectively reduced the Federal government's support of drug treatment programs by 7 percent -- a total of $11.27 million. That legislation sought to take 7 percent of the treatment allocation and set it aside for "prevention" purposes -- an ill-advised means to a well-intentioned end. The House passed the bill almost unanimously, and the Senate followed suit.

We wrote to our representatives. We sent telegrams. We delivered petitions. But the lawmakers weren't reading or weren't hearing or weren't listening. We spoke of the signs of a coming epidemic, but perhaps we didn't have enough evidence then. Perhaps it had to be another one of those American tragedies where lives must be lost before government responds to the crisis.

We in the substance abuse treatment field have had to contend, in recent years, with curious circumstances. While we have gone about the business of trying to treat the misguided, psychologically debilitated, abused and addicted youth of this country -- the children of the rich and poor alike -- we have had to wrestle with social apathy, a contagious permissiveness toward drug taking behavior, and a governmental posture which, at best, has been unresponsive and, at worst, negligent.

For three successive years, funding for the National Institute on Drug Abuse has remained virtually the same. No regard for spiraling costs. No sense of concern for the needs of the service providers. No appreciation of the conditions created by the burgeoning drug problem.

And now, the prospect of having to cut back even further, crippling any capability to respond to this epidemic that will surely claim thousands of young lives.

Organizations such as mine, which operate residential drug free treatment facilities, have been hit by 100 percent increases in fuel costs and 50 percent increases in food expenses. Our situation is so critical that in many instances we have not even been able to purchase winter clothing or desperately needed shoes for our clients. But the fracturing effect of inflation was never even considered when the Congress recently voted to take more than $11 million away from the drug abuse treatment sector. What are we to do? The states cannot make up the difference. And the cities are certainly not able to.

In my home state of New York, the budget for the coming year calls for a 2 percent cut in treatment funds and complete elimination of the prevention effort -- a total of nearly $15 million. And, as for New York City, you might find this an interesting anecdote: I learned just a few days ago, during my effort to find out about any increase in heroin overdose deaths, that the City of New York hasn't kept those statistics for nearly two years! According to the City Medical Examiner's Office, they no longer have any way of documenting how many young people die from overdoses because it costs money to keep track of that, and the city has a fiscal problem. They cut that little item out of the budget!

Eighteen months ago, the purity of street heroin in New York was barely one percent. Last week, the police were confiscating street heroin that was close to 10 percent. A year and a half ago, the price of a kilo of medium grade heroin was $120,000. Today, the cost of a high grade kilo is $60 to 70 thousand. The drug is stronger, the price is getting cheaper and it's more plentiful than at any time during the past twenty years.

What is happening in this country? Where are we going? What will it take to get the powers that be to stop for a moment and realize that for the want of a dollar we're going to lose our children. If that is to be our destiny, history will record that these were the years when our

nation's leaders could not demonstrate the courage and creativity to deal with one of our most insidious enemies.

We have been shortsighted, ignorant, neglectful and irresponsible. But it may not be too late!

The authority of this esteemed committee permits it to recommend an increase in the allocation for the National Institute on Drug Abuse from the current appropriation to the ceiling of the authorization level -- a move which would add approximately $8 million to the treatment network. Beyond that, I would urge that every member of this body use his best influence and good offices to convince the entire Congress that they must take whatever action necessary to meet the challenge of this crisis. The situation must be dealt with strongly and swiftly. And it must be addressed on all levels -- enforcement, prevention and treatment.

I hope and pray that our leaders will take a new and deeper look at the drug abuse tragedy in this country and give to that problem all the help and support that it desperately needs. Quite simply, the future of America depends upon it.

Thank you.

References

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2. New York Times, January 11, 1980
3. New York Times, November 11, 1979
4. New York Times, October 21, 1979
5, 6, 7. New York Times, January 11, 1980
8. New York Times, January 18, 1980
9, 10. New York Post, February 7, 1980
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OPERATION CERBERUS

The total illicit opium production in Pakistan, Afghanistan and Iran for 1979 is an estimated 1,500 metric tons. At least 1,000 metric tons of this tremendous harvest, or a potential 100 metric tons of high quality heroin, could be available for the international illicit market. This is a significant increase from the 1978 crop when a then-unprecedented 700 metric tons of illicit opium were produced in the area. The acervate production is both catalyst and response to increasing demands of the Middle Eastern heroin traffic which is now well established through Western Europe and rapidly advancing to the historically lucrative United States. In the Middle East, a highly unstable political situation and the lack of central government control in critical growing and transshipment areas have imposed severe obstacles to narcotics control at the source and, at the same time, have cleared the way for unrestrained production and movement of these opiates to conversion laboratories and international trafficking organizations in Iran, Turkey and Lebanon.

The significance of the current harvest in the Middle East is best understood by recalling that an annual production of only about 80 metric tons of opium from Turkey was responsible for the heroin traffic to the United States in the 1960's and early 1970's. This traffic resulted in an estimated U.S. addict population of over 700,000.

The heroin addiction problem in America today has greatly improved. Following effective enforcement efforts and the 1972 Turkish Opium Ban, the American market was taken over by heroin from Mexico and, to a lesser extent, from Southeast Asia. By 1979, continued enforcement efforts and the eradication campaign in Mexico have steadily brought the United States to the lowest heroin abuse rate in the last decade. Due to the low availability of heroin, annual U.S. consumption has fallen to about four metric tons and the current addict population is less than 400,000. Street level purity has dropped to 3.5 percent.

The abundant supplies of high quality heroin produced from Middle Eastern opium may well capture the Western market in the early 1980's. This heroin, because of its availability and high purity, could intensify and expand the addiction problem within the United States. The tendency for Middle Eastern heroin to create a prodigious demand has been proven no more clearly than in the Federal Republic of Germany (FRG). The Federal Republic did not have an addiction problem in the early 1970's. In 1974, however, Turkish and Iranian traffickers began importing quantities of Middle Eastern heroin into the country. By mid-1979, there were an estimated 60-80 thousand* heroin addicts in the Federal Republic, a country the size of Idaho with a total population of 62 million. Seizures of Middle Eastern heroin have increased from 0.9 kilograms in 1974 to 85.5 kilograms in 1978 and 90.1 kilograms for the first six months of 1979. Overdose deaths have increased from nine in 1969 to 378 in 1978 and 447 in the first nine months of 1979. The figure for 1978 represented 6.10 deaths per million population, as opposed to the United States which had approximately 4.6 deaths per million population in 1978. The U.S. figures do not include the number of victims from the 250,000 U.S. military personnel stationed in West Germany nor their dependents.

*FRG Drug and Rehabilitation Figure

The Middle Eastern heroin problem is currently spreading to Western European markets which have traditionally been the realm of Southeast Asian heroin. Both The Netherlands and Italy are reporting decreasing availability of Southeast Asian heroin and increased activity by Middle Eastern traffickers. In The Netherlands, Middle Eastern heroin has found increasing addict acceptance despite its significantly higher street-level strength of 65-80 percent versus 20-35 percent for Southeast Asian heroin No. 3, the traditional heroin of choice. In Italy, heroin-related deaths and injuries continue to increase despite the fact that seizures of Southeast Asian heroin have decreased from 74.3 kilograms in 1978 to 23 kilograms in the first nine months of 1979. Conversely, Middle Eastern heroin seizures have increased from 5.6 kilograms in 1978 to 29.6 kilograms in the first nine months of 1979.

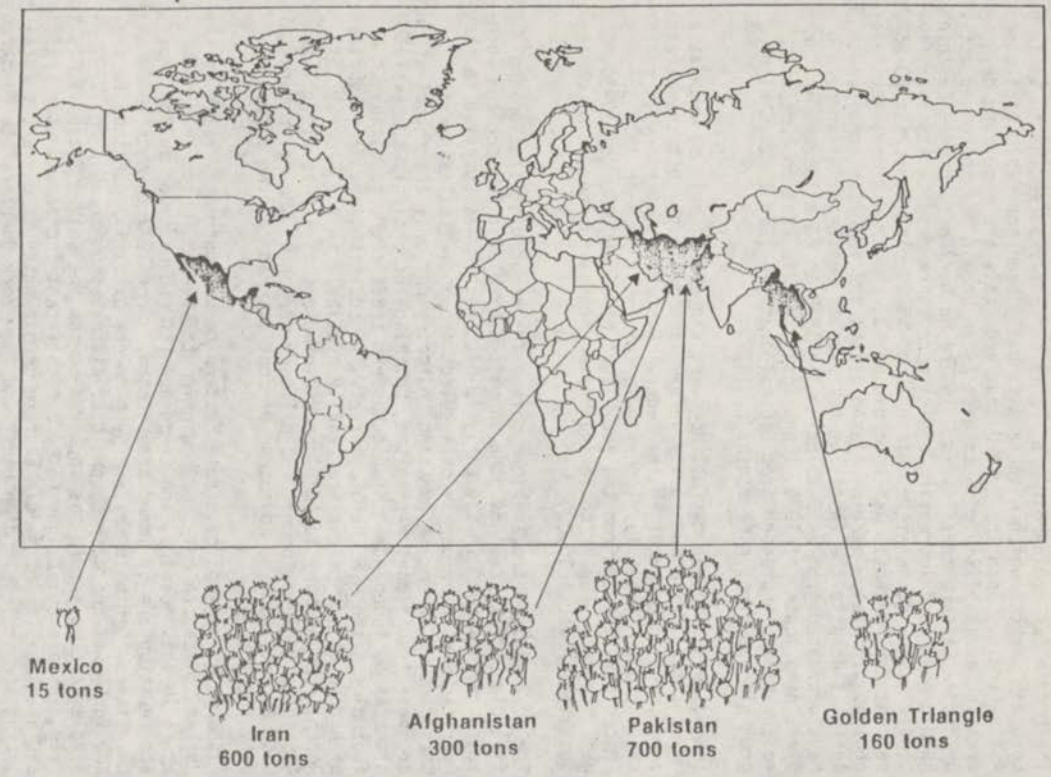
The Western European market, however, can absorb only so much at a given time. Price and purity information indicate that the heretofore insatiable market in the Federal Republic of Germany is reaching saturation. Street level purity is currently 38.8 to 42.0 percent. Prices have dipped from the equivalent of $55-60,000 to $25-30,000, per kilogram. The price in the United States for heroin of equal quality is over $200,000.

The potential of the American market for broad distribution and fivefold profits has not gone unnoticed by Middle Eastern and European traffickers. In the early 1970's, heroin was supplied to the American market primarily by a select group of Sicilians and Corsicans. Current information indicates not only the reactivation of these traditional mechanisms, but also increasingly successful attempts by independent Middle Eastern traffickers to establish a foothold in the U.S. heroin market. In addition, abundant supplies of heroin at low prices are readily available in the Federal Republic of Germany to American distributors of all levels. These Americans include former U.S. military personnel who may return to West Germany to take advantage of contacts made during a tour of duty there.

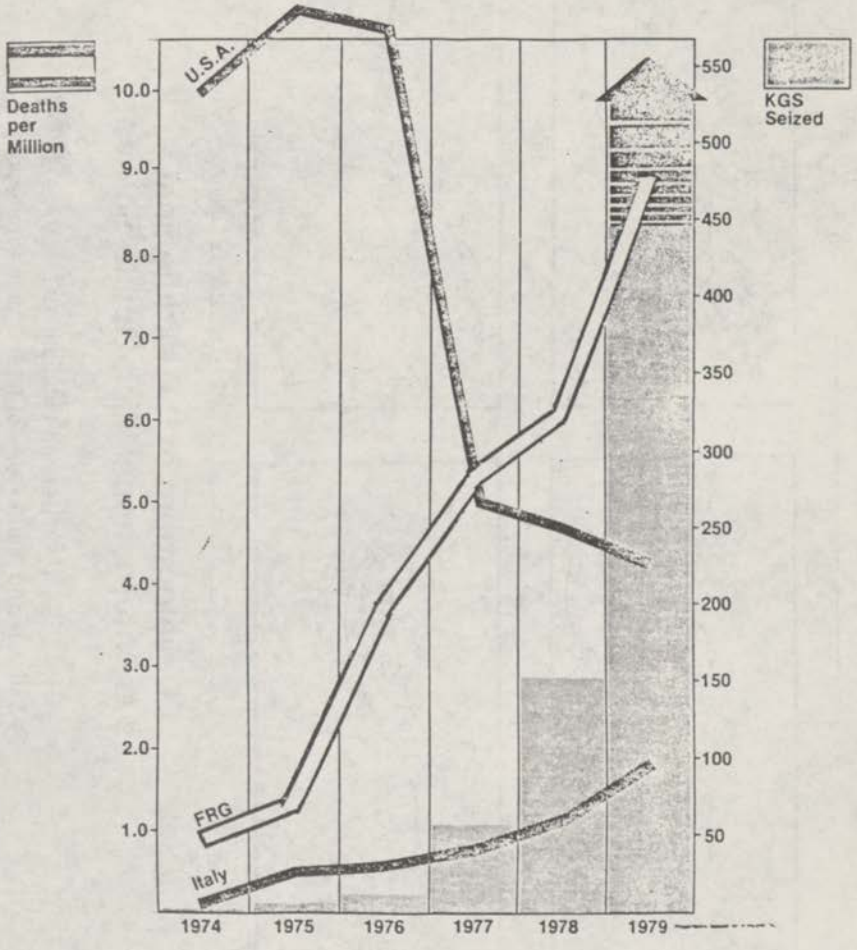
Although quantities of Middle Eastern heroin currently reaching the United States are only now beginning to have an impact on heroin abuse in this country, the trend and its proven tendency for rapid acceleration are of immediate concern. From 1977 through 1978, small quantities of Middle Eastern heroin were primarily confined to the New York City and Washington, D.C. distribution areas. In 1979, Middle Eastern heroin has appeared across the United States. New York City, in particular, has noted a significant increase in the traffic and availability of Middle Eastern heroin which is currently escalating street level "dime bags" and "New York Quarters" to dangerously erratic purity levels ranging from 2.3 to 62.8 percent. Developing information indicates major distributors are predominantly Black and Hispanic groups with Italian and/or Middle Eastern sources of supply. One recent investigation involved the direct importation of Middle Eastern heroin from the Federal Republic of Germany by a major distributor in Harlem.

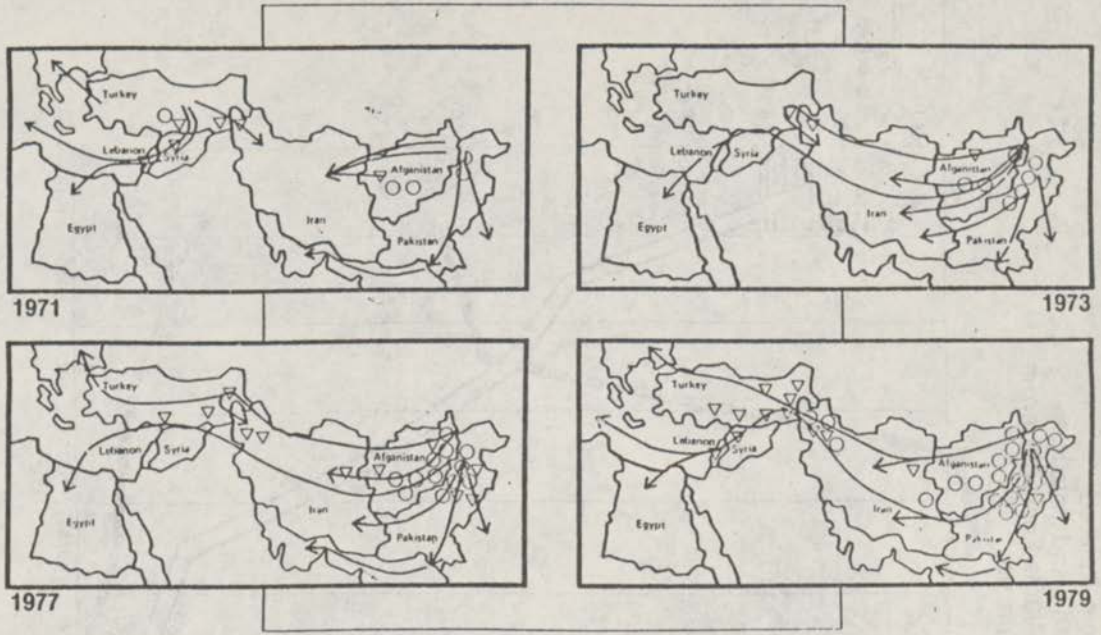
The situation demands swift and decisive action. Although eradication and crop substitution programs at the source will be a long and difficult process, the opium production of the Middle East must not bring us back to the heroin addiction problems this country faced in the early 1970's. And there is no reason it should. Because of our intelligence and liaison programs, we have a comprehensive definition of the problem before it has had a major impact on the U.S. market. Past experience and existing programs have laid firm groundwork for vigorous enforcement in both Europe and the United States and for aggressive diplomatic initiatives in the opium production and conversion areas.

(Estimated)
1979 Illicit Opium Production



Heroin-Related Deaths and Seizures of Middle Eastern Heroin in Europe





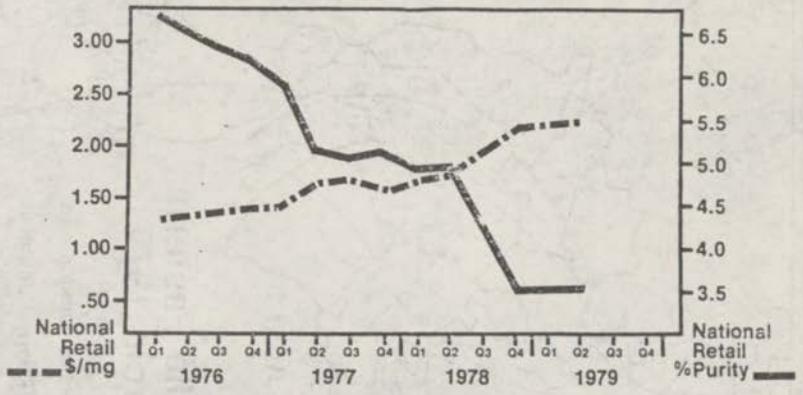
Development of the Middle East as an International Illicit Opiate Source

▽ Conversion Laboratories

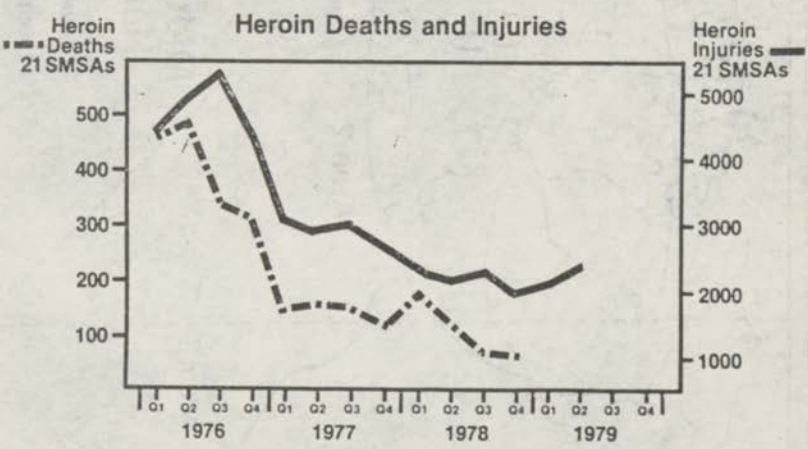
○ Estimated 50 Metric Tons of Illicit Opium Production

Heroin Availability Indicators

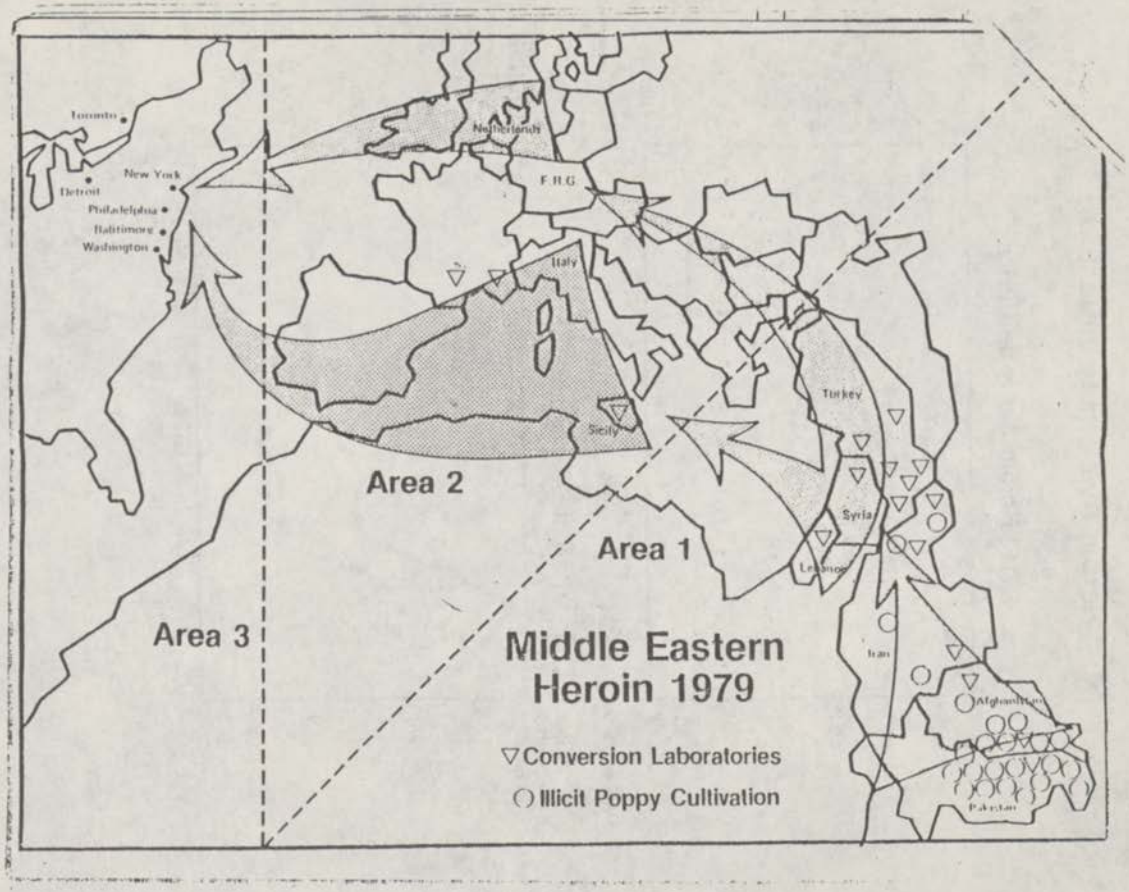
Retail Heroin Purity and Price



Heroin Deaths and Injuries



64-129 O - 80 - 64


Toronto
New York
Detroit
Philadelphia
Baltimore
Washington
Netherlands
F.R.G.
Italy
Sicily
Turkey
Syria
Lebanon
Iran
Afghanistan
Pakistan
Area 1
Area 2
Area 3
Middle Eastern
Heroin 1979
▽Conversion Laboratories
○Illicit Poppy Cultivation

STATEMENT OF:
JACQUELINE HANSON, AMERICAN HEALTH PLANNING ASSOCIATION

ACCOMPANIED BY:
DR. HENRY CAIN
JANET FORBUSH, JBF ASSOCIATES
CAROLYNE DAVIS, THE NATIONAL LEAGUE OF NURSING

Senator WEICKER. All right. The next group will address itself to the matter of Health Resources Administration, and Office of the Assistant Secretary for Health Programs. We have with us the American Health Planning Association, represented by Dr. Cain and Ms. Jacqueline Hanson; JBF Associates, Ms. Janet Forbush; and the National League of Nursing, Ms. Carolyne Davis.

We're glad to have you all here. All right, I think we'd better get right on to the business at hand, so please proceed in any way you wish.

HEALTH PLANNING RECOMMENDATIONS

Ms. HANSON. Mr. Chairman, my name is Jacqueline Hanson. I am president of the American Health Planning Association. With me is Dr. Henry Cain, executive director of AHPA.

I appear before you today as spokesperson for the more than 250 State and local health planning agencies authorized by Congress to control costs and improve resource allocation—who are now hard at work accomplishing these difficult objectives in the health planning world.

On behalf of the staffs and the volunteer participants who do number over 50,000 people in these agencies, I wish to thank you and your staff for your support of health planning. The extraordinary effort that was made to insure that in 1980 health planning agencies would receive funds adequate to sustain and increase their efforts is acknowledged and appreciated across the country, where the benefits of effective health planning are being realized.

We feel the health planning agencies' performance during 1979 and the efforts underway merit your continued support. The investment already made in health planning has brought dividends in an area of the economy which perhaps more than any other has been beset by inflation, without concomitant increase in services or value received.

The administration's total request for health planning is $181,400,000. Included in that figure is $9,700,000 that is budgeted for health care facilities and finance administration for the voluntary closure and conversion of excess hospital capacity.

The total amount that we are requesting on behalf of the health agencies inclusive of administration and program support is $192,400,000. This breaks down as follows:

A 7-percent increase above the fiscal year 1980 funding for the 204 local health systems agencies which will enable them to address new national priorities added by Public Law 96–79, such as mental health planning, promotion of health marketplace competition, and increased attention to the needs of the rural and medically underserved.

A 12-percent increase above fiscal year 1980 as needed for the State

health planning and development agencies, so that these agencies may fully implement the certificate of need and State health plan requirements in the new law.

An additional $1,300,000 is required for the four centers for health planning, the only training and technical assistance institutions available to the boards and staffs of health planning agencies.

We recommend $500,000 in administration and program support for the Bureau of Health Planning so that it can maintain the Health Planning Information Center until this critical data bank is shifted to the National Library of Medicine; and something about which we feel very strongly, $10 million to initiate the area health services development fund, which has been authorized since the initial passage of Public Law 93–641, but which has never been funded. It is an area which most local communities perceive as even more vital to the improvement of health care than the voluntary closure and conversion program requested by HCFA.

PLANNING ACCOMPLISHMENTS

We do want to stress to you that we do not propose these increases simply to support the demands of inflation. Planning is demonstrating its value. In Kentucky, a health planning agency stimulated business consortia to provide both health care cost control and marketplace competition in health care. This included establishment of two new HMO's.

In eastern Connecticut, the health systems agency provided the assistance necessary to local community groups concerned with hospice development to enable them to organize and begin development of a home care model of hospice.

In the Piedmont area of North Carolina, the agency actively assisted residents in obtaining medically underserved area designations for two townships; which directly resulted in their being able to open a long-planned community health clinic, become eligible for medicare and medicaid reimbursement, and place a National Health Service Corps physician in the clinic.

These are only two of a number of examples that we cite in our testimony, to which we draw your attention.

The resource development activities the agencies participate in are often overshadowed by significant savings that resulted from health planning. A recently issued HEW/Bureau of Health Planning program information letter, which is attached to this written testimony, shows results of a survey conducted by independent researchers, and the survey analyzes State planning agency performance in reducing the level of inappropriate capital expansion of institutional facilities.

This study found a decrease of half a billion dollars in total capital expenditures approved from 1978. It estimates that new hospital bed construction has dropped over 90 percent from 1973 to 1979, and 66 percent from 1977 to 1979. The limitations of unneeded hospital growth have been accomplished without compromising the need to replace existing beds, which no longer meet life-safety or other accreditation requirements.

Although 4,170 new beds were approved during the first two quarters of 1979, the net addition approved was only 986 because of 3,184 removals or conversions.

These are activities that took place as a result of the activities under the law that governs health planning, and this data only reflects State agency action.

The local agencies are the primary recipients of proposed certificate of need applications, and give applicants technical assistance on prospective proposal submissions, which often results in cost-saving modifications of subsequent applications.

Mr. Chairman, we would also like to bring your attention to a particularly alarming cut recommended in the President's budget which would quite adversely affect the health planning programs of the country. I refer to the major cut in resources designated for the cooperative health statistics system. We go into some explanatory detail in our written testimony, to which I draw your attention.

Senator WEICKER. Your testimony will be included in its entirety along with the other ones.

Ms. HANSON. Thank you.

We urge, however, considering this recommended cut in the cooperative health statistics system, that the committee appropriate at least as much in 1981 as was appropriated in 1980, and if possible, even some modest increase would be very helpful to help States improve their performance in this critical area.

Mr. Chairman, we thank you and the other members of the committee for this opportunity.

Senator WEICKER. Thank you very much.

[The statement follows:]

Statement of Jacqueline Hanson

My name is Jacqueline B. Hanson. As President of the American Health Planning Association, I appear before you as a spokesperson for the more than 250 State and local health planning agencies which are authorized by Congress to control costs and improve resource allocation, and are now hard at work accomplishing these difficult objectives. On behalf of the staffs and volunteer participants who number over 50,000 people in these agencies, I wish first to thank you and your staff for your support of health planning. The extraordinary effort you made to ensure that in 1980 health planning agencies would receive funds adequate to sustain and increase their efforts has not gone unappreciated in the many local areas of the country which will benefit from effective health planning. I believe their performance during 1979 and increasingly in the coming years merits your continued support of health planning. The investment you have made in health planning has already brought dividends in an area of the economy which perhaps more than any other has been beset by inflation without concomitant increase in services or value received.

This year we are asking for a 12% increase over the Administration's total request of $181,400,000 for health planning which includes $9,700,000 that is budgeted in the Health Care Facilities and Finance Administration for the voluntary conversion and closure of excess hospital capacity. The total amount we are requesting for FY 1981, inclusive of administration and program support, is $192,400,000. This breaks down as follows: a 7% increase above FY 1980 funding for the 205 local health systems agencies to enable them to address new national priorities added by Public Law 96-79, such as mental health planning, promotion of health marketplace competition, and increased attention to the needs of the rural and medically underserved, to name a few; a 12% increase above FY '80 for State Health Planning and Development agencies necessary for these agencies to fully implement the certificate of need and State health plan requirements in the new law; an additional $1,300,000 for the four centers for health planning, the only training and technical assistance institutions available to the Boards and staffs of health planning agencies; $500,000 in administration and program support for the Bureau of Health Planning so that it can maintain the Health Planning Information Center until this critical data bank is shifted to the National Library of Medicine; and $10,000,000 to initiate the Area Health Services Development fund which most local communities

perceive as even more vital to the improvement of health care than the voluntary conversion and closure program funding requested by HCFA.

I want to stress to you, Mr. Chairman, that we do not propose these modest but real increases as "cost-of-living" increases to offset the inflation all of us face (see attachment A), or as pie in the sky "look what we could do for you if only we had a few more dollars." Planning is demonstrating its value. In your own State, Mr. Chairman, health planning agencies not only were effective in capital expenditure control, but also in establishing health promotion and self-care programs in cooperation with major employers, community groups like the YWCA, and the community college system. Area health planners have helped develop and program the nation's first cable TV health channel dedicated to full time health education. In South King County, health planners have worked directly with Weyerhauser Corporation, other businesses, and community councils to establish and coordinate health planning in a new community developed in part by Weyerhauser.

In Kentucky a health planning agency stimulated a business consortium to provide both health care cost control and marketplace competition in health care in the region. This included establishment of two new HMOs.

In Palm Beach, Florida, the planning agency, working with county commissioners, PTAs, and public and private entities developed a comprehensive health education program for all school systems in the area.

In Iowa, the health planning agency was instrumental in establishing a training program for cardiac pulmonary resuscitation with faculty members in 75 school districts trained as basic rescuers.

In Northwest Ohio a planning agency worked directly with the Toledo Metropolitan Area Council of Governments to develop a non-fixed system of transportation for the elderly and handicapped for the entire metropolitan Toledo area.

In Eastern Connecticut the health systems agency provided the assistance necessary to local community groups concerned with hospice development to enable them to organize to begin development of a home care model of hospice.

In rural South Carolina the health planning agencies have helped six rural health initiative programs recruit physicians, develop working budgets, and establish effective community liaison and information referral. The planning agency has also been instrumental in establishing shared services agreements and new provider relationships in that region.

In the Piedmont area of North Carolina, the agency actively assisted residents in obtaining medically underserved area designations for two townships which directly resulted in their being able to open a long-planned community health clinic; become eligible for medicare and medicaid reimbursement; and place a National Health Service Corps physician in the clinic.

In Northern Virginia the health systems agency helped establish a competitive market for laboratory services by promoting the establishment of an intrastate clinical lab that will offer lab services at less cost than with existing laboratories. They also produced, with the cooperation of many M.D.s in the area, a comprehensive physician directory of all specialty areas including physician background, training, fees and billing procedures, and other critical information.

In the Hudson Valley of New York the HSA worked with an existing migrant health care center to develop a satellite clinic to provide services to another underserved area.

In Wisconsin, the health systems agency of North Central Wisconsin identified 16 counties in its service area that were without home health services as of 1977. Through the actions of this agency, State and federal resources were mobilized, needs and services requirements identified, and target populations established. By late 1979, there were fully certified home health agencies in all counties.

These examples are only a very small portion of concrete health plan implementation activities engaged in by health systems agencies during the past year. We don't ask you to take our word for it. Ask the people whose institutions and health service delivery capabilities have been proven through effective, cooperative, voluntary health planning.

These resource development activities are sometimes overshadowed by the

significant savings that have resulted from health planning. A recently issued HEW/Bureau of Health Planning Program Information Letter (see attachment B) highlights results of a survey conducted by independent researchers under contract to the Bureau. The survey analyzes State planning agency performance in reducing the level of inappropriate capital expansion of institutional facilities. This study found a decrease of 1/2 billion dollars in total capital expenditures approved from 1978. Also, it estimates that new hospital bed construction has dropped over 90% from 1973 to 1979 and 66% from 1977 to 1979. These limitations of unneeded hospital growth have been accomplished without compromising the need to replace existing beds which no longer meet life-safety or other accreditation requirements. We quote from page two of the study: "Although 4,170 new beds were approved during the first two quarters of 1979, the net addition approved was 986 because 3,184 removals or conversions to non-hospital use were also approved."

Please note that this data reflects only State agency action; local agencies are the primary recipients of proposed CON applications and give applicants technical assistance on prospective proposal submissions which often results in cost saving modifications of subsequent applications. Thus, local HSA review activity saves additional dollars not registered in State counts, while helping the applicant refine the proposal so that it better meets the needs of the population of the area.

Mr. Chairman, the increases in funding we have requested will enable State and local planning agencies to maintain the momentum established in both resource development and cost control. Less than 1/10 of 1% of health care dollars is now spent on health planning. For every $1,000 spent on health care in 1981, we ask you to allocate less than a dollar for health planning. That small an investment will enable health planning to continue to show results in an area of the economy that must be increasingly responsive to peoples' needs and must control unnecessary public and private expenditures. We believe the small amount requested can go a long way toward making our health care dollar a dollar well spent.

Mr. Chairman, we would also like to bring to your attention one particularly alarming cut in the President's budget, the effect of which would quite adversely affect the health planning programs of the country. I refer to the major cut in resources designed for the Cooperative Health Statistics System.

As you know, the health planning Act requires health planning agencies to rely on statistics that are already being collected by other agencies rather than to build new collection systems themselves. In particular, the planning agencies are instructed to rely upon the Cooperative Health Statistics System for as much of their needed data as possible.

Developing the CHSS to the point where it is becoming genuinely useful to the planning agencies has been a long, difficult process. Most States have not yet put all the pieces together to operate a truly effective health statistics program. Nonetheless, a few of them have done so, and many more are nearing that stage. If the federal support for those efforts is severely cut, a few States may find the internal resources to keep their systems going and to improve them, but most States will have to retrench and will be unable to effectively provide the data necessary for effective health planning.

Without a State capacity for handling health statistics, each health planning agency will have to develop its own statistical systems and surveys, and the health facilities in every area will have to fill out many more kinds of forms.

We fear this set of developments not only because the planning agencies will have to spend more of their own scarce resources on developing new data collection systems, but also because we can foresee a mad scramble for data from the same data sources (namely the hospitals and other facilities) with no coordination or cooperation among the many different users. In the absence of a strong data program in each State, either the planning programs and others will not be very effective or there will be increasing chaos in the scramble for intelligence on what the health industry is actually doing. We would therefore urge that the Committee appropriate at least as much in 1981 as you appropriated in 1980, and if possible, some modest increment to allow some more States to improve their performance in this critical area.

Mr. Chairman, we thank you and the other members of the Subcommittee for having had this opportunity to address our concerns.

AMERICAN HEALTH PLANNING ASSOCIATION
TESTIMONY FOR FY 1981 HEALTH PLANNING APPROPRIATIONS

ATTACHMENT A

The American Health Planning Association's testimony mentions our aversion to focusing the presentation on "cost of living increases" as sole justification for adequate FY 1981 funding for health planning agencies. However, for the reader's information and for purposes of comparison, we hereby submit this attachment as part of the hearing record. This attachment paraphrases data received by AHPA from one local HSA executive director, and is representative, we feel, of the effects of cost of living on the operation of such an agency:

- Obvious increases include amounts for rent, utilities, supplies, and reimbursement to staffs and volunteers for travel expenses to attend mandated meetings and hearings;

- Hiring new employees to fill vacancies is costlier now, due to inflation, than cost of hiring for the same positions even three years ago. For example, by comparison, in July 1976, beginning GS-3 secretaries were hired for $7107; starting in October, 1979, the starting salary for the same position was $8952. To competitively attract competent staff, HSAs have also had to increase beginning salaries for new employe s;

- HSAs have had to increase salaries commensurate with performance to keep and promote staff members with needed experience. Longevity of employment is a desirable feature in most positions, and must therefore be financially rewarded where appropriate; but HSAs have not been able to be as competitive as have others in this regard. For example, one local HSA director reports that he was hired on July 1, 1976, at a salary of $34,000 per annum, and effective October 1, 1979, was at $39,000 per annum -- a 3-year increase of 14.7% (4.5% per year) and a total increase over three years, three months of $5,000. Again, by comparison, a person starting at the Regional or Central DHEW office at a GS-15 level on July 1, 1976, started at an annual salary of $31,309 and effective October 1, 1979, was at $44,915 in the same Grade -- a 3-year increase of 43.4% (13.3% per year) and a total increase after three years, three months of $13,606.

  Also by comparison, to go from top to bottom of staff positions, a GS-3 secretary hired July 1, 1976, started at an annual salary of $7,107 and now makes $9,846 in the same Grade -- a 38.6 per cent increase in three years, three months (11.8% per year). An HSA secretary in a comparable grade started in July, 1976, at $7,000 per annum and now makes $8,500 per annum -- a 21.4% increase in three years, three months (6.5% per year).

[AHPA-FY'81 Testimony attachment B]

December 27, 1979

TO : State Health Planning and Development Agencies
Statewide Health Coordinating Councils
Health Systems Agencies
Centers for Health Planning

SUBJECT : Data Highlights on State Reports of Hospital Capital Expenditures

Based on Program Policy Notice No. 79-08 (May 4, 1979), the State Health Planning and Development Agencies were requested to begin reporting on State certificate of need/1122 actions on proposals of $150,000 or more for hospital expenditure proposals. These reports were submitted for the first two quarters of calendar year 1979 on Form HRA-258. Starting July 1, States began to submit the Record of State and Local Action under Section 1122 of the Social Security Act and State certificate of need programs (HRA-45 Revised).

Attached are summary data tables derived from the State Reports (HRA-258) which cover the first six months of calendar year 1979. The tables include data from all of the SHPDAs. The data tables are preceded by a brief analysis, which highlights the progress the health planning agencies are making in reducing the level of approvals for capital expenditures.

Over the coming year, both the Bureau of Health Planning and the Bureau of Health Facilities Financing, Compliance, and Conversion will be expanding their efforts to analyze available data on certificate of need actions and capital formation generally. The data which is submitted by the State Agencies provides a major source of input to developing trend data on the level of capital expenditures, the potential impact on future operating costs, and the overall effect on the structure of the health care system. As these analytical efforts are completed, they will be forwarded to you.

We appreciate your efforts to complete the State reports for the first six months, and urge the same continued level of cooperation as you forward the individual certificate of need/1122 action forms (HRA-45 Revised) which we started using July 1, 1979.

Florence B. Fiori, Dr. P.H.
Director
Bureau of Health Facilities
Financing, Compliance, and
Conversion

Colin C. Rorrie, Jr., Ph.D.
Director
Bureau of Health Planning

Data Highlights from State Reports on Hospital Capital Expenditures

1. The data in this summary represents the contribution of all States and Territories.

2. Total Volume of Approvals

The total volume of approved capital expenditures during the first two quarters of 1979 was $2.38 billion. If a similar rate of reviewed and approved expenditure is sustained for the second half of the year, there will be about $4.7 - 4.8 billion in approved hospital capital expenditures of $150,000 or above for calendar year 1979. While this figure is higher than the $3 billion dollar voluntary cap proposed in January, 1979, it represents a significant savings over the estimated historical average of $5.2 billion, particularly when the rate of inflation is taken into account.

The following table shows approved expenditure volumes reviewed and approved for each of the first two quarters and also distributes expenditures between physical plant and equipment.

Capital Expenditure Summary ($ in 000s)

	First Quarter		Second Quarter		Total	
	Reviewed	Approved	Reviewed	Approved	Reviewed	Approved
Physical Plant	$926.591	$859,985	$1,213,751	$1,131,853	$2,140,342	$1,990,938
Equipment	$151,137	$141,650	$ 145,047	$ 135,489	$ 296,184	$ 277,139
Total	$1,077,728	$1,000,735	$1,358,798	$1,267,342	$2,436,526	$2,268,077

The total for both quarters is $2,382,323,284 when New York's total approved expenditures is included.

Approved expenditures for equipment are only 12 percent of total proposed expenditures. However, if the reporting threshold had been lower than $150,000, the difference between physical plant and equipment may not have been as great.

3. Net Change in Beds

Although 4, 170 new beds were approved during the first two quarters, the net addition approved was 986 because 3,184 removals or conversions to non-hospital use were also approved.

Bed Change Summary

	First Quarter		Second Quarter		Total	
	Reviewed	Approved	Reviewed	Approved	Reviewed	Approved
Added	+3687	+2648	+1968	+1522	+5655	+4170
Removed	-1098	-1310	-1409	-1449	-2507	-2759
Converted	-207	-207	-218	-218	-425	-425
Net Change	+2382	+1131	+341	-145	+2723	+986

This net change is consistent with a decline in annual bed increases since 1973, presented in the table below. In 1973, the bed increase was 19,538 or 2.1 percent of the total beds. By 1977 these figures had dropped to 5,701 and .6 percent, respectively. At the current rate the 1979 net increase will be 1,972, or about .2 percent.

Bed Increase in Non-Federal Hospitals, 1973-1977, 1979

Year[1/]	No. of Beds	Increase in Beds	% Increase in Beds
1973	933,112	19,538	2.1
1974	951,582	18,470	2.0
1975	968,379	16,797	1.8
1976	980,299	11,920	1.2
1977(est.)	986,000	5,701	.6
1978	N/A	N/A	N/A
(New Beds Approved First and Second Quarters)			
1979[2/]	N/A	1,472 to 3852(est.)[3/]	.2 to .4(est.)

1/Source: National Center for Health Statistics master facility inventory

2/Source: State Reports on Hospital Capital Expenditures

3/A range is provided here because of what may be an unusual number of closings in New York during this period.

4. Highest Levels of Bed Additions and Capital Expenditure Approvals, by State

The States with the largest number of bed additions were, with the exception of Puerto Rico, all from the South or Southwest, areas where in most States the population increase is higher than the national average.

State	Additional beds approv.	Rate of pop. change, 1970-1978	Existing beds/1000
Texas	740	16.7	4.7
Louisiana	510	9.2	4.7
Tennessee	406	11.2	5.4
Alabama	283	9.1	4.9
Florida	182	27.1	5.0
Arkansas	156	13.7	4.7
Georgia	150	11.7	4.8
Puerto Rico	122	N/A	N/A
New Mexico	110	19.6	3.2
Mississippi	104	8.5	5.0

For all of these States except New Mexico the existing bed/1000 population ratio is already 5.0 or above.

The States with the largest amounts of approved capital expenditures were for the most part, Eastern or Mid-Western industrial States.

State	Capital Expenditures	Beds per 1,000
Illinois	$236,456,000	5.0
Pennsylvania	$186,615,000	4.7
Texas	$165,783,000	4.7
Ohio	$150,161,000	4.7
Michigan	$146,481,000	4.4
New York	$114,245,000	4.4
Massachusetts	$108,017,000	4.6
Indiana	$100,896,000	4.5
New Jersey	$ 90,740,000	4.6
Alabama	$ 85,764,000	4.9

5. States Reporting Net Bed Reduction

Of 38 States and Territories reporting net bed changes for the first six months of 1979, 14 listed net negative changes. In California, Connecticut, Massachusetts and Pennsylvania, as a result of negotiations during the review process, more beds were approved for removal or conversion than were applied for.

State	Net No. Beds Approved for Removal or Conversion	Beds per 1,000 population
New York	940	4.4
Michigan	343	4.4
Massachusetts	219	4.6
Iowa	185	5.4
Connecticut	172	3.6
Wisconsin	114	4.8
Pennsylvania	126	4.7
California	86	3.9
Minnesota	38	5.3
South Dakota	19	5.2
Maine	11	4.3
New Hampshire	9	3.9
South Carolina	6	3.7
Hawaii	6	2.5

Twenty-four States and Territories had a net increase in beds and the remainder reported no change.

First and Second Quarter Totals 1979

Table 1. State Reports on Hospital Capital Expenditures (Totals) for 50 States and 5 Territories and District of Columbia and Puerto Rico ($ in 000's)

Total Volume Reviewed:	Total Volume Approved:	% Approved:	Net Number of Beds Proposed:	Net Number of Beds Approved:
$2,552,564	$2,382,323	93.3	2723	986

Table 2. Hospital Capital Expenditures by Type of Expenditures - Physical Plant and Equipment ($ in 000's)

Physical Plant			Equipment		
Reviewed:	Approved:	% Approved:	Reviewed:	Approved:	% Approved:
$2,140,324	$1,990,938	93.0	$296,184	$277,139	93.6

STATE	Physical Plant			Equipment			TOTAL		
	Reviewed	Approved	% Approved	Reviewed	Approved	% Approved	Reviewed	Approved	% Approved
Alabama	69,986	69,986	100.0	15,778	15,778	100.0	85,764	85,764	100.0
Alaska	1,278	1,278	100.0	0	0	0	1,278	1,278	100.0
Arizona	41,472	3,747	9.0	5,692	5,692	100.0	47,164	9,439	20.0
Arkansas	30,065	30,065	100.0	1,595	1,595	100.0	31,660	31,660	100.0
California	59,453	49,585	90.3	13,017	10,870	83.5	63,470	60,455	95.3
Colorado	1,836	1,836	100.0	1,094	1,094	100.0	2,930	2,930	100.0
Connecticut	64,946	56,346	86.8	10,102	8,511	84.3	75,048	64,857	85.4
Delaware	3,398	3,398	100.0	260	260	100.0	3,658	3,658	100.0
District of Columbia	0	0	0	793	793	100.0	793	793	100.0
Florida	68,137	51,850	76.1	7,893	7,268	92.1	76,030	59,118	77.8
Georgia	33,412	33,412	100.0	8,435	8,435	100.0	41,847	41,847	100.0
Hawaii	3,536	3,186	90.1	2,889	2,889	100.0	6,425	6,075	94.6
Idaho	20,869	20,869	100.0	0	0	0	20,869	20,869	100.0
Illinois	245,316	223,206	91.0	14,678	13,350	90.9	259,994	236,556	91.0
Indiana	94,174	94,174	100.0	7,557	6,722	89.0	101,731	100,896	99.2
Iowa	39,558	39,558	100.0	10,960	10,960	100.0	50,518	50,518	100.0
Kansas	3,369	3,164	93.9	2,255	2,255	100.0	5,624	5,419	96.4
Kentucky	24,205	24,205	100.0	6,376	5,824	91.3	30,581	30,029	98.2
Louisiana	46,521	46,521	100.0	10,328	10,328	100.0	56,849	56,849	100.0
Maine	3,544	3,544	100.0	787	787	100.0	4,331	4,331	100.0
Maryland	38,313	38,313	100.0	3,657	3,657	100.0	41,970	41,970	100.0
Massachusetts	95,509	88,710	92.9	26,120	19,307	73.9	121,629	108,017	88.8
Michigan	176,758	176,758	100.0	19,723	19,723	100.0	196,481	196,481	100.0
Minnesota	25,140	25,140	100.0	3,260	3,260	100.0	28,400	28,400	100.0
Mississippi	28,484	28,484	100.0	5,238	5,238	100.0	33,722	33,722	100.0
Missouri	13,821	13,821	100.0	2,424	2,424	100.0	16,245	16,245	100.0
Montana	220	220	100.0	0	0	0	220	220	100.0
Nebraska	18,858	3,858	15.2	380	380	100.0	19,238	3,238	16.8
Nevada	2,100	2,100	100.0	536	536	100.0	2,636	2,636	100.0
New Hampshire	688	688	100.0	808	808	100.0	1,496	1,496	100.0
New Jersey	83,969	83,969	100.0	9,152	6,771	74.0	93,121	90,740	97.4
New Mexico	22,644	17,324	76.5	3,266	1,606	49.2	25,910	18,930	73.1
New York							116,036	114,241	98.4
North Carolina	8,873	8,873	100.0	5,612	5,612	100.0	14,485	14,485	100.0
North Dakota	352	352	100.0	390	390	100.0	742	742	100.0
Ohio	128,804	128,804	100.0	21,357	21,357	100.0	150,161	150,161	100.0
Oklahoma	28,556	28,556	100.0	5,361	5,361	100.0	33,917	33,917	100.0
Oregon	12,470	12,470	100.0	2,019	2,019	100.0	14,489	14,489	100.0
Pennsylvania	179,947	175,269	97.4	11,961	11,346	94.9	191,908	186,615	97.2
Rhode Island	3,019	3,019	100.0	0	0	0	3,019	3,019	100.0
South Carolina	44,485	44,485	100.0	1,395	1,395	100.0	45,880	45,880	100.0
South Dakota	18,090	18,090	100.0	0	0	0	18,090	18,090	100.0
Tennessee	28,168	28,168	100.0	2,836	2,836	100.0	31,004	31,004	100.0
Texas	160,743	142,483	88.6	23,300	23,300	100.0	184,043	165,783	90.1
Utah	37,129	37,129	100.0	238	238	100.0	37,367	37,367	100.0
Vermont	18,581	9,045	48.7	150	150	100.0	18,731	9,195	49.1
Virginia	45,475	45,475	100.0	10,719	10,719	100.0	56,194	56,194	100.0
Washington	35,463	35,463	100.0	6,810	6,810	100.0	42,273	42,273	100.0
West Virginia	43,892	43,892	100.0	3,149	2,749	87.3	47,041	46,641	99.2
Wisconsin	22,116	21,232	96.0	5,402	5,402	100.0	27,518	26,634	96.8
Wyoming	4,300	4,300	100.0	223	223	100.0	4,523	4,523	100.0
American Samoa	0	0	0	0	0	0	0	0	0
Guam	0	0	0	0	0	0	0	0	0
Puerto Rico	17,282	15,500	89.7	207	207	100.0	17,489	15,707	89.8
Trust Territory	0	0	0	0	0	0	0	0	0
Virgin Islands	0	0	0	0	0	0	0	0	0
Northern Marianas	0	0	0	0	0	0	0	0	0
TOTAL	2,140,342	1,990,930	93.0	296,184	277,139	93.6	2,552,564	2,382,323	93.3

NOTE: The Physical Plant and Equipment columns add to less than the total column because New York did not report its capital expenditures by type, but its total capital expenditures are included in the table.

1st & 2nd Quarters 1979		Expenditures ($ in 000's) Total Vol. Rev.	Total Vol.Approv.		Beds Total No. Proposed	Total No. Approved
State						
01	Alabama	85,764	85,764		283	283
02	Alaska	1,278	1,278		0	0
04	Arizona	47,164	9,439		0	0
05	Arkansas	31,680	31,680		156	156
06	California	63,470	60,455		337	-90
08	Colorado	2,930	2,930		0	0
09	Connecticut	75,048	64,857		-94	-172
10	Delaware	3,658	3,658		0	0
11	District of Columbia	793	793		0	0
12	Florida	76,030	59,118		434	182
13	Georgia	41,847	41,847		150	150
15	Hawaii	6,425	6,075		-6	-6
16	Idaho	20,869	20,869		60	60
17	Illinois	259,994	236,456		70	7
18	Indiana	101,731	100,896		50	50
19	Iowa	50,518	50,518		-185	-185
20	Kansas	5,624	5,419		16	0
21	Kentucky	30,581	30,029		75	75
22	Louisiana	56,849	56,849		510	510
23	Maine	4,331	4,331		-11	-11
24	Maryland	41,970	41,970		16	16
25	Massachusetts	121,629	108,017		-71	-219
26	Michigan	146,481	146,481		-343	-343
27	Minnesota	28,400	28,400		-38	-38
28	Mississippi	33,722	33,722		104	104
29	Missouri	16,245	16,245		0	0
30	Montana	220	220		0	0
31	Nebraska	19,238	3,238		0	0
32	Nevada	2,636	2,636		0	0
33	New Hampshire	1,496	1,496		-9	-9
34	New Jersey	93,121	90,740		25	25
35	New Mexico	25,910	18,932		110	110
36	New York	116,038	114,245		-914	-940
37	North Carolina	14,485	14,485		6	6
38	North Dakota	742	742		0	0
39	Ohio	150,161	150,161		34	34
40	Oklahoma	33,917	33,917		68	68
41	Oregon	14,489	14,489		0	0
42	Pennsylvania	191,908	186,615		-118	-126
44	Rhode Island	3,019	3,019		0	0
45	South Carolina	45,880	45,880		-6	-6
46	South Dakota	18,090	18,090		-19	-19
47	Tennessee	31,004	31,004		426	406
48	Texas	184,043	165,783		1386	740
49	Utah	37,367	37,367		5	5
50	Vermont	18,731	9,195		25	5
51	Virginia	56,194	56,194		62	62
53	Washington	42,273	42,273		55	55
54	West Virginia	47,041	46,641		33	33
55	Wisconsin	27,518	26,634		-114	-114
56	Wyoming	4,523	4,523		0	0
60	American Samoa	0	0		0	0
66	Guam	0	0		0	0
72	Puerto Rico	17,489	15,707		155	122
73	Trust Territory	0	0		0	0
78	Virgin Islands	0	0		0	0
	Northern Marianas	0	0		0	0
TOTAL		$2,552,564	$2,382,323		+2723	+986

Changes in Short-stay Non-Federal Hospital Beds: 1st & 2nd Quarters, CY 1979

State	Start of 1979		Added		Removed		Converted		Net Change	
	No. Beds	Beds/1000	Proposed	Approved	Proposed	Approved	Proposed	Approved	Proposed	Approved
Alabama	19911	(5.4)	299	299	16	16	0	0	283	283
Alaska	921	(2.3)	0	0	0	0	0	0	0	0
Arizona	9380	(3.8)	0	0	0	0	0	0	0	-0
Arkansas	10813	(5.0)	190	190	34	34	0	0	156	156
California	88050	(4.0)	390	0	53	90	0	0	337	-90
Colorado	10845	(4.0)	0	0	0	0	0	0	0	0
Connecticut	11516	(3.5)	0	0	94	172	0	0	-94	-172
Delaware	1950	(3.2)	0	0	0	0	0	0	0	0
District of Columbia	4999	(7.5)	0	0	0	0	0	0	0	0
Florida	50377	(5.4)	434	182	0	0	0	0	434	182
Georgia	28795	(5.6)	150	150	0	0	0	0	150	150
Hawaii	2886	(3.2)	0	0	0	0	6	6	-6	-6
Idaho	2822	(3.3)	81	81	21	21	0	0	60	60
Illinois	62447	(5.5)	136	73	66	66	0	0	70	7
Indiana	23814	(4.4)	50	50	0	0	0	0	50	50
Iowa	16620	(5.8)	0	0	185	185	0	0	-185	-185
Kansas	13204	(5.7)	16	0	0	0	0	0	16	0
Kentucky	14165	(4.0)	77	77	2	2	0	0	75	75
Louisiana	19405	(5.0)	525	525	15	15	0	0	510	510
Maine	5257	(4.9)	0	0	11	11	0	0	-11	-11
Maryland	14770	(3.4)	41	41	25	25	0	0	16	16
Massachusetts	Not Avail.		42	23	113	242	0	0	-71	-219
Michigan	38657	(4.1)	20	20	125	125	238	238	-343	-343
Minnesota	21947	(5.5)	93	93	131	131	0	0	-38	-38
Mississippi	13179	(5.5)	114	114	0	0	10	10	104	104
Missouri	Not Avail.		0	0	0	0	0	0	0	0
Montana	3548	(4.7)	0	0	0	0	0	0	0	0
Nebraska	Not Avail									
Nevada	3140	(4.7)	0	0	0	0	0	0	0	0
New Hampshire	3345	(3.8)	3	3	12	12	0	0	-9	-9

Changes in Short-stay Non-Federal Hospital Beds: 1st & 2nd Quarters, CY 1979

State	Start of 1979		Added		Removed		Converted		Net Change	
	No. Beds	Beds/1000	Proposed	Approved	Proposed	Approved	Proposed	Approved	Proposed	Approved
New Jersey	30827	(4.1)	50	50	25	25	0	0	25	25
New Mexico	3781	(3.2)	123	123	13	13	0	0	110	110
New York	80521	(4.5)	105	79	996	996	23	23	-914	-940
North Carolina	23096	(4.1)	6	6	0	0	0	0	6	6
North Dakota	3925	(6.1)	0	0	0	0	0	0	0	0
Ohio	49000	(4.5)	40	40	6	6	0	0	34	34
Oklahoma	14394	(5.2)	73	73	5	5	0	0	68	68
Oregon	9216	(3.8)	0	0	0	0	0	0	0	0
Pennsylvania	Not Avail.		88	88	206	214	0	0	-118	-126
Rhode Island	3535	(3.8)	0	0	0	0	0	0	0	0
South Carolina	11712	(4.0)	35	35	19	19	22	22	-6	-6
South Dakota	3713	(5.4)	0	0	19	19	0	0	-19	-19
Tennessee	27219	(6.2)	441	421	15	15	0	0	426	406
Texas	68095	(5.2)	1549	903	137	137	26	26	1386	740
Utah	4157	(3.3)	70	70	65	65	0	0	5	5
Vermont	1988	(4.0)	25	5	0	0	0	0	25	5
Virginia	23550	(4.5)	146	146	84	84	0	0	62	62
Washington	13363	(3.7)	55	55	0	0	0	0	55	55
West Virginia	9877	(5.4)	33	33	0	0	0	0	33	33
Wisconsin	22309	(4.7)	0	0	14	14	100	100	-114	-114
Wyoming	1653	(3.9)	0	0	0	0	0	0	0	0
Guam										
American Samoa	151		0	0	0	0	0	0	0	0
North Marianas	97									
Puerto Rico	10422		155	122	0	0	0	0	155	122
Trust Territories	532		0	0	0	0	0	0	0	0
Virgin Islands										
TOTAL			5655	4170	2507	2759	425	425	2723	986

Senator WEICKER. Carolyne Davis of the National League of Nursing.

Ms. DAVIS. Thank you. I am Carolyne Davis. I am former dean of the School of Nursing at the University of Michigan. Currently I am the associate vice president there, where I coordinate the activities among our five health science schools, dentistry, medicine, nursing, public health and pharmacy, and work with the university hospital.

I appear before you endorsing the coalition's level of funding of $123.5 million for nursing. The National League for Nursing feels that there is a severe crisis in the nursing shortage, and due to that, we want to give you some impressions.

We believe that the root of many of our nursing problems right now are twofold:

One, there's been an overestimation of the supply; and second, there was an underestimation of the demand for nursing services.

This chart here, I believe, graphically will represent part of the problem of the overestimation of supply. In the second report to Congress, they anticipated a continuation in growth of graduations until the year 1979, and then a gradual decline until the year 1985.

In point of fact, what actually happened is that the graduations never did increase to the level that was expected and projected forward from 1972 on. So that by 1977, we had a 4,000 differential between expected and actual graduations; and in 1978, it was a figure of 6,000. By 1981, that is projected to be at 10,000.

Now let me put this in perspective for you. We have graduating each year about 78,000 students who graduate and enter the nursing market. That represents a 10-percent figure. We used that. We have already begun to see a decline in our graduates.

There is another component of this; Secretary Harris recently stated that she was requesting a reduction of $78 million in support of the nursing education programs because it was felt that the aggregate supply of nurses was adequate, and that the key was to bring a higher proportion of them back into the work force—70 percent of our nurses are now working; 23 percent are not employed, and they are not looking for work. Let's look for a minute at the characteristics of these 423,000 who are not employed currently.

Of that number, one-third of them are over the age of 50, with approximately 23 percent being over 60 years of age. Frankly, with the stress that is involved now in using newer technologies, and the physical output that is necessary, we doubt that it is possible to attract many of those over the age of 60 back into the work force.

Another 34 percent of these unemployed are in the childbearing, childrearing capacity. We know from following them in longer term studies of their activity patterns that they do drop out of the work force particularly during that period of time when their children are under the age of 6. They will gradually reenter the work force once their children come into the 6- to 17-year-old age group; frequently on a part-time basis, and then to go back on full time. We think it is reasonable to anticipate that these people will not be available for work in the near future.

You notice that there was really actually about 4 percent who are employed in nonnursing fields. That would include people like myself who have moved into other health-related activities. Seeking active employment then is only roughly 3 percent of this total, which frankly represents nothing more than a fractional unemployment that one would expect in any employment group.

INCREASED UTILIZATION OF NURSES

Second, in regard to the underestimation of need, the second report to Congress predicted there was going to be a 22-percent increase in the utilization of nurses. This was stated as due to the impact of strong cost containment programs, and yet another part of the same report indicated that an expert panel projected that there could be a 48- to 100-percent increase in the utilization of nurses.

The base year was 1972, and we do know there's been a significant increase in nurse utilization since that date. Increased numbers of nurses are employed now in nursing homes and home care agencies, industrial nursing, and there's been a significant rise in the hospital utilization of nurses. A 42-percent increase in the number of special care units since 1972 have put an increased demand on our nursing staff.

Let me use, for example, my own hospital because I know it best. In a unit such as our neonatal pediatric intensive care and other specialty units such as the burn unit, we have had to double our nursing staffing in the last 5 years.

We have also had to increase our nursing staffing in some of our general care units, but we, like any other part of the country, have not been immune to the shortage of nurses.

Currently we face a vacancy rate of 22 percent among our 1,146 positions in nursing. We have closed beds; we have closed operating rooms; we have resorted to the use of overtime help, of part-time and temporary help and of agency personnel; and we, where possible, increased the utilization of licensed practical nurses and nurse assistants. But intensive care units and other areas that demand skilled nursing care cannot be staffed by other than registered nurses, and that is why we urge that the funding levels of $24 million for institutional support, of $11 million for scholarships, and $22.5 million for loans be retained.

I would submit also this one part of a sample of newspaper clippings that relate to the shortage in the various States in this country. It's one-third of our sample. We will submit an abbreviated statement of this analysis for the record. That is from September of 1979 until February of 1980.

We also feel the need for nurses prepared at the master's level. Currently there are only 4 percent at this level, and clinical nurse specialists are vitally needed to coordinate and guide the activities of other nurses, especially in the various specialty areas.

We would recommend then that there be $13.5 million for the advanced nurse training; and $16 million in trainingships.

Jessie Scott, the recent director of the division of nursing, indicated the most serious constraint in preparing enough nurses for practice was

a chronic shortage of prepared faculty. This, too, then, would address that particular issue.

We have heard a lot about fiscal constraints, and we recognize the problems that are inherent in the system, and that there will have to be some significant savings, but we believe that nursing has studies that will effectively demonstrate cost-effectiveness, not only for nurse practitioners and nurse midwife services, but for a rearrangement and a redelivery of the nursing care itself.

We have studies that can adequately demonstrate effective reduction in number of hospital beds. We can also respectively working with our nursing clinics and ambulatory care, document that we have been able to keep some selective patients out of the hospital. This, again, is a cost-saving device.

We would like then to recommend $7 million in research and $3 million in fellowships, and finally, in closing, we would endorse the $2 million in nurse anesthetist training as the administration proposed, because there is indeed a critical shortage of nurse anesthetists.

Thank you very much. We will submit our detailed statements.

Senator WEICKER. Thank you very much.

[The statement follows:]

STATEMENT OF CAROLYNE DAVIS

I am Carolyne K. Davis, Associate Vice President for Academic Affairs at the University of Michigan, and formerly Dean of our School of Nursing at the University of Michigan. In my current role, I am responsible for coordination of activities between our five Health Science Schools of Dentistry, Medicine, Nursing, Public Health, and Pharmacy. In addition to these units, I work with our University Hospital, a large teaching facility.

I am testifying today on behalf of the National League for Nursing, the largest American coalition of nurses and other health professionals, consumers and home care agencies dedicated to developing and improving the standards of quality nursing education, nursing services and health care delivery in the United States.

I appreciate the opportunity to appear before this distinguished Subcommittee to present our recommendations regarding the Nurse Training Act.

The basic tenent of our statement today is this: We deem it imperative that the Federal Government provide additional fiscal support to both institutions and students engaged in nursing education at appropriation levels equivalent to those in existence in 1978 (as provided for in P.L. 94-63). The alternative is to further exacerbate an already critical shortage of nurses.

The detrimental impact of the excessive reduction of federal support to nursing education, initiated by the Administrative budget requests and proposed authorization levels for FY 1979 and FY 1980, is already having a deleterious effect throughout our health care delivery system.

The nation is entering what may be the biggest nursing shortage ever. Only a few of the nation's 6,732 hospitals and 13,417 nursing homes have a full complement of registered nurses. Critical nursing shortages are being reported from all regions of our country. Some institutions, unable to find enough nurses to fill required positions, have had to close beds, or even entire units, such as, operating rooms and special intensive care areas. The shortage of nurses in many states has hit crisis

proportions among hospitals, nursing homes and home health agencies. The American Hospital Association has stated that an additional 100,000 nurses are required now in order to fill current institutional needs. Empirical evidence of shortages is available from all areas of the country. Newspaper articles, advertisements and state surveys all provide evidence of the mounting crisis in nursing supply. Data available from a sample of states reporting shortages are summarized below.

California -- In its most recent survey, the California Hospital Association reported that unfilled budgeted vacancies constituted 17 percent of the State's full-time nursing staff, and that the projected number of openings state-wide exceeds 8,300. Nearly 90 percent of the hospitals responding to this survey indicated that an additional 1,051 RNs would be needed by 1982. Documented shortages of nurses have now surfaced in all states except Rhode Island and Delaware.

New Jersey reports over 600 RN vacancies.

Georgia -- In a November 1979 survey by the Georgia Hospital Association, approximately one out of every eight full-time budgeted RN positions is not filled. (1,800 budgeted vacancies.) Shortages of nurses are reported throughout the state, not only in the larger communities, but the smaller ones as well.

Texas -- Based upon a January, 1979 survey, estimates indicate that there are 4,129 budgeted unfilled positions for RNs in Texas hospitals. These unfilled positions represent over 12 percent of available positions for RNs. Specific statistics include:

. Positions currently budgeted and unfilled	4,129
. Additional positions for expansion of existing facilities and/or new or expanded services during the next twelve months	2,707
. Additional positions for job reclassification during the next twelve months	854
. Additional positions to replace those who will die, or otherwise leave the hospital industry during the next twelve months	1,327
. Total positions anticipated now and over the next twelve months	9,017

Maryland -- In Maryland, the shortage is escalating. Specific examples include:

.At the University of Maryland, out of 750 budgeted RN positions, 75 are unfilled.

.At Sinai Hospital (Baltimore), 43 positions out of 340 FTE are unfilled.

.At City Hospital (Baltiomre), 80 of 300 budgeted positions are unfilled.

.Prince Georges County (Baltimore), 83 of 409 positions are unfilled.

Ohio -- The Ohio Bureau of Employment Services reported that shortages of registered nurses were reported in 50 of Ohio's 88 counties.

In general, smaller community hospitals have fewer staffing problems and lower turnover than hospitals in larger cities. A notable exception is the large rural southeastern Ohio area which has a very high percentage of vacancy and turnover rates.

Pennsylvania -- The Pennsylvania State Hospital Assocation reported 1,550 budgeted vacancies.

Tennessee -- A THA 1979 survey indicated that there are 9,721 RNs employed in hospitals, representing 60 percent of the total nurses employed. Hospitals responding to the survey stated that if they were able to, and if the numbers would be available, they would like to employ an additional 1,997 RNs. If these figures are projected five years hence, the hospitals would need to employ an additional 5,232 RNs.

The heaviest shortage areas are in West Tennessee and Mideast Tennessee. The Memphis area has the next highest shortage of RNs. The Western Tennessee area's need in five years is projected to increase by 152 percent, South Middle Tennessee 154 percent, and Mideast Tennessee 107 percent, and Memphis, 49 percent.

With regard to hospital beds that have closed due to the shortage, the City of Memphis Hospital has closed 127 beds; Jackson General Hospital in Jackson has closed 37 beds, and Rutherford Hospital in Murfreesboro has closed a wing. Vanderbilt University is functioning on a staff consisting of 2/3 temporary placement nurses. With regard to registries, temporary pools have grown. In Nashville, for example, four such pools exist with three more scheduled to begin operation shortly.

Indiana -- The Indiana Hospital Association revealed

that 84 Indiana hospitals had 1,110 budgeted vacancies for full-time equivalent registered nurses. The number of RN vacancies was 55 more than reported last January, indicating a continued increase in the demand for nurses.

Mississippi reports over 1,000 RN vacancies.

Iowa -- In an April, 1979, survey by the Iowa Hospital Association, data indicated that the greatest number of unfilled positions for RNs occurs in institutions over a 200 bed size, but less than 400 beds. The least number of unfilled positions for RNs is in hospitals that have 101 - 200 beds.

Utah reports a state-wide shortage with approximately 4,000 vacancies.

Virginia -- In a 1978 survey by the Virginia Hospital Association, 15 percent of the hospitals responding indicated that beds have been closed due to a lack of staff with a range of beds closed from two to 52. Fifty-nine percent of the hospitals responding indicated that an additional 1,051 RNs would be needed by 1982, amounting to an 11 percent increase.

Louisiana reports 1,200 budgeted vacancies.

New York -- In the New York City area alone, 1,100 staff nurse vacancies are reported. One dramatic example is Bellevue Hospital where it is reported that many times one nurse has the sole responsibility for 40 patients on any evening shift.

Illinois -- In the Chicago area, 86 hospitals have reported a shortage of 1,083 RNs.

In the face of this crisis, we find it unconscionable that the present Administration is unyielding in its determination to decimate Federal financing for nursing education programs. The Administration, in its budget request for FY 1981, has proposed slashing nurse training funds from the present 1980 level of $106 million to $28.6 million. (This is even more disconcerting when considered in the light of the FY 1978 authorization levels of $206 million.) Embodied in the Administration's FY 1981 request is the total elimination of support for capitation grants, financial distress grants, construction

assistance, advance nurse training grants, traineeships, scholarships, student loans, and support for nursing research.

A May 1978 CBO report to Congress entitled, "Nursing Education and Training: Alternative Federal Approaches," stated the following:

> "In fiscal year 1979, $20.5 million would be targeted to nurse practitioner programs and special projects. All other programs would be terminated. As a result, substantial decreases in the aggregate supply of RNs and a large drop in the supply of RNs with graduate training might be expected." (Underlining added)... "In addition, nursing students would be forced to assume a greater share of their educational costs by paying higher tuition charges." (p.xv.)

In recent years, Congress has demonstrated its sensitivity to the needs of nurse training programs by restoring much of the funding support which the Administration has attempted to eliminate. Apparently, as demonstrated by its FY 1981 budget request, the Administration has paid little attention to the stated concerns of Congress. This Subcommittee, however, has been consistently supportive of Federal funding in the broad areas of nurse training.

The profession of nursing is one of the oldest in this country and indeed, the world itself. While many facets of nursing have changed over the course of time, one factor remains constant: it is the nurse who serves as the primary and cohesive link which binds all of the health professions and delivery mechanisms in obtaining the ultimate goal -- the provision of quality care to the patient. This basic function is one of the pillars of strength of our health care system. It is the nurse who provides the 24-hour contact with the institutional patient - monitoring, assessing, treating, and coordination of care. It is the nurse who functions as the basic component in the delivery of health services outside of our hospitals and nursing homes, through home health agencies, community outreach programs, school nursing, public health nursing, and numerous other voluntary organizations. It is the nurse who, within all of these levels of care, is responsible for the communication and coordination between health professionals and the patient.

As the nation pays more attention to preventive medicine and diseases of the aged, there is a consensus among health

planners that nurses can play an expanding role in the delivery of these services. The role of the nurse as a "patient educator" offers hope for our Nation's health status through the day-to-day repatterning of behaviors toward healthier values and activities. The nurse is the only health care provider prepared with a knowledge base broad enough to encompass the entire range of activities and behaviors related to the health of the individual.

Perhaps this role is of greatest consequence with regard to the elderly of this country. The number of persons age 65 and over increases by over 500,000 each year. Our senior citizens rely primarily on nursing services since extensive nursing care - both institutional and home based - is often the main thrust of their treatment regimens. Already our long-term care facilities report a dire need for registered nurses. The Department of Labor reports a shortage of about 150,000 nurses in nursing homes alone. Current staffing levels indicate that these elderly patients only receive an average of 12.5 minutes of nursing care per patient per twenty-four hours. Therapeutic and rehabilitative care demands more adequate staffing with nurses skilled in gerontological practice. The hardships that will afflict the graying segment of this Nation because of a misguided Federal policy reducing both the numbers of available nurses, and the quality of care that they are able to provide, cannot be ignored. The elimination of existing Federal support to nursing education would have a devastating affect on the elderly.

The increasing Federal role in the provision of primary care services, through the establishment of different diagnosis and treatment incentives; the expanding emphasis on health promotion and prevention as well as the continued expansion of HMOs, through their reliance on nursing services, suggests a further rise in the scope and importance of nursing. Moreover, the consideration of alternatives to costly institutional-based services points towards the expanded use of home health care, a concept initiated and fostered by the nursing profession a century ago.

In this era of economic uncertainty and fiscal constraint, it is often overlooked that the nurse is the most cost-effective provider of care within our health care system. Through advan-

tageous rate differentials, and cost-saving levels of health intervention, nursing is one of the basic cost containment tools available to our country.

Research data is now available indicating that changes in nursing care can affect recovery rates, recidivism and the success of preventive health measures. By varying the organization of care, nursing studies have demonstrated a 40 - 55 percent reduction in the average length of stay of patients with abdominal surgery and renal transplants. Nurse-delivered home and ambulatory clinic care, has demonstrated success in decreasing hospital utilization. As one example, nurse clinic patients return to employment at rates that are significantly higher than physician clinic patients even when corrected for types of disease, socioeconomic background, etc.

Nurse midwives have demonstrated their ability to deliver safe high quality personalized maternity care which is also markedly less expensive than traditional hospital care. Charges for nurse midwifery services at a New York City Child Bearing Center are 37.6 percent of in-hospital care. An audit report noted that the cost to Blue Cross for families delineated at the Center is 66 percent of the cost of the plan had the same family gone to a hospital setting.

Furthermore, it should be noted that decreasing the current ratio of professional nurses to patients in direct care settings has been shown to be a costly proposition. Less educated personnel, such as nursing aides may appear to be less costly, but require so much more supervision that this practice is actually more costly, in addition to the risk that is posed to the patient's well-being. Studies show that aides average about 25% "unoccupied time" during the work day and that nurses spend 25 percent of their time supervising aides and teaching them what to do for patients.

It is difficult to imagine how an Administration so concerned with the containment of health care costs can ignore the cost-effective nature of nursing and proceed on a course which endangers the stability of the nursing profession.

The supply of and demand for nurses has been a subject of much controversy over recent years. The Administration has

relied on reports that suggest that by 1985, the supply and demand for nursing personnel will be in balance. Inherent in this report were several assumptions. First, there would be no major changes in the health care delivery system and that staffing levels per inpatient would increase by only 22 percent. Second, "due to data availability, the year 1972 was critical. In the case of the requirements model, increases noted for the projection period are based upon that year." (p.77.)

This same study concluded that should there be a significant expansion of nurses' roles and responsibilities, the number of nurses required by 1985 could be as high as 1.6 million. However, the Report concluded that:

> "The overall RN requirement range projected for 1985 is between 1,205,600 and 1,716,400 based upon Vector Research. The most likely case based upon an assessment of the model assumptions compared with prevailing conditions in the health care system and current policies yield a requirement range of 1,205,600 to 1,316,300 and probably at the low end of the range. It is concluded that the aggregate national requirement and supply for 1985 will be in balance." (p. 94.) Second Report to Congress Nurse Training Act of 1975.

Other evaluations of the situation have reached substantially different conclusions. A panel of experts appointed to assist in supplying data necessary to complete these studies predicted that, within the context of expected societal changes, the demand for full-time RNs in 1982 would increase from 48 percent to 104 percent above 1976 figures. The panel included experts in the fields of nursing, health education, hospital and health administration, health research and economics.

DHEW retorted that the chances of this assumption becoming a reality, however, are very remote. Increase utilization of health services is inconsistent with the Administration's policies. "These estimates," the DHEW noted, "do not take into consideration the potential impact of strong cost containment efforts." There is indeed no simple answer to the complex problems of predicting future requirements. However, one thing is certain, significant changes in health care delivery have occurred since 1972, especially in terms of the nurse's role. In most tertiary care settings, the number of RNs per patient has increased significantly as the total patient care mix has moved closer toward intensive care due to the signficant decline in the length of stay and increasing technological complexity.

Let me illustrate this phenomenon by two examples of nurse staffing with which I am familiar. At Johns Hopkins Hospital, the nurse staffing pattern for a 14 bed Pediatric Intensive Care Unit has changed dramatically in the last several years alone. In 1976-77, this unit was staffed with one head nurse, one clinical specialist, 18 registered nurses and 10 nursing technicians. Current projections for the 1980-81 year indicate budgeted staff required as one head nurse, one clinical nurse specialist, and 36 registered nurses, with the elimination of the ten nursing technicians. This is an RN staffing increase of 100 percent for that unit alone.

At the University of Michigan University Hospital, our registered nurse staffing requirements for the Newborn Nursery Intensive Care Unit has gone from 37 budgeted positions in 1974-75 to 62.4 for the 1979-80 budget year. Likewise, our Pediatric Intensive Care Unit staffing positions for nursing have risen from 17 in 1974-75 to 45.8 in 1979-80, while our Burn Unit now calls for 46.3 budgeted nursing positions in contrast to 1974-75 when we utilized only 28 nurses. Even in our non-critical care areas our nurse staffing has increased significantly as demonstrated by the following: a single surgical unit has increased from 25 positions in 1974-75 to 38.6 in 1979-80, and a medical unit has added 11.7 nursing positions to its budgeted nursing staff since 1974-75.

Not only has the average daily occupancy rate increased in these units, but also, the intensity of care has increased significantly with more registered nurses needed to carry out such special care activities as monitoring vital functions, ventilation therapy, intravenous therapy with infusion pumps, and the handling of other special technological care.

Modern advances in treatment of patients with bone transplants, radical surgical interventions, burn therapy, neurosurgery and cardiac surgery require intensive care on a twenty-four hour basis. Many intensive care areas now require a 1:1 nurse-patient ratio in order to deliver safe and effective quality care.

While the actual number of nurses needed to meet today's requirements is the subject of great controversy, the fact remains that the supply of new graduates has now declined and the

initial assumptions concerning the ability of the supply to adequately meet the 1985 needs are erroneous. Let us examine now some aspects of the debate:

Secretary Harris in her recent testimony before the House Appropriations Subcommittee on Labor-HEW, stated, "We are requesting a reduction of $78 million in the support of nursing education programs because the aggregate supply of trained nurses is adequate. The test now is to keep a higher proportion of trained nurses actively in the profession."

The Second Report to Congress, Nurse Training Act of 1978, overestimated the number of graduates anticipated from schools of nursing from 1976-77 until 1985. (Figure one in the Appendix shows these projections graphically along with the actual graduations according to NLN data.) More accurate projections based upon actual admissions have recently been prepared by the National League for Nursing. This year for the first time in a decade, graduations from basic nursing programs declined almost two percent. However, the prediction of supply in the Second Report to Congress, while anticipating a decline, did not forsee its occurring either this early or as abruptly, and therefore, we can already conclude that the predictions on the supply side of the equation are too high. Moreover, this early error in predictions will have a compounding effect in the next few years so that by 1985, the Administration's prediction and the actual supply will, in all probabilities, be widely divergent. In 1977, the projection was too high by a factor of 4,000; by 1979, the difference was 6,000; and the differences will continue to increase by 1981 to a difference that could approach 10,000.

These signs of decline in the output of nursing education go back to 1974 when the rate of increase in admissions dropped suddenly. Aggregate admissions have not grown significantly since 1974; and in 1978, the decline in growth rate of admissions was 5.6 percent. Applications to basic programs of nursing also declined 16 percent between 1977 and 1978, the first such decline since 1960. If this current downward trend in applications and admissions is allowed to continue, and the Administration succeeds in eliminating most Federal support for nursing education, the existing shortage will grow worse.

How many nurses are currently available for practice? A September 1977 survey by the ANA indicated 1.4 million nurses held a license to practice. Of that total, 70 percent or 978,324 were in active practice. Of those in active practice, 68 percent worked full-time and 32% worked part-time. Approximately 23 percent were not employed in nursing and were not looking for nursing employment. Three percent or about 43,000 were actually seeking employment, a figure which is well within the "frictional unemployment" range. About 4 percent or 56,780 nurses were employed in other fields. Through the same survey, it was learned that about 25 percent of those not employed were pursuing further education.

The Administration has suggested that the reason for the nursing shortage is the inactive pool of licensed registered nurses. We believe it is unrealistic to expect much assistance from this group for a variety of reasons, since most of those who are inactive appear to have legitimate reasons for this status.

The presence of young children is probably the primary reason for a change to inactive status. 146,062 nurses or 34.5 percent of those nurses who are inactive have children under the age of 17. Nurses of child bearing age have a greater tendency to drop out of the work force and return later as their children mature. The 1977 survey showed a decrease in activity rates for nurses with children under the age of six and a concommitant increase for those with children ages 6 - 17. More than 1/3 of the total inactive nurse work force represent individuals over the age of 50. With increased complexities of technological nursing care it can be expected that the nurse over the age of 50 may not be able to cope with the stress and physical fatigue inherent in modern acute care nursing.

The most current discussion of the required Federal role in resolving nursing supply problems speaks solely to "numbers." However, the National League for Nursing is also concerned with the impact of insufficient Federal financial assistance on the ability of schools of nursing to achieve an optimal level of quality in the preparation of individual nursing students. This preparation includes both theoretical and clinical components, and is dependent on adequate numbers of teachers, administrators, and other supportive personnel, modern physical plants (e.g., classrooms, laboratories,

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and libraries), and a stable financial base that allows for needed flexibility in integrating the latest concepts in nursing education and patterns of care. The Administration's proposed elimination of what is presently 10 percent of a nursing school's annual budget will place a school in the difficult position of combating inflationary pressures and replacing a large portion of their fiscal resources.

Institutional support to schools of nursing has provided funds for recruitment of students as well as remedial programs for disadvantaged students. The cutbacks that schools have experienced in capitation have already been reflected in a decrease in remedial program activities. Talented students are now being recruited to other professional schools, such as business, engineering, and law.

There are serious categorical shortages of nurses as well, and perhaps, the most serious problem of all is the dearth of nurses in leadership positions. Presently, there is a shortage of clinical specialists, teachers, researchers, and administrators for service agencies, educational institutions, and government. During the next decade, an increase in demand for these highly specialized workers is projected. For instance, the demand for nurses with advanced training in community mental health is predicted to increase by 40% during this period. Advanced medical technology has resulted in the need for more highly skilled nurses, who are educated to provide leadership in patient care settings as diverse as infants in high risk nurseries and elderly patients in nursing homes. Clinical nurse specialists are being educated in advanced nurse training programs to assume the responsibility for developing a plan of care over a twenty-four hour period, demonstrating care to other nursing personnel, and providing health teaching and counseling to patients and families. In the near future nurses will need such skills as computer proficiency and scientific and mathematical sophistication to adjust to rapidly changing technologies in hospital settings.

Currently, over 900 budgeted faculty positions are

vacant in educational programs preparing registered nurses. Between 1976 and 1978, there was a 3 percent increase in unfilled faculty positions. Among faculty teaching in all three types of programs which prepare registered nurses, only 58 percent of the faculty is prepared at the minimal or master's level, with under five percent of all faculty having doctoral preparation. Among directors of nursing services, a large proportion only have a basic diploma preparation. Only 25 precent have a baccalaureate degree and even fewer have graduate level preparation, yet these same individuals are responsible for large personnel budgets and significant policy decisions within health care agencies.

Federal funds allocated for advanced nurse training programs, currently support about 82 programs in a variety of specialists areas, such as parent-child nursing, epidemiology, burn trauma, emergency care, gerontology, rehabilitation, mid-wifery, community health, oncology (cancer), critical care and primary care. These funds help schools of nursing to initiate new programs of study, extend current program capabilities and contribute to the development of new knowledge in nursing and patient care. These monies also strengthen the institution of higher education's ability to provide quality training for advanced nursing practice, teaching and administration.

To maintain the quality of direct patient care demands, more nurses require more student financial aid and better educated faculty. Other educational fields learned long ago the value of having students taught by individuals with advanced degrees, prepared to assist them in the synthesis of knowledge. This is especially true for nursing, in view of the day-to-day judgments being made by nurses that affect so many lives.

The number of graduates with advanced preparation in a clinical specialty has greatly increased in the past ten years. In 1968, 34 of all graduate students elected advanced clinical practice, while in 1977, 75 percent of all graduate nurses enrolled in clinical practice programs. Although the total enrollment of graduate students has risen dramatically in the last decade, one must also recognize that many more students are enrolled on a

part-time basis. Thus, the total number of graduates from master's and doctoral programs has not increased at an adequate rate. If traineeships and fellowships for nurses seeking advanced training are curtailed, the resulting decrease in the number of graduate students will have a deleterious effect upon our health care system.

Assuming full-time study for two years, the average young person faces a cost of tuition and living expenses of $12 - $15,000, in addition to a loss of income for that period. At the same time, salaries for most nursing positions have been notoriously low. Clinical nurse specialists can anticipate an average salary of about $16,000 - $18,000 yearly. The salary expenditure curve in nursing is very flat and has a poor salary progression. At an expected salary range of $16,000 - $18,000, a young person who seeks to borrow for graduate education will find a relatively few low-cost options available, and the availability of commercial loans is generally based on one's current or future earning power. We believe the costs of Advanced Nurse Training and traineeships present a serious dilemma which will mitigate against the future benefits of improved health care if students do not receive Federal assistance. Graduate trained nurses represent a national resource and as such ought to have high priority in Federal funding for nursing. Scholarships for exceptionally needy students would complement minority recruitment and retention activities as well as reduce financial hardships for students unable to secure adequate financial aid from other Federal student assistance programs.

In addition, the current nursing loan program, with its loan forgiveness provision, can serve to encourage nurses to practice in shortage areas. If this program is dropped, we will lose another low cost incentive to provide for better geographic distribution of nurses.

Loss of traineeship, scholarship and nursing loan funds will surely exacerbate the already significant decline in enrollments, especially at the advanced nurse training level. This will ultimately lead to a shortage of qualified faculty prepared to teach basic nursing skills, as well as a shortage of advanced clinicians and practitioners who are being prepared to deliver cost effective health care services.

The health of Americans and the health financing responsibility of the Federal Government can benefit from nursing research produced by doctorally prepared nurses. Little attention has been devoted to mobilizing the knowledge and abilities of nurses, which is the largest group of specially trained providers in developing and implementing reform from within the system. Research-based changes in nursing care may lead to savings at least as great as those produced by utilization review. In addition, research-based emphasis on home health care built on nursing services can achieve change but avoid the burdens of new regulations or legislative changes.

Sixteen universities now award doctoral degrees in nursing but these 16 are graduating fewer doctorally prepared nurses this year than five years ago, when there were only nine doctoral programs. Although enrollments in doctoral programs have continued to rise, the large number of part-time students has prolonged the completion time for this degree. Pre-doctoral National Research Service Awards currently support only 119 fellows. In many doctoral programs this is the only form of student assistance available for full-time students. Total funding for Nursing Research has been at a $6 million level for the last four years (In contrast, this year's budget for NIH is over $3 billion!). The benefits that have been demonstrated from nursing research merit expanded support, especially in those areas targeted to cost-effective clinical care.

Nursing makes a unique contribution that has been long neglected both within nursing and the Federal Government. Health is a major concern for most of the nation's taxpayers. Health care has become the third largest industry in the United States and is growing rapidly. Registered nurses constitute the largest group of health professions and yet are grossly underrepresented in most Federal and State health policy and planning councils. Now that nursing has a growing capability to contribute research data to health care policy on a national level, we urge that nurses be appointed to more national health policy-making councils.

We turn now to your distinguished Subcommittee, as we have in the past, to intervene. In recent years, this Subcommittee

has demonstrated a sensitivity to the nursing profession, and the needs of nurse training programs.

RECOMMENDATIONS

There are currently several different Federal programs for financial assistance to nursing schools and students. Because bills which have been introduced and other measures being drafted would, in effect,"rearrange" current authorizations, the National League for Nursing offers specific funding recommendations for several general categories of critically needed aid:

In the area of institutional support (currently provided under §810 of the Public Health Service Act), we recommend that $24 million be appropriated for FY 1981 in order to insure the stability of educational programs in schools of nursing.

Institutional support for baccalaureate programs through the vehicle of capitation assistance is used to support the salaries for faculty positions, faculty development, instructional media material, and some of the operational expenses of the nursing school. A significant portion of nursing schools utilized capitation funds to conduct programs for students from disadvantaged backgrounds; to provide clinical experiences in geographically remote areas; and to provide continuing education programs for nurses. Decreased institutional support will necessitate nursing schools increasing their tuition and other fees, thereby creating a further disincentive for young adults and minorities to enter the profession. The continuance and stability of nursing programs throughout the country are dependent upon augmented institutional financial support to nursing schools.

Elimination of loan support to nursing students, as recommended by the Administration, would provide a further disincentive for students entering nursing. The Administration claims that there is no reason to treat undergraduate nursing students differently than the remainder of the undergraduate population. We disagree. Nurse manpower, as an essential health resource, mandates special consideration, and we recommend that $22.5 million be appropriated for FY 1981 for the nursing student loan program.

The National League for Nursing recommends that $17.0 million be appropriated for Special Projects for FY 1981.

Scholarships, currently provided under §845 of the Public Health Service Act, provide support for individuals of exceptional financial need to enter schools of nursing. These individuals are often of disadvantaged and minority backgrounds, and are students who ultimately will practice in medically underserved areas. We recommend that $11 million be appropriated for FY 1981.

Advanced nurse training is our highest priority because of the documented shortage of faculty and clinical specialists who are capable of assuming leadership positions in areas such as intensive care units and community health. Accordingly, we recommend that $13 million be appropriated in FY 1981 for advanced nurse training.

We also recommend that $18 million be appropriated for nurse practitioner training.

NLN recommends that $16 million be appropriated for traineeship support in FY 1981.

Finally, we recommend that $2 million be allocated to nurse anesthetist training programs in FY 1981.

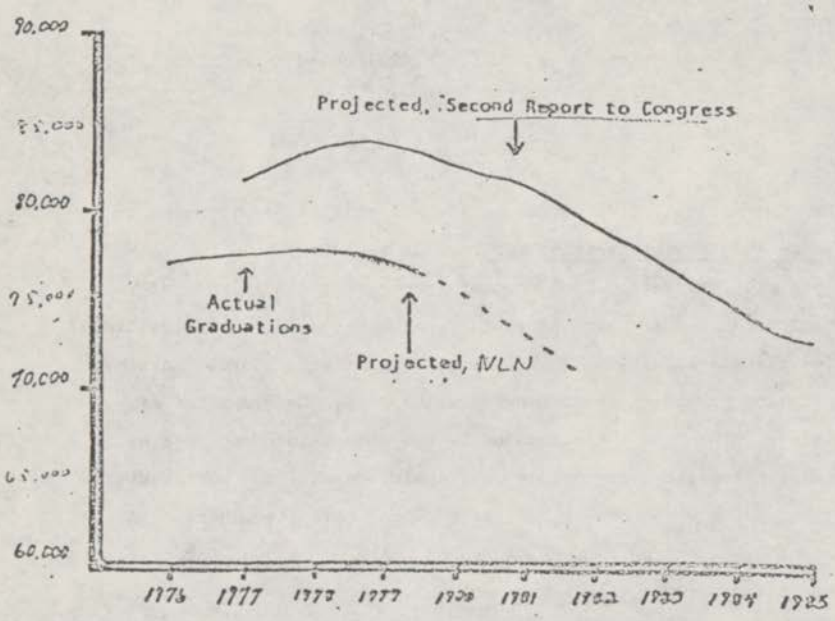
The bottom line for our recommendations is Federal appropriations for nursing educational programs of $123.5 million for fiscal year 1981. This Federal support will address nursing problems beyond those already detailed here. Geographical distribution problems, illustrated by the more severe shortage hardships being faced in certain geographical areas, can be alleviated through the structure of Federal support. Minority representation within the nursing profession can be expanded through Federal assistance and through this impact not only on distribution problems and basic nursing supply levels, but also on national unemployment problems. The extent to which the Federal Government recognizes particular categories of nursing professionals allows it to direct itself towards specialty distribution problems.

Thank you for allowing me to appear on behalf of the National League for Nursing and the millions of patients served by our members.

APPENDIX

Figure I

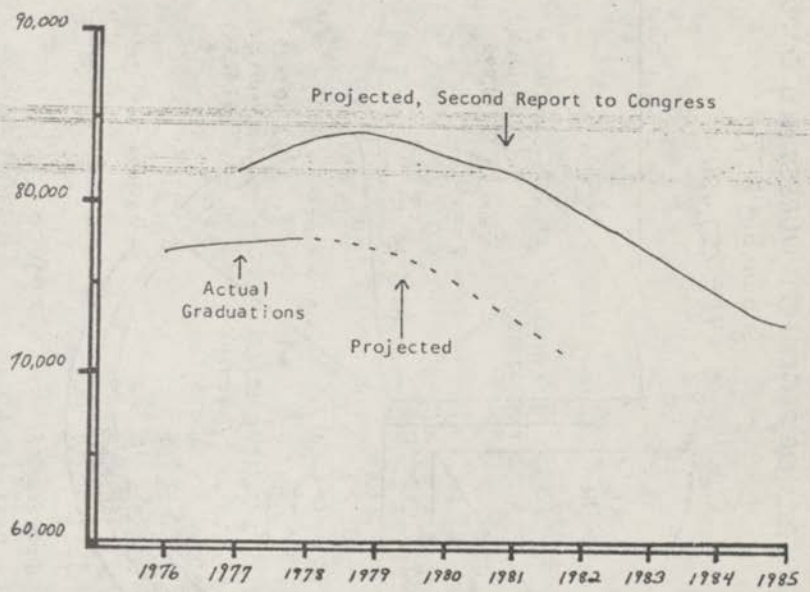
Graduations from Registered Nurse Education Programs, Actual, and Projected to 1985



Source of Projections - Second Report to Congress, Nurse Training Act of 1975

Source of Actual - NLN Surveys of RN Schools of Nursing

Graduations from Registered Nurse Education Programs, Actual, and Projected to 1985



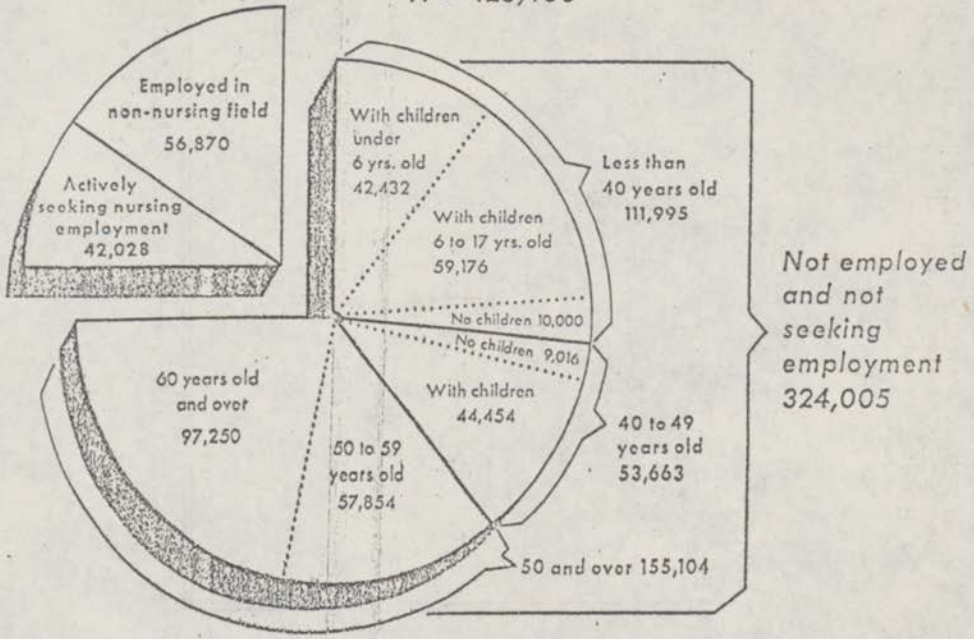
Source of Projection, - Second Report to Congress, Nurse Training Act of 1975

Source of Actual - NLN Surveys of RN Schools of Nursing

CHARACTERISTICS OF REGISTERED NURSES NOT EMPLOYED IN NURSING

September 1977

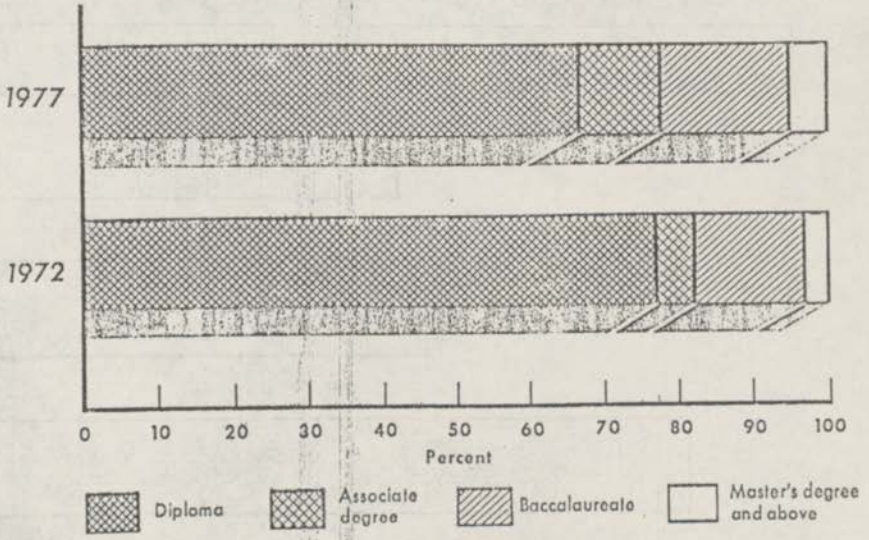
N = 423,400



Source: 1977 National Sample Survey of Registered Nurses

Excludes those who did not indicate age or status of children

ESTIMATED PERCENT* OF REGISTERED NURSES BY HIGHEST NURSING-RELATED EDUCATIONAL PREPARATION, 1972 and 1977



* Adjusted for nonresponse to highest nursing-related educational preparation.

Source: 1977 National Sample Survey of Registered Nurses
A Report on the Nurse Population and Factors Affecting their Supply

HIGHEST LEVEL OF EDUCATIONAL ATTAINMENT, FULL-TIME NURSE FACULTY, BY TYPE OF RN PROGRAM, 1978

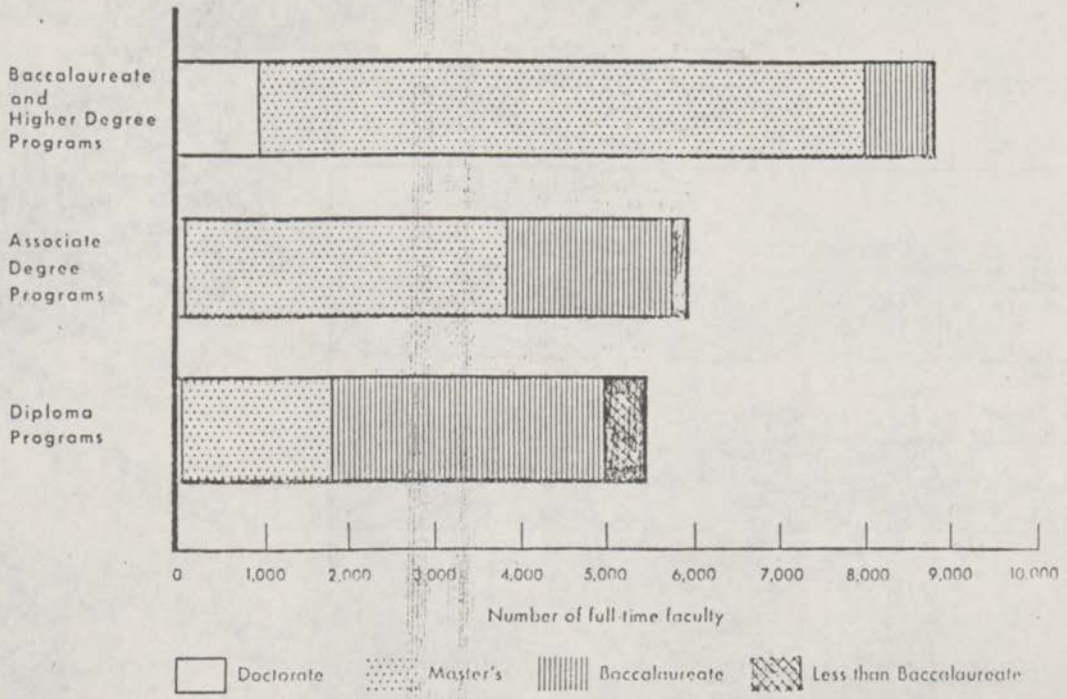


CHART 7

Source: NLN Nurse-Faculty Census, 1978

EVIDENCE SUBSTANTIATING THE ESCALATING SHORTAGE OF REGISTERED NURSES AS REPORTED BY THE NATION'S PRESS, SEPTEMBER, 1979-FEBRUARY, 1980

Dramatic documentation for a shortage of nurses in the United States can be found in a review of recent newspaper articles on the subject. Headlines offering generous bounties leading to the hiring of a qualified nurse are common. (Indianapolis Star, 14 October 1979; Carson City, Nevada Appeal; 18 October 1979; Austin, Texas, Citizen, 15 October 1979.) Small town weeklies and big city dailies have devoted an increasing amount of attention to the nursing manpower shortage that threatens health care in their communities. Approximately 1,200 articles on the nurse shortage appeared in U.S. newspapers in the six month period between September, 1979 and February, 1980. Newspaper articles on the nursing shortage have increased by nearly 300% compared to the number of articles found in the same time period one year ago. The evidence of a national shortage of nurses emerged spontaneously in communities all over the country; these articles offer a rather different picture of the issue than that being given by the Carter administration. Administration statisticians and officials have concluded that there is no nursing shortage and that there will be an ample supply in the forseeable future. Based upon its unfounded conclusions, the administration has determined to reduce nurse training funds by 75% in the coming year.

According to the articles reviewed, the geography of the nurse shortage has changed markedly in a short time. Last year, the states of California, Texas, and Florida -- areas of great population growth -- reported the existence of a crisis in nursing manpower. The crisis in these states has only escalated in the past year. This year, major cities in the midwest and along the eastern seaboard, not long ago a source of surplus nurses, are now experiencing critical shortages of nurses. Indiana, Illinois, Utah, Maryland, Massachusetts, Minnesota, Missouri, Michigan, Wisconsin, Ohio, and Pennsylvania have recognized the nursing shortage as a matter of both state-wide and national proportions. Especially hard hit have been certain large cities: Chicago, Minneapolis, Detroit, Baltimore, and Philadelphia. In Chicago alone, there are an estimated 2,000 budgeted nursing

positions that cannot be filled. On a national basis, there are 100,000 vacant nursing jobs.

A widely circulated review of the nursing shortage written by Patricia McCormack of UPI prompted many local newspapers to review their own nursing manpower situation. All reported concurrence with the UPI assertion that "The nation may be in the biggest nursing shortage ever." (San Jose, California, San Jose Mercury, 1 October 1979; Winston-Salem, N.C., Journal, 30 September 1979; Fort Wayne, Indiana, The Journal-Gazette, 30 October 1979; Rochester, N.Y., The Democrat and Chronicle, 23 September 1979.) The nursing shortage affects big metropolitan areas, rural areas, public hospitals and private ones, the East, the West, the South and the North. Finding qualified nurses is no longer the problem only of poor or isolated regions, but has become the headache and worry of hospital administrators and physicians all over the country. Nurse recruitment has become a permanent administrative problem for hospitals and nursing homes, and professional nurse recruiters have been hired to ease the problem.

Almost every newspaper article on the nursing shortage offered a variety of explanations for the disturbing news that there are not enough nurses to provide the kind of care expected in modern hospitals. Nurses most often cite the lack of adequate financial compensation and the unfavorable working conditions imposed upon hospital nurses. Denver nurses found that the apprentice checkers at their local supermarkets were earning more money per hour than experienced registered nurses. (Rocky Mountain News, 27 September 1979.) One nurse noted, "If I, a college-educated nurse, get $6 or $7 an hour, and the guy who puts on the hubcaps in a factory gets nearly double -- well -- it's a crime." (Chicago Tribune, 14 October 1979.) Perhaps even more troubling to nurses than money are the conditions of working in a hospital, especially if the hospital is already understaffed. In addition to the undesirable aspects of hospital work, such as weekend work and a grueling rotation schedule, nurses point out that there is no incentive to remain a working nurse. There is no place for a talented and ambitious nurse to go in a hospital, if she wants to remain in patient care. If a nurse wants to advance in her profession and to earn more money, she must quit patient care in favor of administration or teaching.

Finally, in a growing number of understaffed hospitals, even more

nurses quit when they can no longer tolerate working 12- and 16- hour shifts and knowing that their patients are not receiving good care. All of these issues contribute to the huge turnover problem in nursing: California reports a 30-50% turnover in nursing positions every year, which costs, in terms of recruitment and training, $187 million dollars a year.

Certain irreversible social and technological changes have also contributed to the nursing shortage. The women's movement has opened the door to traditionally male careers such as medicine and the law. The "new breed of nurse" with a college education and a new degree of self-confidence will not accept perceived deplorable conditions imposed by hospital regimens. New opportunities for nurses outside the hospital have drawn many nurses into independent or expanded roles. Advances in surgical techniques and medical technology have created a huge demand for nurses with special training: coronary care units, renal dialysis units, and burn centers require intensive and experienced nursing if the patients are to benefit from the medical advances.

Yet if everyone has an explanation for the nursing shortage, almost no one has offered a solution for the problem. The only consistent answers have been costly, short-term "Band-aid" remedies that attempt to stave off crisis for a few more months. Flashy recruitment campaigns are common procedures. Some estimates suggest that it costs between $7,000 and $8,000 to recruit a nurse; and hospital administrators consider the money well-spent if the nurse stays for only two years. In addition to bounties ranging from $100 to $1,000 per recruited nurse, hospitals pay for national and local advertisements, trips to recruit nurses from other areas, and they offer to find and subsidize housing for nurses who accept jobs in distant cities. None of these efforts have been too successful. It is reported that Filipino nurses brought to the U.S. at great expense, especially in California and Florida, do not remain for long and experience serious cultural and language problems during their short tenures.

Temporary nurses fill up to 20% of nursing positions in some hospitals. Concurrently, temporary nursing employment agencies reap a hefty profit from providing nurses to beleaguered hospitals at a very high rate. Staff nurses at hospitals, not surprisingly,resent the presence of these temporary nurses who earn considerably more per hour than they do and yet assume none of the

major burdens of patient care such as the paperwork. Furthermore, there is no way that temporary nurses can be trained in hospital emergency procedures -- leaving open the possibility of serious deficiencies in safety standards. (Los Angeles Times, 2 December 1979.)

The high monetary cost of the nursing shortage is paid for by patients. But patients also pay another cost, potentially higher, in the quality of care they receive. Administrators insist that despite the 10-20% nursing vacancies in their hospitals, patient care is not jeopardized. Nurses and physicians tell another story. At best, an understaffed nursing service means that the nurse has no time for the other essentials such as offering emotional support and education for her patients. At worst, the nursing shortage means that patients go without needed supervision, which occasionally leads to unnecessary complications. One Florida physician summed up the situation in his hospital, "We are not providing what we say we are -- quality care." (Daytona, News, 15 January 1980.) Closing down beds and limiting admission has meant that doctors often must postpone admitting patients in need of care or surgery. (Yucca Valley, California, Hi-Desert Star, 30 January 1980, Portland, Oregon Journal, 7 February 1980, Waukegon, Ill, News-Sun, 7 September 1979.) A Minneapolis nurse recounted her nightmares coming true when she found herself making mistakes in patient care because of the number and severity of patients in her charge. (Minneapolis Tribune, 3 December 1979.)

The prognosis for nursing manpower is not optimistic. Despite the President's assurance that the matter is well in hand , experts recognize a different trend. First, in addition to the current decline in nursing school admissions, there is the simple matter of a declining birth rate which means fewer young women will be entering the employment market. Second, all indications are that there will be an ever-increasing need for registered nurses in the coming decades, estimated as some 240,000 more nurses needed by 1985 according to the Department of Labor. The growing percentage of elderly in the population, with accompanying acute and chronic health care needs, demands the expansion of health care services. The continuing improvements in health technology also require an expanding pool of skilled and experienced nurses to monitor and use this equipment. (Baltimore Evening Sun, 1 November 1979.) The manpower needs of a possible national health program have never been adequately addressed.

These newspaper articles eloquently testify to the existence of a severe nursing shortage in the country. As yet there has been no scientific study of the parameters of the issue, no systematic research into the contributing factors of the nursing shortage. It remains something of a mystery how the President can recommend nearly terminating aid to nurses training without any serious effort to understand the dimensions of the current problem or to face the future crisis in nursing manpower. There has been no grass-roots support for the President's proposal; virtually all local newspapers negatively criticize the President's proposed cut-back in articles establishing the nursing shortage in their cities. Even the most cursory review of these articles leads the reader to doubt the widsom of the President's proposal and to hope that Congress will undertake to prevent the President from intensifying an already critical shortage of nurses in the United States.

ADOLESCENT HEALTH SERVICES

Senator WEICKER. Ms. Janet Forbush.

Ms. FORBUSH. Thank you very much for the opportunity to testify. My name is Janet Forbush, and I am president of JBF Associates, which is a private nonprofit consultant service which provides assistance to local community groups, to State agencies and national organizations on issues related to young people.

Our primary emphasis is on young people between the ages of 10 and 18 who are sexually active or already pregnant, or have already become young parents.

Before I begin, I just want to say that I think your remarks, Senator, were particularly compelling when you spoke about the need for advocacy on behalf of the various human services programs that are likely to be examined very carefully in the next couple of months.

I think that in terms of the field I worked in, in the last 10 years, we worked very hard to develop an advocacy network, and yet I think we are cognizant of the fact that we have not developed our forces and gotten our political act together to the extent that is necessary, and therefore I appreciate your comments.

To the extent that we will be able to demonstrate our needs for national support services for pregnant teens and young parents is, of course, in question, but we will work on it.

I am here today to testify with respect to the request from the Office of the Assistant Secretary of Health for the adolescent health services program, which was authorized under new legislation in 1978 by Congress.

The authorization levels for this program began at $50 million for fiscal year 1979; went to $65 million for 1980; and $75 million for 1981. The 1981 request from the Assistant Secretary for Health is $18 million, which keeps us at the same level that the program is now being funded at for fiscal year 1980.

To illustrate the need for this program and the importance of the program, let me cite for you some of the things that have happened since this legislation was initially authorized and subsequently funded in the fiscal year 1979 supplemental to the tune of $1 million last summer. The Office of Adolescent Pregnancy Programs is the unit in HEW responsible for administering this program.

COMMUNITY GRANT REQUESTS

Shortly after Congress made available the $1 million for the program to begin last summer, the requests came in from community groups around the country that were attempting to provide comprehensive health education and social services for pregnant teens and young parents. In all, the Office of Adolescent Pregnancy Programs received over 4,000 requests for grant application kits.

As a result of the application kits being reviewed, ultimately somewhere over 200 communities developed comprehensive proposals; and out of the 212 communities that submitted proposals, the Office of Adolescent Pregnancy Programs was able to fund only 4 projects to the tune of $750,000.

The total amount of the requests, however, exceeded $40 million last summer for the $1 million that Congress had made available.

Here we are in the early part of March, on what should be a nice, bright spring day, and we are waiting now for the deadline for the fiscal year 1980 applications. It is clear that over 4,600 communities have now requested application kits to apply for the $17.5 million that will be made available in the fiscal year 1980 program.

This is some indication of the incredible need and incredible response in communities across the country for this program.

It is also, I think, important to point out that communities have mobilized themselves to make sure that health, education and social service groups are talking to one another as they develop their packages.

This was, in fact, a part of the intent of the legislation, and it is being carried out. Communities are realistic about the prospects for funding, both in the fiscal year 1980 and also now as we look forward to fiscal year 1981. We need that $18 million. We really need much more, and when Congress authorized the $75 million for 1981, they were right on the button. We needed those dollars. We actually need more.

STATE FUNDING OF PROJECTS

What has happened in several States as a result of the incentive and the catalyst made available by the Federal Government is that several State legislatures have begun to examine the prospect of passing legislation that would allow State funds to flow directly to communities to help them pull the services together, to make sure that youngsters who already are pregnant, are already young parents, are going to find their way back into regular school programs or into appropriate job training, job placement programs.

The States of Illinois and Maryland are two that we can cite now as being examples where State legislatures are beginning to examine the need for appropriations at the State level.

By the same token, the State of Indiana recently prepared an interim report that the legislature had developed over the last year, and they, too, will begin to move in that direction.

However, if this $18 million program is not protected, I would venture to say that the incentive and the momentum is probably going to be jeopardized.

A second point that I wish to make today is that this program is important because it relates to other existing Federal projects already underway and helps to make the most out of a limited amount of funding.

This program, working in concert with the title 10 family planning services program, is very important. In the State of Connecticut, for example, there are 17 projects that are established and get partial funding through the State department of health, specifically for maternal and child health funding. In all they have $140,000 to work with, to divvy up among those projects around the State.

I spoke with the coordinator for the program in Connecticut this morning, who pointed out that the remarkable facet of the legislation that was initiated 2 years ago is the fact that family planning people are talking to maternal and child health people and, in fact, they are working with other State agencies involved.

I think it is important to protect the $177 million request that is before Congress now to continue the family planning program and which, in fact, would make sure that teen services will remain an integral part of the family planning clinics.

OFFICE OF ADOLESCENT PREGNANCY

The third point I wish to make today is really unrelated to a funding level, but rather looks at an administrative question, and that is where the Office of Adolescent Pregnancy Programs actually housed? Presently, given that it is under the aegis of the Office of Assistant Secretary for Health, it is somewhat out on a limb by itself.

It is the recommendation of my organization and my colleagues that that program in effect become a part of the Health Services Administration, and specifically be lodged within the Bureau of Community Health Services, so that it is able to become a more coordinated effort within the health services program.

There have been several difficulties over the last year and a half in convincing people that these programs do work together. It is a complicated piece of legislation to administer, to get underway, but we believe that it will work more effectively if the program were moved to the Bureau of Community Health Services.

In closing, since it's impossible to bring the million or so teenagers every year who get pregnant before the hearing room, I'm going to provide you with a poster that was developed by the State department of health in New York. It is controversial, but may be something that will bring the point home more clearly than I have been able to make it today.

Senator WEICKER. You've made the point very, very well. We appreciate it.

Thank you all very, very much for your testimony. I appreciate it.

[The statement follows:]

STATEMENT OF JANET FORBUSH

My name is Janet Bell Forbush, President of JBF Associates. Thank you for the opportunity to testify today on the Adolescent Health Services request, a relatively new though essential aspect of the Assistant Secretary for Health's FY '81 budget proposal.

JBF Associates is a national, non-profit 501(c)4 consultant service specializing in the provision of technical assistance regarding high risk adolescents. The primary emphasis of our organization is on sexually active youth, pregnant teens, young parents and their families. JBF Associates, which is incorporated in the District of Columbia, provides consultation on program development and implementation, policy planning and promotion, and research and evaluation. The work of our organization brings us into contact with service providers, policymakers, and researchers who are interested in young people and their families and are concerned about their future.

Though our country is facing critical national economic concerns at this time---concerns which are likely going to result in a reduction of dollars available for human services, I believe it is imperative that advocate groups articulate the value of programs such as the Adolescent Health Services Program. Therefore, on behalf of my colleagues I am here today to make three essential points about the Administration's request for $18 million dollars for Adolescent Health Services to enable continuation of the work initiated in FY '79.

First of all, JBF Associates is urging Congress to respond favorably to the $18 million dollar request. Though this amount falls far short of the dollars needed in communities that are attempting to provide comprehensive supportive services to pregnant teens and young families; and, despite the fact Congress recognized the need for more funds when it authorized an expenditure of $75 million for FY '81 when the authorizing legislation was passed in 1978, it will provide some essential services to the high risk adolescent parent population.

In this regard it is important to point out that following passage of the legislation---Titles VI, VII, and VIII of the Health Services Extension and Primary Health Care Act of 1978---

virtually hundreds of communities throughout the country began to work together to develop collaborative proposals involving several agencies to ensure the better use of existing resources and trying to improve the services available to pregnant adolescents and young parents. The legislation has already proven to be a remarkable incentive. As a means of illustrating this point, over 200 communities submitted proposals to the Office of Adolescent Pregnancy Programs during the summer of 1979 in competition for $750,000 made available in the FY '79 HEW Supplemental Budget. The proposals submitted amounted to over $40 million in requests. In the current competition for FY '80 funds---$17,500,000.--- over 4,600 communities have requested application kits. These figures highlight the enthusiasm and commitment on the part of communities to work together to try to improve the services available to a unique youth population. By virtue of these collaborative efforts communities have successfully generated more dollar support for services at the local and state level which, in effect, is being facilitated by the Adolescent Health Services Program but not funded by it.

Furthermore, legislators at the state level in Maryland and Illinois, for example, have begun to consider legislation patterned after the federal program. This is based in part on their awareness for the significant need at the local level as well as in recognition of the reality that a relatively small amount of money for coordination will enable groups to generate other resources. My point here is that this new small program has helped to make money and could help to make more if it continues.

However, if this program is not funded in FY '81, it is likely that the incentive and momentum already generated will be seriously jeopardized. And so then will the lives of the adolescents, their infants and family members be jeopardized.

The second point I would like to make concerns the related importance of continuing the funding support for Title X of the Public Health Service Act. Title X is the primary vehicle available to provide family planning services to consumers and it has played a vital role in responding to the needs of teenagers. The Title X program and the Adolescent Health Services Program must

be viewed in concert as primary and secondary health services intervention strategies. Were either to have their existing capability threatened, the beginning efforts to reduce pregnancies among teenagers would be impeded. JBF Associates urges Congress to ensure, at a minimum, the $177 million request of the Administration for Title X of the Public Health Service Act.

The third point I will make today is perhaps more complicated than the others because it addresses an administrative issue rather than a funding concern. Specifically, based on extensive field work throughout the country during the past several years including the last eighteen months, my colleagues and I are convinced that the Office of Adolescent Pregnancy Programs, which is lodged in the Office of the Secretary at the Assistant Secretary for Health level at DHEW, is not situated where it is able to effect needed coordination with other relevant health services programs. While establishing a profile for this office might have been an important and overriding concern when the teenage pregnancy initiative was getting underway in 1977, it now appears that the Adolescent Health Services Program could be strengthened were it closely aligned with the Title V - Maternal and Child Health Services program and Title X - Family Planning. The complexity of the legislation which is responsible for establishing the Office of Adolescent Pregnancy Programs must be emphasized at this point. However, because of its complexity, the program deserves strong and experienced administrative back-up. JBF Associates recommends therefore that the Office of Adolescent Pregnancy Programs be made a part of the Health Services Administration's Bureau of Community Health Services. This arrangement would, in our opinion, foster the needed cooperation and coordination required to maximize the impact of the health services programs and, given the additional administrative capability, would permit the Office of Adolescent Pregnancy Programs to perform the coordination responsibilities it has been charged with in the legislation vis a vis social service and education constituencies.

JBF Associates is hopeful that our recommendations will be useful. Thank you for the opportunity to testify.

STATEMENTS OF:
JAMES GREEN, NATIONAL EDUCATION ASSOCIATION
WILLIAM KANE, ASSOCIATION FOR THE ADVANCEMENT OF HEALTH EDUCATION
JEAN TUFTS, NATIONAL SCHOOL BOARDS ASSOCIATION
CAROL C. PARR, PH. D., NATIONAL COALITION FOR WOMEN AND GIRLS IN EDUCATION
JEAN SIMON, NATIONAL ADVISORY COUNCIL ON WOMEN'S EDUCATIONAL PROGRAMS

GENERAL EDUCATION PROGRAMS

Senator WEICKER. We will now move on to the Elementary and Secondary Education.

All right, we have for the National Education Association, Mr. James Green; Association for the Advancement of Health Education, Mr. William Kane; National School Boards Association, Ms. Jean Tufts; National Coalition for Women and Girls in Education, Carol Parr; and the National Advisory on Women's Educational Programs, Bernice Sandler.

Now you all have the enviable task of dividing up 15 minutes, and I won't tell you how to do it, but when you do it, I will pass the information along to my colleagues.

Mr. GREEN. Mr. Chairman, I will try to keep within the framework. I am James Green, assistant director of NEA. We appreciate the opportunity of being able to testify before the subcommittee.

Inflation has taken its toll on all the educational programs, and the almost weekly increases in the cost of energy will require that every program be increased to maintain the fiscal 1980 level of purchasing power.

I will not attempt to run through all the programs. We would like to mention three to you very briefly. The first of these programs is that of teacher centers. Teacher centers provide a variety of programs, specifically designed and targeted to meet the needs of classroom teachers in in-service education as they perceive those needs in relationship to the communities where they are working.

There are currently only 61 grants, funding about 100 teacher centers, serving about 60,000 elementary and secondary teachers. In an effort to preserve and improve the teacher centers program, NEA proposes funding for fiscal year 1981 at the level of $52 million, and this figure would assure the funding of at least one teacher center in every State.

Another program is that of impact aid. It is a valuable program, whose purpose has been obscured by years of criticism and attack. The original and continuing purposes of the impact aid program are, first, to compensate local school districts for failure to provide real property revenues for the education of federally connected children; and second, to guarantee that federally connected children receive a minimum level of education by compensating school districts for providing those services.

In the light of the fact that impact aid is a viable program for providing financial support to all school districts, we recommend a funding of at least $772 million for fiscal year 1981.

The third program I wish to mention is the education for the handicapped. NEA fully supported the enactment of this legislation. We supported the concept of a free and appropriate public education for all the handicapped children, and in the least restrictive environment as determined by the maximum teacher involvement.

One overriding concern that's been expressed by all of the teachers dealing with this law is the lack of Federal funds to adequately address the needs of the handicapped youngsters. Although Congress authorized an accelerating funding schedule, appropriations to date have fallen far short of meeting the staggering financial burden that's imposed on the schools.

In an effort to effectively address these needs for the special children for whom the programs were designed, NEA recommends $1.5 billion be authorized for fiscal year 1981.

Thank you for the opportunity.

Senator WEICKER. Thank you very much, Mr. Green.

Mr. Kane?

HEALTH EDUCATION FUNDING

Mr. KANE. Thank you. I am William Kane, executive director of the Association for the Advancement of Health Education. The association represents health educators throughout the country who are committed to helping individuals improve their health through education and disease prevention programs.

The majority of our members are public school teachers and university personnel working in the area of education.

I am here to ask your support for $5 million funding for title 3, part 1 of the Elementary and Secondary Education Act, Public Law 95–561.

The funding for that program was not included in the fiscal year 1981 budget. Some people here today are concerned about being cut out of the budget. We are asking to be put in. I realize that's a danger.

Under the proposed regulations for Public Law 95–561, grants would be awarded to State and local education agencies to establish and improve comprehensive public education programs in this country's schools both in the elementary and secondary level.

This funding would be administered by the new Department of Education's Office of Comprehensive School Health Education. This would for the first time establish a focal point in the Office of Education, or the Department of Education, for school health education.

Our members in the public schools and State departments of education who work directly with the Department of Education will welcome and need this leadership from the Federal Government.

HEALTH EDUCATION PROJECTS

Some examples of activities that might be appropriate under the proposed regulations include projects that provide health education in-service for teachers, projects that contribute to the advancement of a coordinated school health program, projects that address the major national health concerns by providing learning experiences in those areas.

And some of these areas include smoking, alcohol, pregnancy preven-

tion, weight control and obesity, physical fitness, mental health, safety, accident prevention, stress reduction, and dental health.

Another example would be projects that use and coordinate appropriate resources of public and private agencies and organizations concerned with developing, improving, and expanding school health education.

This is particularly important, and I would ask you to refer to the entire text which is submitted regarding some suggestions for working with community agencies that are currently funded to do something about the health of children in the schools. It seems that the money is not getting to the kids, and we are greatly concerned about that.

The Surgeon-General's recent report, "Healthy People," was very clear in its message. It stated that the potential to improve the overall quality of the life of Americans lies in not treatment and rehabilitation, but in prevention programs.

It's a dream of every American that each child will have the opportunity to develop to the fullest of his or her potential. Funding the Health Education Act will help insure that this can become a reality. It will help insure that each child will live longer and the quality of each day lived will be improved.

Thank you.

Senator WEICKER. Thank you very much, Mr. Kane.

[The statement follows:]

STATEMENT OF WILLIAM KANE

I'm William M. Kane, Ph.D., Executive Director of the Association for the Advancement of Health Education. The Association is one association of the American Alliance for Health, Physical Education, Recreation and Dance, which represents 50,000 educators throughout the country. Our member educators are committed to helping individuals improve their health through education and disease prevention programs. I am here to ask your support for five million dollars funding for P.L. 95-561, The Health Education Act of 1978. Funding for this program was not included in the President's budget request. Before discussing P.L. 95-561, I would like to provide you with a brief overview of school health education. Health education has long been recognized as an important part of elementary and secondary education. The 1918 report of the National Education Association's commission on the reorganization of education included health as one of the seven cardinal principles of education. The 1922 Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association approved a resolution to appoint a committee to prepare a program of health education for public schools. That program -- Health Education - A Program for Public Schools and Teacher Training Institutions, was published in 1924. Health Education was revised in 1930, 1941, 1948, 1961 and 1975, and continues to be the curriculum "Bible" for health education.

Today, several national health and education organizations have position statements and resolutions calling for health education in the schools. These supporters include: the American Academy of Pediatrics, the American Heart Association, the American Medical Association, the American Lung Association, the National Congress of PTA, the American Dental Association, and the Association for the Advancement of Health Education. The latter, the Association for the Advancement of Health Education, the Association which I am representing today, was the sub-structure of the National Education Association which represented NEA on the Joint NEA/AMA Committee.

The recent Surgeon General's report Healthy People called for a revolution in this nation's health strategy which would emphasize strategies for preventing the major causes of death. In background papers prepared for that report, Surgeon General Julius Richmond called for a "comprehensive national policy with respect to the health of our children -- a policy whose thrust is the enhancement of health and prevention." This emphasis on prevention was echoed by Michael McGinnis, Deputy Assistant Secretary of Health, Education and Welfare, speaking at a recent conference on child health perspectives. He stressed his belief that in the 1980's

"the shift must be from curing to caring" and that greater attention to health education efforts among children and youth is an important part of this shift.

Lehmann in a paper prepared for Healthy People emphasized that "Health education in the school is especially important because both lifelong behavior patterns and development of chronic disease have their roots in childhood." Healthy People identified the schools, which have large captive audiences, as useful centers of health education and accident prevention activities.

P.L. 95-561, the Health Education Act of 1978, demonstrates Congress' concern for the health of school aged children. This concern and the intention of Congress is reflected in the following statement from the report of the Senate Committee on Human Resources which accompanied the act:

> "The Committee believes additional emphasis must be placed on preventive health education in our public schools.
>
> Changes in personal lifestyle and a better understanding of good health principles are the key to improvements in the health of individuals and prevention of disease and illness.
>
> It is the Committee's hope that the programs under (Part I) will encourage a greater interest in providing preventive health education in our elementary and secondary schools."

Public law 95-561, the Health Education Act of 1978, provides grants to local education agencies and state education agencies for projects that are designed to establish and support programs of comprehensive health education in elementary and secondary schools. The "comprehensiveness" of school health education is emphasized to indicate that the program includes more than single-subject "programs." However, the proposed regulations require all applicants to include in each project plan learning experiences on smoking and health. The proposed regulations also call for the applicant in its comprehensive health education program to give attention to ten other major national health concerns and to include other subjects, as appropriate.

Health education experts believe that the various subjects can be taught more effectively in a broad and integrated curriculum than in piece-meal fashion. The idea is to treat the various health-related subjects in a conceptual framework that stresses soundly-based decisions, prevention over remediation, and positive health practices in full and effective living.

One potential goal that could be accomplished under this act is in the area of leadership and coordination. There are currently several single-subject programs being funded by Congress which are designed to educate school aged children about health. Leadership and coordination for integrating these into the schools is

desperately needed, but currently is not available. Specific example: the Bureau of Health Education recently received ten million dollars for smoking prevention education. A major target population for these smoking prevention programs was school-aged children.

During fiscal year 1980 the Department of Agriculture has twenty million dollars for nutrition education in public schools. Components of that program include nutrition education for school children and development of nutrition education curriculum materials.

The Bureau of Health Education has awarded (grants/contracts) to state departments of health to establish risk reduction programs. These programs are to be targeted to the major risks to an individual's health in each state. Many state departments of health have indicated that education programs for public school children will be a component in their programs.

Title B of the Health Services and Center Act of 1978 has 17.5 million for dealing with adolescent pregnancy has money ear-marked for education programs in pregnancy prevention. Most adolescents are in public schools. The money is currently going to family planning clinics and other service providers who develop pamphlets and posters in an unsuccessful attempt to fulfill the education/prevention requirements of the mandate.

In addition to Congressionally mandated programs, the American Lung Association, the American Heart Association, the American Dental Association, the American Dairy Council, the American Cancer Society, Avon, Weight Watchers International, and a host of other organizations are developing special interest health education materials and curriculums for kids in schools.

State directors of health education, those responsible to state superintendents of public instruction, and professionally prepared school health educators, have been overwhelmed and critical of the problems this disorganized approach has caused. These people have been inundated with the special interest group requests - all with good intentions - seeking access to kids through school programs. Many of these health education units and materials prepared outside the schools by special interest groups are not readily adaptable to school curriculum and structure. Schools need help to establish linkages, with health education projects currently designed to serve students; modify health education programs developed outside the school for use in the school; assist groups without expertise in school health education to tailor programs to school-age children's needs; and

to coordinate and integrate existing health education components into a comprehensive program which will insure the individual components will achieve the intended effects. In short, ways to link the health education funds with the target group -- kids -- must be found. The overall objectives of each of these single-subject components can be more effectively realized in schools if the individual components can be integrated into a comprehensive, sequential program that can impact on kids.

A model to do that is only one of the potential products funding this amendment would encourage.

The proposed regulations governing the administration of grants under P.L. 95-561 suggest the funds be available for comprehensive school health education projects that --

"(A) Contribute to the advancement of a coordinated school health program.

(B) Identify and demonstrate effective methods, materials, practices, organizational patterns, and administrative procedures that develop or strengthen the comprehensive school health education program; and

(C) Develop or strengthen a comprehensive school health curriculum, that --

(1) Includes learning experiences for smoking and health;

(2) Addresses the following major national health concerns by providing learning experiences either in the project or in other aspects of its comprehensive school health education program:

(a) nutrition and food.

(b) values of exercise.

(c) weight control and obesity.

(d) immunization.

(e) mental health.

(f) medical, dental and other health care.

(g) consumer health interests.

(h) environmental conditions effecting health.

(i) alcohol and drug abuse.

(j) safety and accident prevention.

(3) Provides learning experiences also, as appropriate, on -

(a) community health;

(b) dental health and oral hygiene;

(c) chronic disease-risk factors and prevention;

(d) communicable disease-prevention and control;

(e) family life education;

(f) first aid and cardio-pulmonary resuscitation;

(g) health careers;

(h) personal grooming and body care;

(i) physical fitness;

(j) sleep, rest, and relaxation; and

(k) work and recreation;

(4) Selects and organizes these learning experiences in a progressive sequence according to the assessed needs, interests, developmental level, and previous experiences of students."

Five million dollars funding would allow the Department of Education to award grants to thirty local education agencies averaging approximately $75,000 and to fifteen state education agencies averaging $150,000. The proposed regulations would require the agencies to develop strategies that contribute to the advancement of the coordinated state or local school health program.

This small amount of money will at last establish within the Department of Education a component responsible for the health education of school children.

Health education has the potential to extend the number of years an individual will live, and to improve the quality of each day lived. One of America's most cherished dreams is that each child will have the opportunity to develop to the fullest of his or her potential. Funding P.L. 95-561 will be a giant step toward helping children achieve that goal.

SCHOOL BOARDS' RECOMMENDATIONS

Senator WEICKER. Ms. Tufts?

Ms. TUFTS. I am Jean Tufts, first vice president of the National School Boards Association, and an elected school board member from Exeter, N.H. I represent 95,000 school board members across this country who are looking to the future of our Nation in realizing it rests on the well being of our children.

As policymakers, school board members are concerned with providing education for the children in our elementary and secondary schools. The Federal Government's contribution to supporting the educational program in school districts has been substantial, particularly for children who have special needs.

In this era of rapidly rising costs, school board members are attempting to squeeze every possible benefit from financial resources they have at their command. I will be testifying here today before your committee and leaving to go to a school district meeting where we will hope to get a budget through with 1,000 angry taxpayers.

Unfortunately, the goals of the school boards are not always realized, primarily because of lack of resources. School boards nationally obtain about 45 percent of their resources from local funds, 45 percent from their State funds, and about 10 percent from the Federal resources.

In other words, the Federal Government does play a significant role, especially, as I said, in the area of special needs.

The National School Boards Association believes that Federal funding for ongoing programs should be supported and in some areas increased. I would like to urge the committee to consider education funding in the context of the total system of educational services and resources, including Federal funding for child nutrition and for the portion of revenuesharing moneys which go to school districts.

I will be brief today. We have submitted our full text.

Senator WEICKER. We will put it in the record.

Ms. TUFTS. I would just like to highlight our highest priorities for funding.

EDUCATION FOR HANDICAPPED, ESEA, IMPACT AID

No. 1 is the education for all handicapped children, Public Law 94–142. The administration's proposal for fiscal year 1981, we feel, is woefully inadequate. In this mandated program, NSBA requests an appropriation which can support the Federal share of at least 18 percent of excess costs. This level increases the administration's request from $922 million to $1.477 billion.

This is one area where the Federal Government has mandated programs for the children at the local level; and we need help in supporting those programs, particularly with all the costs that have been cited by everybody today of fuel and transportation, and other costs that are going up, over which we have very little control.

Our second priority is the ESEA title I, basic grants. We request to maintain the present level of services. In this time of high inflation, it requires an appropriation of $2.977 billion for fiscal year 1981.

Title I basic grants are a proven success—5 million children are receiving services in 9 out of 10 of our school districts.

We also support ESEA title I concentration grants. To provide for adequate funding for school districts with unusually high numbers of poor children, this program should total $400 million.

Another area that has been mentioned previously is the impact aid program. The administration proposals for cuts in the impact aid program, we feel, are not justified. National School Boards Administration has always supported this program as a way of compensating 4,500 school districts for the loss of tax revenues resulting from their inability to tax Federal installations for the cost of educating children of employees assigned to those installations.

YOUTH EMPLOYMENT AND OTHER EDUCATION SPECIAL FUNDS

Another area of importance to us is the use of youth employment. I realize that the authorization has a cut, but we recommend to the committee that it recognize the value of the proposal that will be before you, and be prepared to appropriate fully the necessary funds.

Senator WEICKER. I think everyone knows the value of the proposal. I think everybody is more than a little suspicious that after 6 years of high minority and youth unemployment, that 6 months before the election, a proposal comes before us. That's the difficulty.

Ms. TUFTS. I realize there are difficulties with the program.

Senator WEICKER. It's not with the concept, I can assure you. Many of us have felt that this area was neglected for a long time.

Ms. TUFTS. I think that we would urge that the education side of that project be funded.

Another area is the architectural barrier removal. Removal again was mandated by Congress and should be completed by June of 1980. School districts cannot accomplish this task alone. The removal of architectural barriers is not a recurring cost. The initial investment of the renovation will permanently make school buildings accessible to handicapped children, and we would like to see that funded at $25 million.

We have two other areas. One is the census analysis. The forthcoming census will be taken in a way as to require school district boundary imposition over the census maps. The resulting census tools can be utilized in the allocation of title I funds and other important purposes.

And lastly, Career Education Incentive Act. These programs are compatible and supportive of other initiatives directed at the issue of youth employment—$30 million is needed from the Federal Government as its share of a 5-year matching program.

I thank you for this opportunity to present our priorities.

Senator WEICKER. Thank you very much.

[The statement follows:]

Statement of Jean Tufts

I am Mrs. Jean Tufts, First Vice President of the National School Boards Association. Our association is a federation of fifty state associations comprising 16,000 school disticts, with 95,000 school board members. School board members are elected by local citizens and, in most cases are fiscally independent of other local units of government. However, we are very much in partnership with each level of government and, accordingly, many of our programs derive substantial resources from the Federal government. Regardless of the mix of financial resources available to a school district, our members' primary purpose is to provide the highest quality educational services possible. We believe that our constituents have elected us to be responsible for the management and oversight of the kind of educational enterprise which will nurture children in such a way that they will grow up to be strong, capable, healthy and whole adults. To that end, the NSBA Delegate Assembly reaffirmed a longstanding resolution last April urging the President and the Congress to provide adequate and efficient financing for federal education programs by (1) fully funding authorized levels of need, (2) continuing to appropriate funds one year in advance, and (3) recognizing that the local cash-flow conditions required that previously enacted appropriations not be deferred or rescinded.

TABLE

National School Boards Association
Budget Request Fy 1981
(in millions)

	FY '79	FY '80	Administration Response	NSBA Request
Education for All Handicapped Children	$805	$874.5	$ 874.5	$1,477
ESEA Title I Basic Grants	2,680	2,630	2,844	2,977
ESEA Title I - Concentration Grants	---	200	300	400
Impact Aid	786.1	772	378	1,004
Youth Employment	---	---	*	50**
Architectural Barriers	---	---	0	25
Analysis 1980 Census Data	---	---	1	2.6
Career Education	20	20	20	20

* unknown

** $50 million for planning plus $850 million in program funds for 1982

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INTRODUCTION: STATEMENT OF GENERAL CONCERN

Especially in this era of rapidly rising costs, school board members are attempting to squeeze every possible benefit from the financial resources they have at their command. Unfortunately, the goals of school boards are not always realized, primarily because of the lack of resources. School boards nationally obtain approximately 45% of their revenues from local resources, 45% from state resources, and about 10% from Federal resources. In other words, the federal government plays a significant role, especially in the area of special needs.

The increasing demand for resources to meet specific needs is most critical in areas such as handicapped education where cost in general is twice that of regular classroom instruction, and in areas of educationally disadvantaged children, for whom the economic impacts constrain their expected academic growth rate. These "high cost" or "special needs" groups are growing as a percentage of the total youth cohort, while the total number of children continues to decline. Will it be possible for children with special needs to get better schooling and services as total enrollments diminish, (and the economies of scale they represent) and when an unstable economy may mean limited resources for everyone?

Common sense should dictate that we make the welfare of children, especially those who are most in need of special services, our highest priority. For a substantial number, the prospects for the future are clouded. Nationally, three million arrests were made for juvenile crimes last year; millions of children and adolescents suffered from drug and alcohol abuse; one million teenage girls became pregnant; a million youngsters ran away from home; and suicide was the highest killer of teenagers after accidents. We know that the abuse and neglect of children has reached shocking proportions, that hundreds of thousands of children lead miserable lives in institutions, that millions are physically, mentally, or emotionally disabled, that half a million are in foster care. We know also that well over a million children under the age of 15 are not in school, that the national school dropout rate is 15%, and that upwards of 500,000 children age 16 and under, most of them from migrant families, are working in the fields because of loopholes in child labor laws, and that the real unemployment rate for urban black youths is believed to be over 60 percent.

HOLISTIC EXAMINATION OF FEDERAL FUNDING

I would entreat members of the Committee to think of your actions in the larger context of a total system of educational services and resources. Public schools continue to receive smaller and smaller portions of local and state re-

sources and now it appears that the Administration is asking for reductions in program funding from a variety of Federal sources. We realize that your jurisdiction does not extend into Child Nutiriton or General Revenue Sharing, however, reductions in these programs are also being proposed. The result, if sustained, can be devastating in the aggregate. Last Wednesday the Senate Agriculture Committee voted to support the Administration's cuts in Child Nutrition programs. We do not know what will happen to General Revenue Sharing funds, but if the states are denied these funds we know that as much as $1 billion will not find its way to support local educational services.

If this Committee and numerous other committees act separately and make cuts in programs over which they have jurisdiction without considering the accumulated effect, we are afraid that there will be an ominous threat to many school systems across this nation. Many districts are presently fighting daily to maintain their fiscal integrity, and many are losing the fight. Failure to fund the Federal share of mandated programs will simply transfer the financial burden to the local districts which may not have the capacity to generate additional revenues.

Now I would like to draw your attention to the following priority education programs over which you have jurisdiction.

EDUCATION FOR ALL HANDICAPPED CHILDREN ACT, P.L. 94-142

In the area of Handicapped, we feel that the Administration's proposal of $922 million for 1981 fiscal year is woefully inadequate. The President's budget stated that "the Federal government will continue (its) 1980 policy of providing approximately 12% of the national per pupil expenditure." However, the increase of $48 million only accounts for a 7% devaluation of the purchasing power of these funds. If the rate of inflation is calculated at the 1979 rate of 13.2%, the appropriation figure needs to be adjusted at $115.5 million to maintain 12% federal contribution to excess cost of educating eligible students. It should be recalled, however, that the original authorizing language of P.L. 94-142 projected that the Federal government should be providing 40 percent of the national average per-pupil expenditure by this time. Using a formula of 40 percent of a national average per-pupil expenditure rate of $2,033, times a minimum of 3.85 million children counted, the fiscal 1982 authority of P.L. 94-142 is, in fact, a minimum of $3.130 billion. If a conservative estimate of inflation - 10% - is used and if 18% of excess cost is shared by the Federal government, then the appropriation would be $1.477 billion.

Since the procedures for achieving the purposes of P.L. 94-142 are specified and the costs are mandated, NSBA requests an appropriation which can support a Federal share of at least 18% of the excess cost of educating children with handicaps. This action requires an increase in the Administration's request from $922 million to $1.477 billion.

ESEA TITLE I - BASIC GRANTS

Title I basic grants are a proven success. Five million children are receiving services from this program in 9 out of 10 school districts in the nation. The NIE evaluation of Title I programs indicates that students receiving these services achieve measured gains in the basic skills - reading and mathematics. We are concerned about two fiscal issues in this program: (1) the inclusion of all eligible children in the program, and (2) the reduction of purchasing power of program funds.

Only about 50% of the eligible children are participating in the program currently. These children are concentrated in the lower elementary grades. Since measurable gains of student progress have been made where Title I has been available, it is to be hoped that an expansion of the program will serve those eligible schools not now participating, and those underserved grades within participating schools.

The impact of inflation on the cost of delivering Title I services is assumed to be as great as it is in any other segment of the economy. This impact on last year's appropriation of $2.63 billion will devalue the purchasing power of school districts by 13.2%, or $312 million for the 1980 school year. The Administration's proposal of $2.844 billion for the 1981 school year would be reduced by $375 million if the annual inflation rate goes no higher than 1979. It is essential to maintain the present level of services. This requires an appropriation of $2.977 billion for FY 1981.

ESEA TITLE I - CONCENTRATION GRANTS

The Concentration Grant Program is designed to build on Title I successes so that local education agencies with the very highest concentrations of disadvantaged children, (those school districts with either 20% of their students classified as disadvantaged, or a total of 5,000), can expand their compensatory education services and deal with education problems in the early years before they become insoluble. In addition, new dollars can be put to use to fund "summer bridge" efforts aimed at preserving educational gains achieved during the year and lost by youngsters during the summer when a lack of funds prevents the operation of summer programs.

ESEA Title I can be a vehicle for significant improvements in basic skills achievement levels and the Concentration Grants provision is targeted to those school districts with the greatest problems. The $400 million request will make adequate the Federal effort to improve educational opportunities in school districts with the greatest concentration of educational problems.

Furthermore, the Administration recognized in its requests for Concentration Grants two years ago that the needs for extra funds in districts with high concentrations of Title I eligible students required at least $400 million. If anything has changed, it is the need to increase the funding in areas of high concentration.

Title I services are having a positive impact on children enrolled. It has been demonstrated that through the use of Title I funds -

- children with the greatest need are receiving services;
- some of the poorest districts receive as much as 18% of their total budgets from this program;
- funds are 5 1/2 times more likely to be utilized in high poverty areas than in districts with low concentrations of poor children.

Finally, there are wide variations in costs of services from region to region. Moreover, the rates of inflation differ dramatically. In urban areas the rates of increase have been higher and are calculated from higher bases. This double effect has caused severe devaluation of the purchasing power of Title I dollars in urban centers, where larger concentrations of Title I eligible children live. $400 million is a minimum appropriation.

IMPACT AID

The National School Boards Association has always supported the full funding of this program as a way of compensating the 4,500 school districts for the loss of tax revenues resulting from their inability to tax federal installations for the costs of educating the children of employees assigned to those installations. The Administration's proposal drastically cuts the entitlement levels in both the "a" and "b" payments. The President's proposed budget lowers the payments to districts with "a" children by $57 million below FY 1980, and districts with "b" children, $568 million below FY 1980. These kinds of cuts cannot be justified, especially since school districts are faced with constantly increasing expenses. One example is the skyrocketing cost of fuel which is used to heat, cool and light buildings and to transport children. The denial of Impact Aid in combination with rising costs may mean impossibly large property tax increases at the local level and/or the reduction of educational services.

We request that Impact Aid be provided for all districts through Tier II

according to the formula established by Congress. This requires $436 million for districts with "a" children and $568 million for districts with "b" children.

YOUTH EMPLOYMENT

I would draw your attention to a yet unauthorized initiative supported by the President -- Youth Employment. We applaud the President in his effort to address this most serious problem area.

As members of the Committee know, the rate of unemployment among young adults ages 16-24 is more than twice that of the population as a whole. Among black disadvantaged youths in many urban areas, the rate has reached an alarming 60%. Surprisingly, many of the individuals in this age group are heads of households and not just looking for supplemental incomes. Yet, they lack the basic skills and knowledge necessary for acquiring and maintaining full time employment. We believe that a concerted national effort must be taken on behalf of this very large segment of our population to: 1) enhance their opportunities for self-fulfillment, 2) relieve the national economic impact associated with their high rates of long-term unemployment, and 3) advance the general well-being of our employment oriented society.

School districts cannot rely on existing programs to address the problem of unemployability. We must create programs which command high priority and visibility. The President's Youth Employment initiative directs its attention to exactly these points. Although the legislation has not been authorized to date, we would hope that the Committee recognizes the value of the proposal and is prepared to appropriate the necessary funds. This would require the Committee to support $50 million for planning in FY 1981 and $850 million for program operations in FY 1982.

The impact of the Youth Employment proposal will not affect the efforts of Congress to hold down spending for the FY 1981 fiscal year since the bulk of the program funding will not become available until FY 1982. The $850 million targeted during FY 1982 comes to $850 per participant. Individuals most likely to benefit from the President's initiative are now or soon will become dependent on the social welfare support systems. When that figure is compared to the costs associated with welfare, a success rate of only 1 in 10 would allow the program to pay for itself.

ARCHITECTURAL BARRIER REMOVAL

The removal of architectural barriers in local schools has been mandated by Congress. This mandate is to be implemented by June, 1980 or school districts may face the cut off of all federal funds. If the Congress fails to help carry

the burden, local school districts will be forced to turn to already overburdened taxpayers for funding. The mood of the taxpayers and numerous tax limitations now in place or being considered complicate the issue for many local school districts. Congressional help is required.

The removal of architectural barriers is not a reoccurring cost; the initial investment of renovation permanently will make school buildings accessible for handicapped children.

- A 1977 NSBA Survey of 195 school districts in 34 states indicated that the average cost for renovation of a school building is $17,300 (in 1977 dollars).
- The NSBA Survey data illustrated an Urban/Suburban/Rural variation. Urban districts will incur the highest cost at $18,000 per building. Small districts with fewer than 5,000 students will spend $17,400 per building if they are suburban and $12,250 if they are rural. Suburban districts, because their buildings are generally newer, estimate costs of $11,600 per building.
- A 1977 New Jersey survey reports that the average cost per school district for barrier removal will be $72,600. This study assumed that only half of the buildings in each district would be renovated. Many of the buildings are old, with multiple levels which will require elevators. The cost of a two-stop elevator is $66,000 each. The New Jersey School Boards Association estimates the 409 schools in the State will require this expensive addition.

ANALYSIS OF 1980 CENSUS DATA

Section 1521 of the Education Amendments of 1978, P.L. 95-561, required the Department of Commerce (Census) to produce 1980 census information by school district for use in Title I allocations and for other purposes. That information can be produced only after school district boundaries are superimposed on census maps, a costly and time consuming process. States rely on these data. It provides the only source of general population counts for school districts which are not coterminous with general government jurisdictions.

The costs for this activity are minimal in comparison with aid distributions and are conservative in view of the work to be done. The Census Bureau estimates the cost to be $3.8 million (to be furnished by HEW) if their employees undertake the task. NCES estimates the cost to be $2.6 million. Its past experience in managing the 1970 census activity suggests that the estimate is accurate. School districts need these tools of management to improve the overall operations of public schools.

CAREER EDUCATION INCENTIVE ACT - P.L. 95-207

Career education programs are serving important functions for local school districts. Career education programs are compatible and supportive of other initiatives directed at Youth Employment. These programs have demonstrated their capacity to aid young people in preparing for an orderly transition from youth to the adult world of work.

It is important to increase the funding level to $30 million to allow states to develop useful programs. Failure to increase the funding level forces states to match federal funds at a level not originally intended in the authorization. The authorization in P.L. 95-207 called for a matching arrangement based on increasing federal funding to a third-year peak, followed by a drop to a point in five years where the states will accept 100 percent of the responsibility.

Finally, these funds will make an important contribution to achieving equal opportunity in education and employment, particulary for those who have difficulty in learning about available opportunties which can help them achieve economic security and job satisfaction.

CONCLUSION

Mr. Chairman, we recognize that we are asking you to increase the Administration's proposals. However, we believe that our requests are most prudent when viewed in the long term, and as an equitable share of the total responsibility for the future of this nation. State and local units of government will be heartened if this Committee continues to invest federal monies in the future, and resist the pressure for budget cuts or restraints that, in terms of economic impact, will be symbolic at best.

NATIONAL ADVISORY COUNCIL ON WOMEN'S EDUCATIONAL PROGRAMS

Senator WEICKER. Jean Simon, is that correct?

Ms. SIMON. That's correct.

Senator WEICKER. National Advisory Council on Women's Educational Programs.

WOMEN'S EDUCATIONAL EQUITY ACT

Ms. SIMON. My name is Jean Simon. I am pleased to represent the National Advisory Council on Women's Educational Programs.

Our council member, Dr. Bernice Sandler, was here for an hour and a half, but had to leave for an urgent appointment this afternoon, and our written testimony will be submitted for the record.

Senator WEICKER. It will be included in its entirety.

Ms. SIMON. In view of the time constraints, I think I have something like 2½ minutes, I'll try and be as succinct as possible. But I do want to express to you this afternoon our strong interest in the appropriation for the Women's Educational Equity Act program for fiscal year 1981.

Secretary Hufstedler, in making her announcement on the Department of Education's budget for fiscal year 1981, said there were four areas of special concern. One of them was promoting equity for women in education by helping school districts to comply with title IX requirements; our remarks today deal with this priority.

We are pleased, of course, that the Secretary wanted to increase the appropriation for fiscal year 1980, but it's a formula for funding that we want to discuss briefly today between tier 1 and tier 2 programs in the Educational Equity Act.

In order to understand the two-tier approach, we just want to give you a brief historical overview. Congress originally passed the Women's Educational Equity Act in 1974, with one mission: "To provide educational equity for women in the United States."

Grants and contracts were authorized by the Commissioner, and these grants and contracts were to have national significance for replication throughout the country.

The funded activities included development and dissemination of textbooks, curriculums, educational materials, relating to educational equity, training for school personnel, and so on.

Then in a reauthorization of the Women's Educational Equity Act in 1978, Congress saw fit to put in a second part or a tier 2 program funding. This would be designed to meet the requirements of title IX of the Education Amendments of 1972.

These programs, which would be funded, would have special local significance, so we would have tier 1, national significance, and tier 2, with local significance.

The original authorization of $80 million was set to be triggered off for tier 2 when the original appropriations for tier 1 reached $15 million. Now the Secretary has proposed that there be a change in the law, that the trigger be reduced to $10 million instead of the $15 million.

The council has recommended a funding level of $30 million, which would continue tier 1 activities at the authorized level, and permit a reasonable opportunity for initiating tier 2.

If the legislation were amended to limit funding for tier 1 to $10 million, there would actually be a reduction in the spending level because of the 15-percent inflation rate and, of course, the 15-percent inflation rate is more like 19 percent as of today.

So on behalf of the council, we strongly object to any amendment of the Women's Educational Equity Act which would lower the trigger to $10 million. Local education agencies applying for tier 2 funds will not need to develop model programs, but can use those that would be developed under the tier 1 program.

The new regulation for the Women's Educational Equity Act, which has yet to be published, but will be shortly, has established priorities for funding which direct that 25 percent of these grants will be targeted to the specific needs of disadvantaged minority women—10 percent of the grants will be targeted to the needs of handicapped women and girls.

SEX BIAS AND STEREOTYPING

Women have entered the labor force in increasingly large numbers in the past decade, an average of over 1 million each year. The trend, of course, will continue into the 1980's. But whether they will continue to congregate and be concentrated in low-paying, low-status jobs will depend to a large extent on the affirmative action taken by our educational system.

We want to eliminate sex stereotyping in educational programs and training, and we believe that this starts in early childhood, continues through educational programs in elementary and secondary schools.

Women need guidance and counseling to overcome socialization that

has kept them in this narrow range of occupations. Racial and ethnic minority women need special help in overcoming a double handicap.

The Women's Educational Equity Act program has produced materials to assist in all of these situations. While I looked for a good example in the State of Connecticut, Senator, I couldn't find one, I'm sorry to say.

Senator WEICKER. Don't apologize.

Ms. SIMON. Don't blame me.

Senator WEICKER. I think that it's amazing how all the witnesses, both yesterday and today, somehow found examples in Connecticut, and I'm sure when Senator Magnuson is here, all of them shifted to Seattle.

Ms. SIMON. I have one for Seattle. [Laughter.]

Just let me give you a couple of good examples. In Charleston, W. Va., we have classroom materials that were designed to give girls and boys a special awareness of their sex roles, their attitudes toward their sex roles, so they could make informed choices.

The school district of Philadelphia, Pa., has a comprehensive set of guidelines for the selection of nonsexist textbooks and materials.

Congress has been most responsive to the needs for women's educational equity in many ways. The Vocational Education Act and the Career Education Incentive Act specifically address the need to overcome sex bias and stereotyping.

The National Advisory Council on Women's Educational Programs is pleased to have made a contribution to the language in the statutes and regulations of these two acts, but the basic thrust of educational equity for the coming decade, we feel, must be based on the widest possible use and dissemination of WEAA materials already in existence.

We strongly urge the appropriation of $15 million to continue the efforts already begun under Tier 1, and we request an added appropriation of $15 million so that Tier 2 can go into effect.

Thank you very much, Senator.

Senator WEICKER. Thank you very much, Ms. Simon.

[The statement follows:]

STATEMENT OF BERNICE SANDLER, COUNCIL MEMBER, NATIONAL ADVISORY COUNCIL ON WOMEN'S EDUCATIONAL PROGRAMS

Mr. Chairman and member of the Subcommittee, my name is Bernice Sandler. I am pleased to represent the National Advisory Council on Women's Educational Programs this morning to express our strong interest in the appropriation for the Women's Educational Equity Act program for fiscal year 1981. In her statement on the Department of Education Budget for Fiscal Year 1981, Secretary Hufstedler said there were four areas of special concern -- one of them was "promoting equity for women in education by helping school districts comply with Title IX requirements." Our remarks this morning deal with this priority. While we are pleased that the total appropriation requested is more than the amount for fiscal year 1980, it is the formula for funding the Tier I and Tier II programs that we would like to discuss briefly today.

In order to understand the two tier approach, an historical overview is helpful. Originally passed by Congress in 1974, the Women's Educational Equity Act was given the mission "to provide educational equity for women in the United States." (P.L. 93-380) Grants and contracts were authorized by the Commissioner of Education for activities which extended to all levels of education, from pre-school through post-secondary and adult education. The funded activities included the development and dissemination of textbooks, curricula, and educational materials relating to educational equity; training for school personnel to emphasize guidance and counseling in sex equity; and educational activities to increase opportunitites for underemployed and unemployed adult women.

In a reauthorization of the Women's Educational Equity Act in 1978, its mission was expanded to include a second program which would "provide financial assistance to enable educational agencies and institutions to meet the requirements of Title IX of the Education Amendments of 1972." (P.L. 95-561) Congress, at the same time, divided the authorized activities into those with "national, statewide or general significance" (Tier I), and "special programs and projects of local significance" to provide equal educational opportunities for both sexes, and to achieve compliance with Title IX of the Education Amendments of 1972, (Tier II).

With an authorization of $80 million, the Tier II projects would be triggered whenever the funds were appropriated in excess of $15 million.

Under the original authorization for $30 million, the appropriation in 1976 was $6.3 million; it was increased to $7.2 million in 1977; in 1978, to $8.2 million; in 1979, to $9.0 million; and for this year, to $10 million. The Advisory Council has looked forward to the time when there would be full funding for the first level, so that funds could then be available to channel Tier I's exciting new materials and products into local schools, community groups, and other special interest groups who need help to comply with non-discrimination laws. The Council has recommended a funding level of $30 million which would continue Tier I activities at the authorized level, and permit a reasonable opportunity for initiating Tier II. If the legislation were amended to limit funding for Tier I to $10 million, there would actually be a reduction in the spending level because of the 15% inflation rate. We cannot afford to halt the forward momentum toward the goal of educational equity. We still have a long way to go in overcoming sex bias, and we look to the Congress to support and encourage the efforts that are being made to do this.

We strongly object to any amendment of the Women's Educational Equity Act which will lower the "trigger" to $10 million. Local education agencies applying for Tier II funds will not need to develop model programs, but can use those that were developed under Tier I for their special needs. The new regulation for the Women's Educational Equity Act has established priorites for funding which direct that 25% of the grants be targeted to the specific needs of disadvantaged minority women, and 10% of the grants be targeted to the needs of handicapped women and girls. The National Advisory Council on Women's Educational Programs held a public hearing in Jackson, Mississippi and heard testimony on the educational needs of black women and girls; at a hearing in Phoenix, Arizona, we learned from Indian women and girls of their educational needs; last year we conducted a Black Women's Symposium which made it very clear that black women have unique problems in today's society. All of these critical areas will suffer losses if the funding for Tier I is limited to $10 million;

those most in need will not receive the full benefits intended by Congress if the trigger level is reduced from $15 million to $10 million.

Women have entered the labor force in increasingly large numbers in the past decade -- an average of over a million each year. The trend is expected to continue in the 80's. Whether they will continue to congregate in low-paying, low-status jobs (80% of clerical employees are women) and whether they will continue to earn only 59% of what men earn will depend to a large extent on affirmative action taken by our educational system. Efforts to eliminate sex stereotyping in educational programs and training must be made from early childhood on. Young women need to benefit from role models of women who work in non-traditional occupations; they need guidance and counseling to overcome the socialization that has kept them in a narrow range of occupations; they need to know that they have a wide range of educational and career choices. Older women who are trying to enter or re-enter the labor market so they can support themselves and their families need the help of educational programs that will provide the basis for a career; they may also need support services and special counseling to explore their options. Racial and ethnic minority women need special help in overcoming a double handicap. The Women's Educational Equity Act program has produced materials to assist all of these situations.

- A project in Kansas City, Missouri, has helped women to overcome career entry barriers by providing internship opportunities, and a career reference bank for job-seekers.

- In Bellingham, Washington, the YWCA has developed materials for teachers to use in middle and high school classes that will allow young women to consider non-traditional career choices.

- In Charleston, West Virginia, classroom materials were designed to give students an awareness of their own attitudes toward sex roles, so they could make informed education and career choices.

- A history of the significant contributions of black women from 1776 to 1976 is being researched and a series of books written at Benedict College in Columbia, South Carolina.

- The school district of Philadelphia, Pennsylvania, developed a comprehensive set of guidelines for the selection of non-sexist textbooks and materials.

- Women prisoners in Dade County, Florida, were helped to develop skills so they could support themsleves upon release.

- A demonstration model at Goucher College in Baltimore, Maryland, showed how volunteer experience could be equated with paid work experience.

These are only a few of the many quality products of the Women's Educational Equity Act -- all of which have national significance and can be adapted to classrooms and situations anywhere. The enthusiasm that has been observed by the members of the Advisory Council as we have visited the sites of these programs has been encouraging to us as well as to the participants. Wide dissemination of these products to schools, community groups, and parent organizations is underway, contributing to the elimination of sex bias and stereotyping in education.

Congress has responded to the needs for women's educational equity in many ways -- the Vocational Education Act and the Career Education Incentive Act specifically addressed the need to overcome sex bias and the stereotyping. The National Advisory Council on Women's Educational Programs was pleased to have contributed to the final language in those statutes and regulations. But the basic thrust of educational equity for the coming decade must continue to be based on the widest possible use and dissemination of WEEA materials that have been tested in the field. We strongly urge the appropriation of $15 million to continue the efforts already begun -- and the added appropriation of $15 million to make results of these efforts available in local communities to as many students as possible.

NATIONAL COALITION FOR WOMEN AND GIRLS IN EDUCATION

Senator WEICKER. Carol Parr of the National Coalition for Women and Girls in Education.

Dr. PARR. Mr. Chairman, I am appearing before you today as a representative of this coalition, which is a federation of more than 50 nongovernmental organizations working to strengthen Federal policies and practices affecting sex equity in education.

We are pleased to have this opportunity to testify in support of an appropriation of $20 million for the Women's Educational Equity Act program for fiscal year 1981.

I am not going to read to you the names of the specific organizations. I will spare us all of that.

Senator WEICKER. Well, your statement in its entirety will be included in the record, complete with the names of those organizations that you represent.

TIERS 1 AND 2 FUNDING

Dr. PARR. You now have before you a budget proposal from the administration that would alter the $20 million formula and would allow the total amount requested for fiscal year 1981 be divided equally between tier 1 and tier 2, and although we applaud the provision of $20 million for the WEAA program, we agree with the Administration that funds should be appropriated for local initiatives under tier 2. We strongly object to the reduction of the trigger level for tier 1 from $15 to $10 million.

As we stated earlier, we endorsed the two-tiered approach on the principle that a certain base amount, authorized by the current legislation at $15 million, would be available for tier 1 activities before tier 2 activities would commence.

In its written testimony, the National Advisory Council has described some of the innovative practices, programs, and projects that have been funded under this program. I am not going to go on and provide you with any additional examples.

I would like to bring out a personal opportunity that I have had—an opportunity to work with grant recipients around the country for the past 2 years providing technical assistance. I am very excited about what they are doing.

I am particularly excited about the impact of some of the small grants funded under this program. There are some $25,000 grants that are given out, and I think in this particular program it is exemplary in that for a $25,000 grant for Federal aid, it is having an incredible amount of impact for that small amount of money.

Additional evidence for the need for $15 million for tier 1 can be inferred from the very large volume of proposals that are submitted for funding. In 1978, for instance, there were almost 500 applications submitted, with budget requests totaling nearly $40 million. Of these, only 70 projects could be funded.

A major portion of each grant application is devoted to a statement of the problem the proposed program is designed to address. Whatever other deficiencies the applications may have, few of the grant writers

find it difficult to document the problems of limited educational opportunities encountered by women and girls.

I, too, would like to call the attention of the subcommittee to the fact that the new priorities will provide for 25 percent of the grant awards in 1981 to be set aside for women and girls who are defined as disadvantaged by race and ethnic heritage. An additional 10 percent of funds will be set aside for grant programs for physically disabled women and girls.

Thus, we believe that a failure to increase the funding for tier 1 to $15 million, the level that's provided in legislation, will limit the program development in these critical areas, and as a result, the millions of women and girls who suffer double discrimination as a result of race, ethnicity, and condition of handicap, will not derive the full benefits of the program.

In conclusion, the National Coalition for Women and Girls in Education urges Congress to appropriate the $20 million which has been asked for by the administration and provided for in the budget for the Women's Educational Equity Act in 1981. Funding at this level should be allocated so that $15 million is provided for the national developmental activities authorized under tier 1; and an additional $5 million is made available to local school districts so they can continue, and in some instances begin, the process of providing equal opportunity for all students, male and female alike.

Senator WEICKER. Thank you very much. Thank you all very much. I greatly appreciate your testimony, and we will try to do the best we can.

[The statement follows:]

STATEMENT OF CAROL C. PARR

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE, I APPEAR BEFORE YOU TODAY AS A REPRESENTATIVE OF ORGANIZATIONS ACTIVE IN THE NATIONAL COALITION FOR WOMEN AND GIRLS IN EDUCATION, A FEDERATION OF MORE THAN FIFTY NONGOVERNMENTAL ORGANIZATIONS WORKING TO STRENGTHEN FEDERAL POLICIES AND PRACTICES AFFECTING SEX EQUITY IN EDUCATION. WE ARE PLEASED TO HAVE THIS OPPORTUNITY TO TESTIFY IN SUPPORT OF AN APPROPRIATION OF $20 MILLION FOR THE WOMEN'S EDUCATIONAL EQUITY ACT PROGRAM FOR FY '81. THE FOLLOWING COALITION ORGANIZATIONS SUPPORT THIS STATEMENT:

AMERICAN ASSOCIATION OF COMMUNITY AND JUNIOR COLLEGES
AMERICAN ASSOCIATION OF UNIVERSITY WOMEN
AMERICAN PERSONNEL AND GUIDANCE ASSOCIATION
ASSOCIATION OF INTERCOLLEGIATE ATHLETICS FOR WOMEN
FEDERAL EDUCATION PROJECT
FEDERATION OF ORGANIZATIONS FOR PROFESSIONAL WOMEN
LEAGUE OF WOMEN VOTERS OF THE UNITED STATES
NATIONAL COMMISSION ON WORKING WOMEN
NATIONAL FEDERATION OF BUSINESS AND PROFESSIONAL WOMEN'S CLUBS, INC.
NATIONAL STUDENT EDUCATIONAL FUND
NATIONAL WOMEN'S STUDIES ASSOCIATION
PROJECT ON EQUAL EDUCATION RIGHTS OF THE NOW LEGAL DEFENSE AND EDUCATION FUND
PROJECT ON THE STATUS AND EDUCATION OF WOMEN, ASSOCIATION OF AMERICAN COLLEGES
WOMEN'S EQUITY ACTION LEAGUE
WOMEN'S EQUITY ACTION LEAGUE EDUCATIONAL AND LEGAL DEFENSE FUND
WIDER OPPORTUNITIES FOR WOMEN

THE WEEA PROGRAM HAS BEEN ONE OF THE COALITION'S LONG STANDING INTERESTS AND CONCERNS. COALITION PARTICIPANTS HAVE BEEN ACTIVELY INVOLVED WITH THIS PROGRAM SINCE ITS INCEPTION. WE HAVE SERVED AS AN IMPORTANT LINK BETWEEN THE PROGRAM AND OUR RESPECTIVE CONSTITUENCIES AROUND THE COUNTRY AND, ON SEVERAL PREVIOUS OCCASIONS, HAVE TESTIFIED BEFORE CONGRESS IN SUPPORT OF WEEA.

ON ONE OCCASION, OUR TESTIMONY FOCUSED ON THE REAUTHORIZATION OF THE PROGRAM. AT THAT TIME, WE SUPPORTED A REVAMPED WOMEN'S EDUCATIONAL EQUITY ACT WHICH WOULD EMBRACE THE ORIGINAL GOAL -- EDUCATIONAL EQUITY FOR WOMEN AND GIRLS -- AND WOULD AUTHORIZE ACTIVITIES DESIGNED TO FACILITATE ATTAINMENT OF THAT GOAL. WE ADVOCATED A TWO-TIERED STRUCTURE, WITH THE FIRST TIER OF FUNDS

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(NOW SET AT $15 MILLION) DEVOTED TO THE ORIGINAL PURPOSE OF THE ACT -- DEVELOPMENT, DEMONSTRATION AND DISSEMINATION OF MODEL PROGRAMS AND PROJECTS -- AND SECOND TIER FUNDS WHICH WOULD BE EARMARKED FOR PROJECTS OF LOCAL SIGNIFICANCE TO IMPLEMENT TITLE IX. OUR SUPPORT WAS CONTINGENT ON THE ESTABLISHMENT OF A PERMANENT TRIGGER AMOUNT FOR TIER I ADEQUATE FOR THE DEVELOPMENT OF INNOVATE APPROACHES TO SEX EQUITY AT ALL LEVELS OF EDUCATION FROM PRE-SCHOOL THROUGH ADULT EDUCATION.

YOU NOW HAVE BEFORE YOU A BUDGET PROPOSAL THAT WOULD ALTER THAT FORMULA AND WOULD ALLOW THE TOTAL AMOUNT REQUESTED FOR WEEA FOR 1981 -- $20 MILLION -- TO BE DIVIDED EQUALLY BETWEEN TIER I AND TIER II. ALTHOUGH WE APPLAUD THE PROVISION OF $20 MILLION FOR THE WEEA PROGRAM, AND ALTHOUGH WE AGREE WITH THE ADMINISTRATION THAT FUNDS SHOULD INDEED BE APPROPRIATED FOR LOCAL INITIATIVES UNDER TIER II NEXT YEAR, WE OBJECT STRONGLY TO THE REDUCTION OF THE TRIGGER LEVEL FOR TIER I FROM $15 MILLION TO $10 MILLION.

AS WE STATED EARLIER, WE ENDORSED THE TWO-TIERED APPROACH ON THE PRINCIPLE THAT A CERTAIN BASE AMOUNT -- AUTHORIZED BY CURRENT LEGISLATION AT $15 MILLION -- WOULD BE AVAILABLE FOR TIER I ACTIVITIES BEFORE TIER II ACTIVITIES COULD COMMENCE. WE ARE CONCERNED THAT, IF A TECHNICAL AMENDMENT IS ALLOWED THIS YEAR TO ALTER THE FUNDING FORMULA FOR THE WEEA PROGRAM, A DANGEROUS PRECEDENT WILL BE ESTABLISHED FOR FUTURE YEARS -- A PRECEDENT THAT WILL SEVERELY LIMIT THE EFFECTIVENESS OF THE PROGRAM.

SINCE ITS FIRST ROUND OF FUNDING, IN 1976, THE WEEA PROGRAM HAS SUPPORTED THE DEVELOPMENT OF A WIDE RANGE OF PRODUCTS AND PROGRAMS DESIGNED TO FOSTER THE ELIMINATION OF SEX BIAS IN EDUCATION. TO DATE, THE WEEA DISSEMINATION CENTER IN NEWTON, MA HAS RECEIVED OVER 30,000 INQUIRIES ABOUT WEEA PRODUCTS. BY JUNE 1980, TEACHERS, ADMINISTRATORS, COUNSELORS, PARENTS AND STUDENTS SHOULD HAVE ACCESS TO MORE THAN 175 NON-SEXIST AND NON-RACIST EDUCATIONAL PRODUCTS, THOSE ALREADY ON THE MARKET AS WELL AS THOSE IN THE REVIEW AND MASS PRODUCTION STAGES. COMPARED TO WHAT WAS AVAILABLE TEN, FIVE, OR EVEN TWO YEARS AGO IN THIS AREA THESE FIGURES REPRESENT A TREMENDOUS ACCOMPLISHMENT FOR A VERY SMALL PROGRAM. THIS ACCOMPLISHMENT IS MAGNIFIED EVEN FURTHER WHEN WE CONSIDER THAT PRODUCTS DEVELOPED WITH WEEA FUNDS HAVE NATIONAL AS WELL AS REGIONAL IMPACT AND PROVIDE EQUAL EDUCATIONAL OPPORTUNITIES FOR BOYS AS WELL AS GIRLS.

TESTIMONY OF THE NATIONAL ADVISORY COUNCIL HAS DESCRIBED SOME OF THE INNOVATIVE PROJECTS FUNDED UNDER THIS PROGRAM. I'M SURE YOU'LL AGREE THAT EFFORTS OF THIS TYPE ARE A GOOD INVESTMENT OF FEDERAL DOLLARS TO ACHIEVE EQUAL OPPORTUNITY IN EDUCATION. YET, DESPITE THE ACCOMPLISHMENTS OF THE WEEA PROGRAM, AND THE PROMISES OF SUCCESS, AND DESPITE LAWS SUCH AS TITLE IX, RECENT

STUDIES AND EVENTS INDICATE THAT EDUCATIONAL EQUITY FOR WOMEN AND GIRLS IS STILL A DISTANT DREAM, NOT AN IMPENDING REALITY. TO CITE JUST A FEW EXAMPLES:

- A RECENT REPORT FROM THE NATIONAL ASSOCIATION OF STATE UNIVERSITIES AND LAND GRANT COLLEGES INDICATES THAT IN 1979 ONLY 21% OF THE ADMINISTRATIVE POSITIONS AT STATE SCHOOLS WERE OCCUPIED BY WOMEN. ALTHOUGH THIS FIGURE REPRESENTS A SIGNIFICANT INCREASE FROM 1971, CLOSER EXAMINATION OF THE STATISTICS INDICATES THAT:
  - -- OVER 58% OF THE WOMEN ADMINISTRATORS WERE EMPLOYED IN THE LOWEST ADMINISTRATIVE POSITIONS;
  - -- WOMEN ACCOUNTED FOR ONLY 6.5% OF ALL PRESIDENTS OR CHANCELLORS, CHIEF OFFICERS OF ADMINISTRATIVE DIVISIONS OR ASSOCIATE OR ASSISTANT CHIEF OFFICERS;
  - -- THERE WERE NO WOMEN ADMINISTRATORS IN DENTISTRY, MEDICINE, BUSINESS OR LAW; AND
  - -- ONLY 10.8% WERE DEPARTMENT CHAIRS AND THERE WERE NO FEMALE DEPARTMENT CHAIRS IN THE FIELDS OF LAW, ENGINEERING, JOURNALISM, MANAGEMENT OR VETERINARY MEDICINE.

- PEER (THE PROJECT ON EQUAL EDUCATION RIGHTS OF THE NOW LEGAL DEFENSE AND EDUCATION FUND) CONDUCTED A STUDY OF STATE AND NATIONAL PORGRESS IN THREE AREAS OF EDUCATION -- HIGH SCHOOL ATHLETICS, EDUCATIONAL ADMINISTRATION AND VOCATIONAL EDUCATION. THE FINDINGS PRESENT A DISMAL PICTURE OF THE STATUS OF GIRLS AND WOMEN IN THESE AREAS:
  - -- IN EDUCATIONAL ADMINISTRATION: ALTHOUGH SEVEN OUT OF EVERY TEN TEACHERS ARE WOMEN, ONLY ONE OUT OF EVERY TEN TOP SCHOOL ADMINISTRATORS ARE WOMEN;
  - -- ONLY ABOUT 11 % OF THE STUDENTS IN TRADITIONALLY MALE VOCATIONAL EDUCATION PROGRAMS (AGRICULTURE, TECHNOLOGY AND TRADES AND INDUSTRY) ARE FEMALE;
  - -- ONLY ONE-THIRD OF HIGH SCHOOL INTERSCHOLASTIC ATHLETES ARE GIRLS.

- ACCORDING TO WEAL EDUCATIONAL AND LEGAL DEFENSE FUND'S SPRINT PROJECT, BUDGETS FOR WOMEN'S ATHLETIC PROGRAMS AT COLLEGES AND UNIVERSITIES AVERAGE BETWEEN 16 AND 20% OF THE TOTAL BUDGETS FOR ATHLETICS -- AND YET WOMEN COMPRISE OVER HALF OF TODAY'S POPULATION OF UNDERGRADUATE STUDENTS.

ADDITIONAL EVIDENCE OF THE NEED FOR $15 MILLION FOR TIER I OF THE WEEA PROGRAM CAN BE INFERRED FROM THE LARGE VOLUME OF PROPOSALS SUBMITTED FOR FUNDING. IN 1978, 493 APPLICATIONS WER SUBMITTED WITH BUDGET REQUESTS TOTALLING NEARLY $40 MILLION. OF THESE, ONLY 70 PROJECTS COULD BE FUNDED. A MAJOR PORTION OF EACH GRANT APPLICATION IS DEVOTED TO A STATEMENT OF THE PROBLEM THE PROPOSED PROGRAM OR PRODUCT IS DESIGNED TO ADDRESS. WHATEVER OTHER DEFICIENCIES THE APPLICATION MAY HAVE, FEW GRANT WRITERS FIND IT DIFFICULT TO DOCUMENT THE PROBLEMS OF LIMITED EDUCATIONAL OPPORTUNITIES ENCOUNTERED BY WOMEN AND GIRLS.

THE FINAL REGULATION GOVERNING THE ADMINISTRATION OF THE WEEA PROGRAM FOR THE NEXT FOUR YEARS IDENTIFIES SEVERAL NEW PRIORITY AREAS FOR FUNDING UNDER TIER I. INCLUDED IN THESE PRIORITIES ARE:

- PROGRAMS WHICH WILL BENEFIT THE NEEDIEST WOMEN AND GIRLS AS DEFINED BY RACE AND ETHNIC HERITAGE (25% OF THE GRANT AWARDS IN 1981 WILL BE MADE IN THIS PRIORITY); AND

- EDUCATIONAL EQUITY PROGRAMS FOR DISABLED WOMEN AND GIRLS (10% OF THE GRANT AWARDS IN 1981 WILL BE MADE IN THIS PRIORITY).

THUS, FAILURE TO INCREASE THE FUNDING FOR TIER I TO THE $15 MILLION LEVEL PROVIDED IN THE LEGISLATION WILL LIMIT PROGRAM DEVELOPMENT IN THESE CRITICAL PRIORITIES. AS A RESULT, MILLIONS OF WOMEN AND GIRLS WHO SUFFER DOUBLE DISCRIMINATION AS A RESULT OF RACE, ETHNICITY, OR CONDITION OF HANDICAP WILL NOT DERIVE THE FULL BENEFITS OF THE PROGRAM.

IN ADDITION, DIRECT INVOLVEMENT OF STUDENT AND COMMUNITY GROUPS IS VITAL TO THE SUCCESS OF THIS NATIONAL PROGRAM. HOWEVER, THEY ARE ELIGIBLE TO COMPETE FOR ONLY 25% OF TIER II FUNDS WHEREAS THEY CAN COMPETE FOR ALL OF TIER I FUNDS. THEREFORE, FAILURE TO PROVIDE $15 MILLION FUNDING FOR THE FIRST TIER WILL DECREASE THE LIKELIHOOD OF AWARDS BEING MADE TO GROUPS THAT ADVOCATE EDUCATIONAL EQUITY IN SCHOOLS AND LOCAL COMMUNITIES AROUND THE COUNTRY.

IN CONCLUSION, THE NATIONAL COALITION FOR WOMEN AND GIRLS IN EDUCATION URGES CONGRESS TO APPROPRIATE $20 MILLION FOR THE WOMEN'S EDUCATIONAL EQUITY ACT FOR 1981. FUNDING AT THIS LEVEL SHOULD BE ALLOCATED SO THAT $15 MILLION IS PROVIDED FOR THE NATIONAL DEVELOPMENTAL ACTIVITIES AUTHORIZED UNDER TIER I AND AN ADDITIONAL $5 MILLION IS MADE AVAILABLE TO LOCAL SCHOOL DISTRICTS SO THAT THEY CAN CONTINUE, AND IN SOME CASES BEGIN, THE PROCESS OF PROVIDING EQUAL OPPORTUNITY FOR ALL STUDENTS, MALE AND FEMALE ALIKE.

EDUCATION FACILITIES AND LOANS

STATEMENTS OF:

FATHER WILLIAM GEORGE, OFFICE OF THE PRESIDENT, GEORGETOWN UNIVERSITY
DORICE SMALLWOOD
STEFANIE ROBINSON
HARRY ROBINSON, CHATHAM COUNCIL ON HUMAN RELATIONS, EMERGENCY SCHOOL AID ACT PROGRAM

CONSTRUCTION LOANS AND GRANTS

Senator WEICKER. The next is education facilities and loans. We have Father William George, Office of the President, Georgetown University; Dorice Smallwood, Chatham Council on Human Relations, Emergency School Aid Program with Stefanie Robinson and Harry Robinson.

Please, all make yourselves comfortable. I've got a little problem ahead of me now in that I have just had a delegation from Connecticut waiting in my office for about 20 minutes, and I'm going to have to get going up there.

If we could mention first of all; all statements will be included in their entirety for the record, and depending on the length of the testimony, I may or may not have to leave here before it's all over. So let's start right off with Father George.

Father GEORGE. Mr. Chairman, I am Father William George, Assistant to the President of Georgetown, and I am going to be very brief

because I know other panel members have come from far and wide. I just live across town, and I can catch the staff and perhaps the committee at a more convenient time. But I would like to ask——

Senator WEICKER. I don't want anybody to feel rushed. Please don't do that. We will try to give everybody an opportunity to speak.

Father GEORGE. Well, I would like to ask the committee to consider the facilities programs in the education department—college housing and the grants for construction for higher education; as well as keeping up on the loan programs for reconstruction and renovation or replacement of facilities.

Universities have had to postpone their maintenance problems because of rising costs and decreasing funds available over the last 10 years. Unless certain facilities are replaced, renovated, or reconstructed, there is going to be a major expense in having to rebuild with new construction throughout the country. It is a rather large proportion.

I ask you to perhaps read the latest issue of Time magazine. I just saw it this morning, and it has a major article on the maintenance problems of higher education facilities. I didn't come prepared with it. The last statement is on the imagination and the creativity of the University of Connecticut. They have done something rather innovative up there, using their students to help in the renovation process. But it's a major problem.

I'd ask the committee to consider keeping these facilities open and appropriating so that you can do something now; so that you don't have a huge costly problem in the end.

Young minds that are healthy, imaginative and intelligent are the greatest resource we have, and you can't really help them if you don't have a place to do it. So on behalf of Father Healy, thank you.

Senator WEICKER. I agree with you. Tell that to my colleagues. Some of the old minds around here are sort of going to be retired. It's the young ones we ought to be concentrating on.

Father GEORGE. I didn't make one further point. If the reconstruction, renovation, and sometimes if it's necessary, replacement, is connected with energy-efficient programs—if that's given a priority, you get much more for the value of that reconstruction. You can make some of these old buildings really use less energy and convert from oil and gas to things like coal and solar and clean ways of doing it. If that was connected, it would make double sense to me.

[The statement follows:]

Statement of Father William George

Mr. Chairman, we are Frs. T. Byron Collins, S.J. and William L. George, S.J., Special Assistants to the President of Georgetown University.

	Authorization	1979 Actual	1980 Estimate	1981 Estimate	University Recommendation
College Housing Loans	$110,000,000	$58,692,000	$108,000,000	$118,000,000	$118,000,000
Annual Interest Grants* (HEW Title VII)	13,500,000	-	29,000,000	26,000,000	29,000,000
Grants for Construction*					
Undergraduate	300,000,000	-	-	-	50,000,000
Graduate	80,000,000	-	-	-	30,000,000
Loans for Construction, Reconstruction, and Renovation*	200,000,000	-	-	-	To remain active

The Higher Education Community, especially the independent colleges and universities sector, is in serious need of federal assistance in renovation, reconstruction and replacement of academic facilities.

Federal and state funding for higher education facilities has been drastically curtailed for a decade; coupled with high interest rates and inflationary costs, the country's colleges and universities have had to defer much needed maintenance and renovation costs. As an example, in 1971, fuel costs at Georgetown University were approximately $356,000 and $1,830,000 in 1978. Electric costs in 1971 were $455,000 and $1,288,387 in 1978, even though the University reduced its consumption of electricity by 34%. These kinds of increases have caused Georgetown University, as well as other universities to postpone needed renovations, which are presently reaching the critical point - renovate now, or look to enormously higher costs for new construction in a very short time. Now is the time to appropriate funds for higher education construction programs so that the nation's colleges and universities can maintain their ability to educate our greatest national resource, imaginative, intelligent, youthful minds.

The level of funding requested would permit those universities in the most need to begin renovation, reconstruction or replacement of facilities.

Georgetown University has felt the facilities crisis in having an academic facility program which has recently come in with bids of $5,800,000 over the estimated costs. The University urgently needs some assistance less the entire $22,000,000 project be jeopardized. We would ask the Committee to consider $1,000,000 in grant and $2,200,000 in direct loans to continue this Department of Education approved construction project. The University will supply the remaining $2,600,000 from its other resources.

On behalf of our President, Rev. Timothy S. Healy, S.J., we thank you for the opportunity to appear before this Committee.

* House passed authority as contained in Education Amendments of 1980, Report No. 96-520.

Education

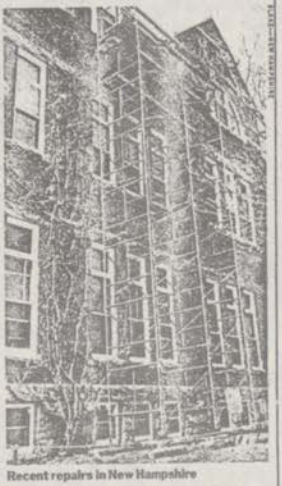
Dilapidation in Academe

Under all that ivy, costly college halls and walls are crumbling

At the University of Massachusetts' Amherst campus the red brick façade of the 28-story library has turned into a new sort of flying buttress. Since last fall, chunks of brick have come crashing onto the surrounding concrete patio, which is now fenced off to protect passing students. At California's San José State University, badly fitting window frames caused drafts that sent shivering nude models scurrying from the art studio. The 30 models, aged 21 to 52, went on strike, in part because they were tired of posing clad only in "goose flesh." At San Francisco State University, an electric fan, running some 14 hours a day, is all that keeps the library's transformer from overheating—and breaking down. At an Ivy League university, maintenance crews had to tie rags around floor-to-ceiling columns to funnel water leaking from the roof into buckets. When full, the buckets were emptied out a nearby window and set back in place.

Such stories are not unusual on many U.S. campuses today. Visiting parents, barely used to finding their children knee-deep in noise and petty vandalism, are now, like universities themselves, encountering organic dilapidation in academe. For want of maintenance, roofs leak, ceilings crumble, fuses blow, pipes go bump in the night and expire. According to the National Association of College and University Business Officers, it would take roughly $30 billion just to catch up with accumulated neglect of campus buildings.

About 70% of all college buildings in the U.S. were erected after 1950, more than one-third of them in an eight-year spurt following 1966, when federal funds flowed freely and administrators hustled to accommodate the baby boom. Cutting corners with low-grade materials, designers often created buildings that aged prematurely and consumed heating oil as if it would cost 16¢ per gal. forever. With their budgets severely strained, school officials have paid only for the absolute necessities: soaring energy bills, teachers' salaries, research costs. As a result, maintenance budgets have shrunk proportionally, just as buildings and machinery have begun to fall apart. Georgia's state university system, for instance, estimates it needs $12 million annually to get the buildings on its 32 campuses back into shape, but last year spent only $2.25 million.



Recent repairs in New Hampshire



Artists' model using her own heater at San José State studio

"The trick is to put in small amounts of money before the sewer backs up."

State legislatures and rich alumni naturally prefer to contribute to a prestigious project like a science lab, often without providing money to maintain it. Says Sy Zachar, an analyst working on a study of physical plant maintenance funded by the Carnegie Corp.: "It's easy to find some foundation eager to donate a new tax-deductible library or a shiny new *anything*. But what donor wants to put a plaque on a steam pipe?" At the University of California at Berkeley, administrators nickname the list of "deferred maintenance" problems the "Crummy and Seedy Project."

Another difficulty is that alumni and administrators rarely see, or quite believe, the slow, steady decay that goes on. Says Paul T. Knapp, executive director of the Association of Physical Plant Administrators of Universities and Colleges: "Up East they cover it with ivy, so you can't see the buildings falling apart. People tend to think these places are too important to wear out." But in maintenance, a stitch in time means long-term salvation. Says William Massy, a vice president at Stanford University: "The trick is to put small amounts of money in early, before the sewer backs up or the lights go out." But, Keith Spalding, president of Franklin and Marshall College, points out, "very few private colleges depreciate their buildings. It is tempting to balance the budget by failing to fix the roof." Case in point: last year the University of New Hampshire neglected a leaky roof. Because of winter snow seepage, not only the roof but ceilings and interior walls needed repair.

Because legislatures are somewhat freer with money than alumni, private universities have fallen further behind than public. Some schools, especially in the Midwest, have kept up with maintenance problems by appropriating renewal funds. But most campuses are in trouble. Says Paul Romberg, president of San Francisco State: "Deterioration of buildings has been so severe we may have to consider curtailing some academic programs." The "millions" needed for repair, says Romberg, "are a small investment compared with the enormous potential loss to taxpayers."

One way of coping at least with the look of college dorms, which potential donors tend to see first, may be to enlist student support. In an experiment in "dormitory democracy," students at the University of Connecticut took over all the lighter maintenance in one older dorm: building walls, painting, waxing, replacing light bulbs. For six years the plan has kept costs down. And giving the students responsibility also has cut back significantly on vandalism. ■

12/79 COLLEGE HOUSING PROGRAM FY 78
NEW CONSTRUCTION FOR SEVERE HOUSING SHORTAGE (000)
LISTED BY STATE, FUNDED AND UNFUNDED

EXHIBIT A	APPLICANTS	FUNDED	UNFUNDED	TOTAL DEMAND	NATIONAL DEMAND %
Alabama	9	$ 3,782	$ 13,744	$ 17,526	3.99
Alaska	1	-	428	428	.10
Arizona	4	-	11,900	11,900	2.71
Arkansas	1	-	400	400	.09
California	17	19,114	31,158	50,272	11.44
Colorado	2	-	3,575	3,575	.81
Connecticut	3	-	8,185	8,185	1.86
Delaware	-	-	-	-	
District of Columbia	3	4,504	3,023	9,527	1.71
Florida	7	-	18,849	18,849	4.29
Georgia	1	-	1,066	1,066	.24
Hawaii	1	-	1,602	1,602	.36
Idaho	-	-	-	-	
Illinois	9	-	16,784	16,784	3.82
Indiana	3	-	6,629	6,629	1.51
Iowa	3	-	5,097	5,097	1.16
Kansas	2	-	929	929	.21
Kentucky	2	9,069	-	9,069	2.06
Louisiana	1	3,165	-	3,165	.72
Maine	2	-	2,255	2,255	.51
Maryland	7	-	19,569	19,569	4.45
Massachusetts	8	4,950	18,562	23,512	5.35
Michigan	6	5,970	4,936	10,906	2.48
Minnesota	3	-	7,914	7,914	1.81
Mississippi	11	4,000	13,452	17,452	3.97
Missouri	4	-	5,181	5,181	1.18
Montana	1	-	641	641	.14
Nebraska	4	-	6,767	6,767	1.54
Nevada	-	-	-	-	
New Hampshire	2	-	3,020	3,020	.70
New Jersey	5	-	20,409	20,409	4.65
New Mexico	-	-	-	-	
New York	11	11,300	17,872	29,172	6.64
North Carolina	8	1,568	13,739	15,307	3.48
North Dakota	3	-	5,803	5,803	1.32
Ohio	4	-	6,371	6,371	1.45
Oklahoma	-	-	-	-	
Oregon	3	-	2,999	2,999	.68
Pennsylvania	14	2,139	24,494	26,633	6.06
Rhode Island	2	-	5,918	5,918	1.35
South Carolina	7	5,499	7,275	12,774	2.91
South Dakota	-	-	-	-	
Tennessee	6	-	8,491	8,491	1.93
Texas	9	4,100	17,294	21,394	4.87
Utah	-	-	-	-	
Vermont	3	-	1,623	1,623	.37
Virginia	8	4,050	8,504	12,554	2.86
Washington	1	-	3,728	3,728	.85
West Virginia	-	-	-	-	
Wisconsin	2	-	6,027	6,027	1.37
Wyoming	-	-	-	-	
National Totals	203	$83,210	$356,213	$439,423	100.00%

Table A-3
Fuel Consumption and Cost: All Institutions

Type of Fuel	1972-73 N	1972-73 Therms Consumed (in thousands)	1972-73 Total Cost (in thousands)	1972-73 Dollars Per Therm	1974-75 N	1974-75 Therms Consumed (in thousands)	1974-75 Total Cost (in thousands)	1974-75 Dollars Per Therm	Percent Change N	Percent Change Therms Consumed	Percent Change Total Cost	Percent Change Dollars Per Therm
Fuel oil, total	1703[a]	923,574	75,418	.082	1692[a]	789,009	170,812	.216	- .6	-14.6	126.5	163.4
#6 Fuel oil	466	618,974	46,096	.074	458	525,577	111,279	.212	- 1.7	-15.1	141.4	186.5
#5 Fuel oil	194	51,513	4,235	.082	171	37,096	8,136	.219	-11.9	-28.0	92.1	167.1
#4 Fuel oil	238	55,906	4,889	.087	239	47,178	10,618	.225	.4	-15.6	117.2	158.6
#2 Fuel oil	1355	197,181	20,198	.102	1372	179,158	40,779	.228	1.3	- 9.1	101.9	123.5
Natural gas	2342	1,904,670	106,963	.056	2349	1,807,878	165,570	.092	.3	- 5.1	54.8	64.3
Coal	233	474,146	26,190	.055	236	429,835	53,247	.124	1.3	- 9.3	103.3	125.5
Purchased electricity	2844	842,116	330,068	.392	2865	845,841	520,475	.615	.7	.4	57.7	56.9
Purchased steam	61	76,679	14,467	.189	85	105,341	30,176	.286	39.3	37.4	108.6	51.3
Propane	56	1,016	156	.154	75	1,298	425	.327	33.9	27.8	172.4	112.3
Other	34	27,214	1,544	.057	14	34,213	3,164	.092	-58.8	25.7	104.9	61.4
Total	2982	4,249,415	554,806	.131	2984	4,013,415	943,869	.235	.1	- 5.6	70.1	79.4

[a]Unduplicated total of institutions using oil.

Table 14.—Graduate enrollment in 4-year institutions of higher education, by sex, by attendance status, and by institutional control: United States, fall 1965 to 1985[1]

[In thousands]

Year (fall)	Total graduate degree-credit enrollment	Sex		Attendance status		Control	
		Men	Women	Full-time	Part-time	Public	Private
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1965[2]	697	465	232	256	441	440	257
1966[2]	768	503	265	285	483	489	279
1967[2]	849	547	302	317	532	550	299
1968[2]	885	558	327	337	548	584	301
1969	955	590	366	364	591	666	289
1970	1,031	632	399	379	652	724	307
1971	1,012	615	397	388	624	712	300
1972	1,066	627	439	393	673	757	308
1973	1,123	647	476	409	714	799	324
1974	1,190	663	527	428	762	852	338
1975	1,263	700	563	453	810	906	357
				Projected[3]			
1976	1,320	726	594	473	847	948	372
1977	1,367	738	629	488	879	981	386
1978	1,408	751	657	501	907	1,011	397
1979	1,439	755	684	511	928	1,034	405
1980	1,468	762	706	520	948	1,058	410
1981	1,489	760	729	526	963	1,071	418
1982	1,500	760	740	529	971	1,082	418
1983	1,498	745	753	527	971	1,079	419
1984	1,479	729	750	519	960	1,067	412
1985	1,456	706	750	510	946	1,052	404

[1] Includes resident and extension graduate degree-credit enrollment. The estimates, 1965-68, and data, 1969-1972, differ from figures in 1973 and earlier editions of *Projections of Educational Statistics* because they include extension graduate enrollment, which previously was included in undergraduate and first-professional degree-credit enrollment figures.

[2] For method of estimating total graduate enrollment, 1965 to 1968, see appendix A, "Estimation Methods," secs. 3a, 3b, 3h, 3i, 3k, and 3l.

[3] The projection of graduate enrollment is based primarily on the assumptions that, for each sex, full-time graduate enrollment expressed as a percentage of full-time undergraduate and unclassified enrollment in 4-year institutions will follow the 1968 to 1975 trend through 1985 and that the percentage of full-time graduate enrollment in public institutions will remain constant through 1985. For each type and control category of institution, it was assumed that the percentage that full-time graduate enrollment was of total graduate enrollment in 1975 would remain constant through 1985.

NOTE.—Data are for 50 States and the District of Columbia for all years. Because of rounding, details may not add to totals.

SOURCES: Enrollment data and estimates are based on U.S. Department of Health, Education, and Welfare, National Center for Education Statistics, publications: (1) *Opening [Fall] Enrollments in Higher Education*, annually, 1965 through 1968, 1971 through 1975. (2) *Fall Enrollment in Higher Education, Supplementary Information*, 1969 and 1970, and (3) unpublished data from *Resident and Extension Enrollment in Institutions of Higher Education*, fall 1966 and 1967, and (4) *Residence and Migration of College Students*, fall 1968.

Table 6.--Total enrollment in all institutions of higher education, by sex, by attendance status, and by institutional control: United States, fall 1965 to 1985

[Resident and extension opening fall enrollment]

Year (fall)	Total enrollment	Sex		Attendance status[1]		Control	
		Men	Women	Full-time	Part-time	Public	Private
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1965	5,920,864	3,630,020	2,290,844	4,082,257	1,838,607	3,969,596	1,951,268
1966	6,390,000	3,856,000	2,534,000	4,433,000	1,952,000	4,349,000	2,041,000
1967	6,911,000	4,133,000	2,778,000	4,792,000	2,119,000	4,816,000	2,095,000
1968	7,513,091	4,479,649	3,035,442	5,210,155	2,302,936	5,430,652	2,082,439
1969	8,004,660	4,477,649	3,258,459	5,498,883	2,505,777	5,896,868	2,107,792
1970	8,580,887	5,043,642	3,537,245	5,815,290	2,765,597	6,428,134	2,152,753
1971	8,948,644	5,207,004	3,741,640	6,072,389	2,871,412	6,804,309	2,144,335
1972	9,214,860	5,238,757	3,976,103	6,022,389	3,142,471	7,070,635	2,144,225
1973	9,602,123	5,371,052	4,231,071	6,189,493	3,412,630	7,419,516	2,182,607
1974	10,223,729	5,622,429	4,601,300	6,370,273	3,853,456	7,988,500	2,235,229
1975	11,184,859	6,148,997	5,035,862	6,841,334	4,343,525	8,834,508	2,350,351
				Projected[2]			
1976	11,693,000	6,383,000	5,310,000	7,049,000	4,644,000	9,298,000	2,395,000
1977	12,146,000	6,575,000	5,571,000	7,220,000	4,926,000	9,716,000	2,430,000
1978	12,572,000	6,746,000	5,826,000	7,374,000	5,198,000	10,118,000	2,454,000
1979	12,928,000	6,890,000	6,038,000	7,485,000	5,443,000	10,464,000	2,464,000
1980	13,214,000	6,999,000	6,215,000	7,559,000	5,655,000	10,747,000	2,467,000
1981	13,477,000	7,092,000	6,385,000	7,615,000	5,862,000	11,012,000	2,465,000
1982	13,629,000	7,135,000	6,494,000	7,621,000	6,008,000	11,183,000	2,446,000
1983	13,643,000	7,085,000	6,558,000	7,545,000	6,098,000	11,232,000	2,411,000
1984	13,524,000	6,988,000	6,536,000	7,405,000	6,119,000	11,175,000	2,349,000
1985	13,360,000	6,865,000	6,495,000	7,243,000	6,117,000	11,070,000	2,290,000

[1] Estimated for all years prior to 1968. See appendix A, "Estimation Methods," sec. 3k.

[2] The projection of total degree-credit enrollment in all institutions of higher education, for each sex, is based primarily on the following assumptions: (a) The 1974 percentage that full-time undergraduate and unclassified enrollment was of the population aged 18-21 years will follow the 1965-to-1975 trend through 1985. (b) The percentage of full-time undergraduate and unclassified enrollment in public 2-year institutions will equal 100 percent less the percentage of full-time undergraudate and unclassified enrollment in the three other type and control categories of institutions; the percentage of full-time undergraduate and unclassified enrollment in the three other categories will each follow their 1968-to-1975 trend through 1985. (c) For each type and control category of institutions, the percentage that full-time undergraduate and unclassified enrollment is of total undergraduate and unclassified enrollment will follow the 1968-to-1975 trend through 1985. (d) The percentage that projected first-professional degrees for 1976-77 are of full-time first-professional enrollment in 1975 will remain constant through 1985. (e) The 1975 percentage of first-professional enrollment in public institutions will remain constant through 1985. (f) For each type and control category of institutions, the percentage that full-time first-professional enrollment was of total first-professional enrollment in 1975 will remain constant through 1985. (g) The percentage that full-time graduate enrollment is of full-time undergraduate and unclassified enrollment in 4-year institutions will follow the 1968-to-1975 trend through 1985. (h) The 1975 percentage of full-time graduate enrollment in public institutions will remain constant through 1985. (i) For each type and control category of institutions, the percentage that full-time graduate enrollment was of total graduate enrollment in 1975 will remain constant through 1985.

The projection of total non-degree-credit enrollment in all institutions by sex is based primarily on the assumption that full-time enrollment, expressed as a percentage of population aged 18-21 years, will follow the 1965-1975 trend to 1985.

For each sex, it was assumed that full-time non-degree-credit enrollment in public 4-year, private 4-year, and private 2-year institutions would remain constant at their 1975 levels.

For each type and control category of institutions it was assumed that the percentage that full-time non-degree-credit enrollment was of total non-degree-credit enrollment in 1975 would remain constant through 1985.

For further methodological details, see appendix A, table A-1.

NOTE.--Data are for 50 States and the District of Columbia for all years. Because of rounding, details may not add to totals.

SOURCE: Enrollment data and estimates are based on U.S. Department of Health, Education, and Welfare, National Center for Education Statistics, publications: (1) *Opening (Fall) Enrollment in Higher Education*, annually, 1965 through 1968, 1971 through 1975 (2) *Fall Enrollment in Higher Education, Supplementary Information*, 1969 and 1970, and (3) unpublished data from *Resident and Extension Enrollment in Institutions of Higher Education*, fall 1966, and 1967.

Population on which projections are based is shown in appendix B, table B-2.

Table 16.--Earned degrees, by level and by sex of student: United States, 1964-65 to 1985-86

Year	Bachelor's degrees[1]			First-professional degrees[2]			Master's degrees[3]			Doctor's degrees (except first-professional)[4]		
	Total	Men	Women	Total	Men	Women	Total	Men	Women	Total	Men	Women
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
1964-65	501,248	288,538	212,710	28,755	27,748	1,007	117,152	77,544	39,608	16,467	14,692	1,775
1965-66	570,248	299,196	221,052	30,799	29,657	1,142	140,548	93,063	47,485	18,237	16,121	2,116
1966-67	558,075	322,171	235,904	32,472	31,178	1,294	157,707	103,092	54,615	20,617	18,163	2,454
1967-68	631,923	357,270	274,653	34,787	33,737	1,550	176,749	113,519	63,230	23,089	20,183	2,906
1968-69	728,167	409,831	318,286	36,018	34,499	1,519	193,756	121,531	72,225	26,183	22,752	3,436
1969-70	791,510	450,234	341,276	35,724	33,940	1,784	208,291	125,624	82,667	29,866	25,890	3,976
1970-71	839,730	475,594	364,136	37,946	35,544	2,402	230,509	138,146	92,363	32,107	27,530	4,577
1971-72	887,273	500,590	386,683	43,411	40,723	2,688	251,633	149,550	102,083	33,363	28,090	5,273
1972-73	922,362	518,191	404,171	50,018	46,489	3,529	263,371	154,468	108,903	34,777	28,571	6,206
1973-74	945,776	527,313	418,463	53,816	48,530	5,286	277,033	157,842	119,191	33,816	27,365	6,451
1974-75	922,933	504,841	418,092	55,916	48,956	6,960	292,450	161,570	130,880	34,083	26,817	7,266
1975-76[5]	909,000	484,000	425,000	58,690	49,420	9,270	316,000	173,000	143,000	35,000	27,000	8,000
						Projected[6]						
1976-77	918,000	485,000	433,000	60,100	48,790	11,310	338,000	185,000	153,000	37,000	28,000	9,000
1977-78	969,000	507,000	462,000	63,480	49,880	13,600	356,000	194,000	162,000	37,000	28,000	9,000
1978-79	998,000	517,000	481,000	64,730	49,950	14,780	370,000	200,000	170,000	36,000	27,000	10,000
1979-80	1,005,000	520,000	485,000	65,400	49,750	15,650	382,000	205,000	177,000	36,000	26,000	10,000
1980-81	1,011,000	522,000	489,000	67,270	50,590	16,680	392,000	208,000	184,000	37,000	26,000	11,000
1981-82	1,022,000	527,000	495,000	68,700	51,220	17,480	402,000	212,000	190,000	39,000	27,000	12,000
1982-83	1,017,000	522,000	495,000	69,920	51,660	18,260	408,000	214,000	194,000	40,000	28,000	12,000
1983-84	1,005,000	514,000	491,000	70,840	51,860	18,980	412,000	214,000	198,000	41,000	28,000	13,000
1984-85	987,000	502,000	485,000	71,570	51,930	19,640	410,000	211,000	199,000	42,000	28,000	14,000
1985-86	953,000	480,000	473,000	71,980	51,720	20,260	405,000	207,000	198,000	42,000	28,000	14,000

[1] In the 1971 and prior editions of *Projections of Educational Statistics*, bachelor's degrees were not shown separately but were combined with first-professional degrees.

[2] The following specified degrees are reported as first-professional: Dentistry (D.D.S. or D.M.D.), law (LL.B or J.D.), medicine (M.D.), theology, veterinary medicine (D.V.M.), chiropody or podiatry (D.S.C. or D.P.), optometry (O.D.), and osteopathy (D.O.).

[3] Master's degrees differ from those published in the 1968 and prior editions of *Projections of Educational Statistics* because of adjustments to secure comparability with current reports of these degrees. For estimation details, see appendix A, "Estimation Methods," sec. 1. Master's degrees also differ from those published in the 1969 through 1971 editions because of discrepancies among the reported numbers of degrees.

[4] Doctor's degrees include the Ph.D. in any field as well as such degrees as doctor of education, doctor of juridical science, and doctor of public health (preceded by a professional degree in medicine or sanitary engineering). They exclude degrees defined as first-professional, such as doctor of veterinary medicine.

[5] Estimated.

[6] The estimation and projection of degrees by level and sex of student are based on the following assumptions:

(A) The estimates of bachelor's degrees by sex for 1975-76 and the projections of these degrees through 1985-86 assume that the percentage that degrees in these years are of first-time degree-credit enrollment 4 years earlier will follow the 1964-65 to 1974-75 trend through 1985-86; the projections for 1979-80 through 1985-86 are based on the projected first-time degree-credit enrollment figures in table 14.

(B) The estimates of total first-professional degrees for 1975-76 and the projections of these degrees through 1985-86 were obtained by summing the number of degrees in the individual field. (For methods of projecting first-professional degrees in individual fields, see footnotes to table 21.) The estimates of first-professional degrees by sex for 1974-75 and the projections of these degrees through 1985-86 assume that the percentage of degrees conferred on women in each field of study would follow the 1964-65 to 1978-79 trend through 1985-86. For 1975-76 through 1978-79, the estimate of the percentage of degrees conferred on women in each field was assumed to be the same as the percentage of women enrolled in the first year of first-professional programs in the same field either 3 or 4 years earlier. For law, theology, and "other" a 3-year time lag was used. For medicine, dentistry, and "other health profession," a 4-year time lag was used.

(C) The estimates of master's degrees by sex for 1975-76 and projections through 1985-86 assume that the percentage that master's degrees are of the average of first-year enrollment for advanced degrees 1 and 2 years earlier will follow the 1964-65 to 1974-75 trend through 1985-86. The estimates of first-year enrollment for advanced degrees by sex for 1975 and projections through 1985 assume that the 1974 percentage that first-year enrollment for advanced degrees was of graduate enrollment will remain constant through 1985-86 (49.4 percent for men and 52.8 percent for women).

(D) The estimates of doctor's degrees by sex for 1975-76 and projections through 1985-86 assume that the percentage that doctor's degrees are of the average of first-year enrollment for advanced degrees 7 and 8 years earlier will follow the 1964-65 to 1974-75 trend through 1985-86.

For further methodological details, see appendix A, table A-2.

NOTE.—Data include 50 States and the District of Columbia for all years. Because of rounding, details may not add to totals.

SOURCES: Degree and enrollment data and estimates are based on (a) U.S. Department of Health, Education, and Welfare, National Center for Education Statistics, publications: (a) *Earned Degrees Conferred by Institutions of Higher Education*, 1964-65 through 1974-75, (b) *Opening (Fall) Enrollment in Higher Education*, 1964 through 1968 and 1971 through 1974, (c) *Enrollment for Advanced Degrees*, fall 1961, 1962 and 1963, (d) *Enrollment for Master's and Higher Degrees, Fall 1964*, (e) *Enrollment for Master's and Higher Degrees, Fall 1965: Summary Report*, (f) *Students Enrolled for Advanced Degrees*, fall 1966 through 1974, (g) *Fall enrollment in Higher Education, Supplementary Information*, 1969 and 1970; and (2) American Bar Association publication; Millard H. Ruud, "That Burgeoning Law School Enrollment Slows," *American Bar Association Journal*, 59: 150-153, February 1973.

EMERGENCY SCHOOL AID ACT

Father GEORGE. Thank you. Dorice Smallwood is going to lead the next contingent.

Ms. SMALLWOOD. Mr. Chairman, I am very appreciative of being here, with Mr. Harry Robinson, who is the Vice President of the National Conference of Christians and Jews, and Ms. Stefanie Robinson, who is with the Montclair, N.J. Board of Education.

Present in the room, I might also add, and out in the halls, too, are community group representatives from 17 States across the Nation—including your State of Connecticut—and we are all here to speak as advocates concerning our particular priorities.

We would like to present for the record our testimony and also try to summarize just exactly what that testimony consists of, and why we are here.

Mr. Chairman, we are here to testify on the national organization program of the Emergency School Aid Act. We are here as representatives of the communities presently served by nonprofit organizations participating in this grant program, and all the communities who are seeking to address the challenges of school desegregation and educational inequity.

This year there are 176 ESAA nonprofit organizations in 41 of our States, which are working hard to make desegregation and integration a reality. These organizations have served hundreds and thousands of parents, students, school staff, and other members within the community. In my testimony I have attached pages 7 and 8 which identify geographically the location of these various 176 ESAA nonprofit grants.

NONPROFIT PROJECTS

Also you have before you the fiscal year 1981 budget request for $15 million for ESAA NPO's. We are mindful of the things that you said prior to our particular testimony of the fiscal realities which you face. Some would characterize them as financial crises. We urge you to consider, however, that the $15 million request already represents a reduction of more than 13 percent in the present level of service.

This reduction becomes even more impactful when it is compared to the level of needs. Nonprofit projects approved by the Office of Education for this year, but unfunded because of the lack of moneys or fiscal shortfall, totaled $11.4 million. Combined with the amount actually needed, $17.2 million, the needs represented by legitimate OE-approved NPO applications totaled $28.5 million for fiscal year 1979.

Even assuming that the level of need will not grow as it relates to desegregation, which assumption is contrary to the recent reports on the current and future status of desegregation, the fiscal year 1981 request of $15 million is little more than half of the fiscal year 1979 needs.

Congress recognized the vital, often unique role, that community organizations play in achieving desegregation that works when it made provisions to fund organizations under the Emergency School Assistance Act program back in 1971.

Last month it was Senator Schweiker who recognized their value by introducing a bill on community organizations to run alternative education programs, calling them the best vehicle. This vehicle must not be lost in the desegregation effort.

FISCAL YEAR 1980 FUNDING CUT

Although we are aware of the present charge to address the fiscal year 1981 budget, we would be remiss in our responsibility as support-

ers of the equal educational opportunity if we did not now raise the issue of fiscal year 1980 funding levels.

Despite the President's fiscal year 1980 budget request of $15 million for nonprofit organizations, their budget was slashed by two-thirds to $5 million. Please bear in mind, this represents a dramatic departure from the present and projected funding levels: $17.2 million for fiscal year 1979, $5 million for fiscal year 1980, and $15 million for fiscal year 1981. In terms of lack of continuity and a break in momentum, the effect will be devastating.

A number of us across this Nation, including those here in attendance today, representing 176 organizations that are presently funded, have been working for months to determine why such a drastic cut was made. From what we can determine, the central factor in that cut was an evaluation study done by the Rand Corp., an evaluation which was condensed, synthesized, and interpreted in such a way as to be damning of ESAA-funded NPO efforts.

RAND STUDY OF ESAA-FUNDED NPO'S

We have done extensive investigations to determine the essence of the Rand findings and recommendations, and as succinctly as possible, this is what we have found:

In its original consideration of provisions for funding of nonprofit organizations, Congress envisioned two roles of these organizations: One, to serve as facilitators of the desegregation process; and two, to be supporters of the implementation of a desegregation plan. However, the initial law and the regulations written to implement the law, and all subsequent guidelines and regulations, address only the supporting function, and not the advocacy facilitating role. This was deemphasized in the regulation.

A 1978 report by Rand Corp., however, evaluated nonprofit organizations in both roles, and concluded, not surprisingly, that ESAA-funded NPO's are less effective in the facilitating advocacy role than non-ESAA-funded NPO's.

However, rather than recommending a decrease in ESAA NPO funding, the Rand Corp. advised a change in Office of Education policy to make NPOs less subject to school district approval and dominance. Questioned by OE, a member of the evaluation team at Rand stated that, if anything, ESAA funding for nonprofits should be increased.

Senator WEICKER. Let me just say this, I've got to leave here in 3 minutes, and I wonder if I might not just hear from the Robinsons before I leave the chamber. I don't like to deprive anybody—and you may continue with your statement but I've got others waiting for me. So if we can hold on your statement for a minute and let me just hear from both of them, I gather you are all speaking for the same subject, at least I will give them my courtesy of being here.

NPO-SCHOOL BOARD INTERACTION

Ms. ROBINSON. Thank you, Senator. I am here from a local school district, and my point here is to reinforce the efficacy of the NPO's relationship with the school board. As Montclair, like many communities

across the country, was torn apart by conflict over desegregation, the NPO group applied for ESAA funds, developed some projects, worked with the community and the students. This group worked in an advocacy role and in a mediating role with dissenting groups in the community. They weren't a rubber stamp for the board of education. They played the devil's advocate at appropriate points, but they helped to maintain open lines of communication between groups that would not and could not have been able to talk around such a conflicted and emotional situation as desegregation.

The NPO helped us successfully integrate in Montclair. I don't represent a large district, and I don't represent a lot of districts and a lot of figures, but I represent a situation that was very, very real, and I was a part of it. I just wanted you to hear that.

Senator WEICKER. Thank you.

NPO'S AND DESEGREGATION

Mr. ROBINSON. Thank you, Senator Weicker. The National Conference of Christians and Jews, a nonprofit organization having been involved in the desegregation process for any number of years, is concerned that other NPO's might be cut off and that the process of desegregation may be retarded.

We recognize the fiscal factors that are a way of life, but we don't want that to be a reason to retard this desegregation process. I will very quickly just point out to you, for example, that in the entire busing situation that arose from the Charlotte/Mecklenburg decision, we now have in Charlotte, N.C., an ESAA-funded program that has over the past 5 years reached 200,000 students, teachers, and parents. We have taught the students to run their own human relations programs. They now do that within the 21 high schools and junior highs, and there are 74,000 students who have been involved in the program alone.

According to our director in North Carolina, she says that is the only program doing any human relations training—any interaction among the students—in the entire area. But for that NPO and the National Conference of Christians and Jews, there would be no efforts made to do anything in the area of interracial and interethnic organizations.

I think we as a major national organization, if you would use our situation and project it across the country, you'd have to also be cognizant of the smaller organizations. We are all united and commited in trying to maintain the desegregation effort because we do not want a deterioration of race relations, and the quality of life would be significantly retarded. We have always been told that education is the step up to improve the quality of life, and not only for black and poor people, but for all Americans. We are certainly cognizant of that, and we are pushing for it. We appreciate you taking the time, and we won't delay you. Thank you very much.

Senator WEICKER. Thank you. I appreciate it.

Go right ahead.

Ms. SMALLWOOD. At this particular point I will go ahead and ask that Congress reexamine its decisions as it related to the fiscal year 1980 budget appropriation of $5 million for nonprofit organizations. Also I hope that you will consider our testimony as it relates to the fiscal year 1981 appropriations.

Community involvement and community support of the school desegregation process is threatened by these projected cutbacks. These cutbacks, we feel, are likely to erode the gains that have been made thus far in school desegregation.

We also feel that it could pay very dangerous dividends in terms of increased racial isolation, educational inequity, and community tension forcing history perhaps to repeat itself.

[The statement follows:]

STATEMENT OF DORICE SMALLWOOD, E.R.E.A. NONPROFIT ORGANIZATION

Mr. Chairman and members of this distinguished committee, I am most appreciative of the opportunity to appear before you to present testimony on the Nonprofit Organization Program of the Emergency School Aid Act (Title VI of P. L. 95-561).

I speak today on behalf of those communities presently served by nonprofit organizations participating in this grant program, and all other communities which are seeking to address the challenges of school segregation and educational inequity.

This school year there are 176 ESAA-funded community groups in 41 of our states which are working hard to make desegregation and integration a reality. These organizations have served hundreds of thousands of parents, students, school staff and other members of the community. In Charlotte-Mecklenberg, N.C., for example, a district well-known for landmark school desegregation litigation, the ESAA-funded nonprofit organization reached over 74,000 in the last year.

ESAA NPO funding, this year totalling 17.2 million dollars, often is the catalyst of thousands of additional man hours and other in-kind resources. In Chatham County, Georgia, for example, an ESAA NPO generated over 4400 hours of volunteer service from the community to its schools, which also bolstered community confidence in the desegregated, quality education offered by its schools and helped stem white flight. Thus a small investment in many communities has a ripple effect with great yield.

You have before you a FY'81 budget request of 15 million dollars for ESAA NPO's. We are mindful of the fiscal realities which you face--some would characterize them as fiscal crises. We urge you to consider, however, that the 15 million dollar request already represents a reduction of more than 13% in the present level of service.

This reduction becomes even more impactful when it is compared to needs. NPO projects approved by the Office of Education for this year but unfunded because of lack of monies totalled 11.4

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million. Combined with the amount actually funded, 17.2 million, the needs represented by legitimate, OE approved NPO applications totalled 28.5 million dollars. Even assuming the level of need will not grow, which assumption is contrary to recent reports on the current and future status of desegregation, the FY '81 request of 15 million is little more than half the FY'79 needs!

Congress recognized the vital, oftimes unique role that community organizations play in achieving desegregation that works, when it made provisions to fund such organizations under the Emergency School Assistance Program in 1971. That unique NPO role and their potential for success had to do with their flexibility, credibility, responsiveness, resourcefulness, and autonomy. Those characteristics are just as important, if not more so, today. Last month Senator Schweiker recognized their value by introducing a bill to fund community organizations to run alternative educational programs, calling them "the best vehicle". This vehicle must not be lost in the desegregation effort. We urge your support of the FY'81 budget for NPO's.

Although we are aware of your present charge to address the FY'81 budget, we would be remiss in our responsibility as supporters of equal educational opportunity if we did not now raise the issue of FY '80 funding levels. For these constitute a very real and immediate crisis in the momentum of school desegregation in this country.

Despite the President's 1980 budget request of 15 million for NPO's, their budget was slashed by 2/3's to 5 million. Please bear in mind, this represents a dramatic departure from present and projected funding levels: 17.2 million for FY'79, 5 million for FY'80, and 15 million for FY'81. The effect in terms of lack of continuity, of a break in momentum, will be devastating.

A number of us across the nation have been working for months to determine why such a drastic cut was made. From what

we can determine, the central factor in that cut was an evaluation study done by the Rand Corporation, an evaluation which was condensed, synthesized and interpreted in such a way as to be damning of ESAA-funded NPO efforts.

We have done extensive investigation to determine the essence of Rand's findings and recommendations, and, as succinctly as possible, this is what we have found:

1. In its original consideration of provisions for the funding of nonprofit organizations, Congress envisioned two roles for these organizations---to facilitate the desegregation process and to support the implementation of a plan. However, the inital law and the regulations written to implement the law---and all subsequent guidelines---have addressed only the supporting function, and denied the initiating or facilitating role.

2. A 1978 report of the Rand Corporation, however, evaluated nonprofit organizations in both roles and concluded, not surprisingly, that ESAA-funded NPO's are less effective in the facilitating, advocacy role than non-ESAA-funded NPO's. However, rather than recommending a decrease in ESAA NPO funding, the Rand Corporation advised a change in Office of Education policy to make NPO's less subject to school district approval and dominance. Questioned by OE , a member of the evaluation team at Rand stated that if anything, ESAA funding for nonprofits should be increased.

3. The original Rand report, in four volumes, was distilled into a six page memo by the Office of Education, on which basis the decision to cut NPO funding appears to have been made. As might be expected in such a drastic condensation, much of the thrust of Rand's evaluation was lost. In addition, the presentation of the summary left the impression that the Rand evaluation had been generally negative of ESAA NPO's, which it was not.

4. According to the OE executive summary, the purpose of the Rand study was to assess the effectiveness of ESAA-funded nonprofits versus non-ESAA-funded NPO's. If that were so, a negative evaluation might imply the need to reduce ESAA funding for NPO's. However, in a letter from Rand dated August, 1977, the stated purpose of the study was to discover the most effective means to fund community organizations involved in the desegregation process, so as to assist the administration and Congress in formulating sound desegregation policies, including those governing non-profits. Clearly the implications of a negative evaluation in this context would be a change in policy, not a decrease in funding.

We submit to you that the Rand report and companion summaries and correspondence should be carefully re-examined. This would

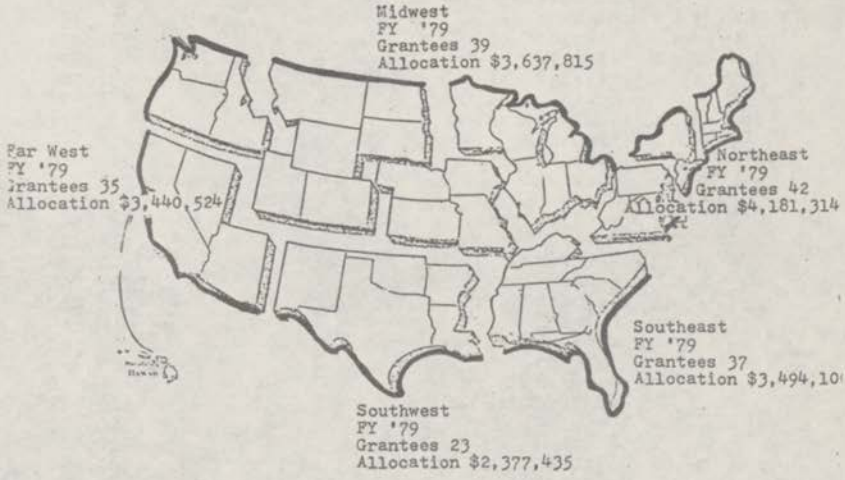
serve two purposes. One is to rightfully restore the monies cut from the ESAA NPO budget based upon misunderstanding and misperceptions surrounding this report. The second purpose is that for which Congress commissioned the study, that is, to provide direction in policy changes to improve and increase desegregation efforts of NPO's. Such a re-examination would be most appropriate at this time, in that new regulations governing ESAA-funded nonprofits will soon be released, and should reflect both legislative intent and recommendations based on pertinent research data. We would be happy to assist in any efforts to these ends.

Finally, we sincerely hope and trust that you better understand the spirit in which we seek budget considerations which will ensure that desegregation efforts move forward and that resegregation be stopped.

AN OVERVIEW OF THE GEOGRAPHIC DISTRIBUTION

OF ESAA NON-PROFIT GRANTEES

ON A REGIONAL BASIS



Total Number of ESAA Non-Profit Projects 176

Total FY '79 Obligated Funds $17,165,456

Total FY '79 Unmet Needs $11,408,166 (eligible, justifiable, desegregation related needs-yet unfunded because of lack of supplemental funds)

Total FY '80 Appropriation $5,000,000

Total Need for N.P.O. Supplemental $28,573,622

The ESAA FY '80 $5 million appropriation, as proposed by the Department of Education will be distributed on a national competitive basis and not on the precedented state allocation formula. The dramatic discrepancy between what is needed and what has been appropriated will critically impact desegregation efforts in all regions. The attached chart identifies participating grantees and appropriations by states for Funding Year '79-'80.

NON-PROFIT ORGANIZATIONS TO BE IMPACTED BY THE FY '80 SHORTFALL
(Geographic Distribution of FY '79
ESAA N.P.O. Grantees on a
State Apportionment Basis)

Region	State	Number of Grantees	Total State Apportionment
SOUTHWEST	Texas	17	$ 1,753,732
	Louisiana	6	623,703
SOUTHEAST	Alabama	6	512,546
	Florida	7	721,572
	Georgia	8	653,270
	Mississippi	5	491,701
	North Carolina	4	648,973
	South Carolina	5	466,038
NORTHEAST	Virginia	5	469,780
	West Virginia	0	0
	Maryland	4	392,698
	Delaware	2	52,111
	Pensylvania	6	533,505
	New Jersey	4	544,291
	New York	14	1,692,754
	Connecticut	4	145,092
	Massachusetts	2	136,862
	Maine	0	0
	Rhode Island	0	0
	Vermont	0	0
	New Hampshire	0	0
	District of Columbia	1	214,221
MIDWEST	Ohio	4	550,283
	Indiana	3	232,906
	Michigan	3	581,796
	Minnesota	1	50,786
	Wisconsin	1	113,837
	Illinois	9	944,841
	Iowa	1	32,424
	Kansas	1	34,298
	Nebraska	0	0
	North Dakota	1	19,083
	South Dakota	0	0
	Missouri	3	270,967
	Arkansas	2	208,761
	Oklahoma	4	165,698
	Tennessee	4	341,170
	Kentucky	2	125,263
FAR WEST	California	13	2,279,777
	Arizona	3	257,583
	New Mexico	4	253,630
	Colorado	4	180,756
	Utah	1	41,547
	Nevada	0	0
	Montana	1	29,037
	Wyoming	1	17,867
	Idaho	0	0
	Oregon	1	45,509
	Washington	3	112,865
	Alaska	0	0
	Hawaii	4	221,953

STATEMENT OF BEVERLY LONG, NATIONAL MENTAL HEALTH ASSOCIATION

My name is Beverly Benson Long. My permanent home is Atlanta, Georgia, but I am spending this year in Washington, D.C. while serving as President of the National Mental Health Association.

For a number of years I have been active in numerous mental health activities. Most recently, 1977-1978, I served as a member of the President's Commission on Mental Health. From 1975-1979, I was Chair of the Georgia Governor's Advisory Council on Mental Health, Mental Retardation and Substance Abuse. I have been President of the MHA in Georgia as well as the Metro Atlanta Chapter. In addition, I have been involved on several boards and councils responsible for health and human services planning.

My varied experiences in Georgia and responsibilities at the National level have given me a broad exposure to problems of mental health and illness in this country. I have learned how our government can help reduce the public cost of mental illness.

I am pleased to have the opportunity to share some of my concerns as I present the MHA's recommendations for federal support of mental health programs in FY 1981. In a time of double-digit inflation and the call by many to limit expenditures, I hope I can make a persuasive case that an increased investment of tax dollars in mental health programs is sound fiscal policy.

The fact is, the government is already spending vast amounts of money -- $79 billion in 1978 on health (re: HCFA), and utilizes no process for allocating the money in relation to the disability caused. If we look at the costs of mental illness, it is clear that the allocation of resources to attaining and maintaining mental health is totally disproportionate. Major adjustments are urgently needed.

How much does mental illness cost?

Much of the cost of mental/emotional disability is hidden in general health care costs. We do know, however, that in 1977, 11% of the direct cost of all health care - or $17 billion was identified as costs for the mentally disabled (re: PCMH).

To this we must add:

a) the 54% of treatment for identified mental disability

provided by primary care physicians (HEW NEWS, May 15, 1979) and not included in the figure above ...

b) the costs of psychosomatic disabilities misdiagnosed or mislabeled as physical illness and treated outside the mental health specialties,

c) the costs of physical disabilities like hypertension, ulcers, and a host of others thought to have stress-related causative factors,

d) the costs of prescribed drugs, about 62% of which are for alleviation of emotional symptoms.

There is little doubt to me that -- if we could find a way to total all the costs of emotional and mental disturbance -- at least half of what is spent on health is a result of mental and emotional illness. In 1978, this country spent $192.4 billion (Health Care Financing Administration) on health, likely $96.2 billion as a results of mental and emotional illness.

We can lay aside every humane aspect of the need to help our mentally and emotionally handicapped people -- we can forget our responsibilities to those who don't speak for themselves and still the urgency of allocating resources to reduce and alleviate mental health problems remain glaringly evident. At least one-third of the hospital beds in the U.S. are occupied by those diagnosed as mentally ill. The cost in non-productivity alone demands immediate attention.

It is time that resources are allocated on the basis of fact and reason, not on long outmoded traditions, and not only on the demands of the strong.

Is mental health currently considered an important part of overall health, and allocated resources commensurate with the problem? I think the facts speak for themselves.

1) Less than 6% of the federal health dollars are allocated to the Alcohol, Drug Abuse & Mental Health Administration to reduce problems of mental health, alcohol and drug dependency.

2) While HEW's 1980 health research budget was $3.4 billion, mental health research in the NIMH budget was only 4.3% of that total. Adding drug and alcohol research, it comes to 6.3%.

Again, it seems evident to me that federal health resources must be allocated on a more rational basis if we are to impact the problems involved, including the skyrocketing costs of health care and the non-productivity resulting from disability. And as I've demonstrated above, mental health research, services and training programs clearly warrant a larger share of the federal health investment.

I'd like to submit for the record, a detailed description of the recommendations of the Coalition for Health Funding which incorporates our Association's concerns for federal funding of mental health programs in FY 1981. I will only highlight a few of them here.

1) A continued investment in mental health services.

The MHA has and will continue to pursue passage of a Mental Health Systems Act.

This legislation will help insure that an appropriate array of coordinated community mental health services are available to all who need them. In addition, it encourages partnerships in the delivery of services among all levels of government and between the public and private sectors.

While we are hopeful for passage of a Systems Act this year, it is no certainty. We urge an extension of the Community Mental Health Centers legislation, with funding at least at the level of FY 80, until a Mental Health Systems Act is operational.

2) An increased investment in mental health research and research training.

The President has recommended $163 million for research. We suggest $135 million which will simply restore the mental health research budget to about 88% of its purchasing power in 1969. This will support 1,747 grants including 1,004 new and competing awards. Again, let me remind you that NIMH's investment in mental health research is less than 5% of the total health research budget of HEW.

Priority areas include inter-disciplinary research into the causes, prevention, and treatment of mental illness, as well as the acquisition of mental health. Areas of effort would include research on bio-chemical, lifestyle, environmental, and service delivery aspects of the problem.

In research training, the President recommends $18.7 million, no increase over FY 80. We suggest $31 million to assure a stable core of trained individuals to carry knowledge gains forward to the future.

3] Support for prevention programs.

We suggest $10,000,000 on the FY 81 budgets to support NIMH's Office of Prevention and fund through grants and contracts worthy prevention programs across the country.

In the past, we have given far too little attention to preventing disability, yet there is a large and rapidly growing data base on which to begin substantive prevention programs.

4) Increased services for the chronically mentally ill through:

a) the Community Support Program ($28,500,000) for long-term mentally ill adults and,

b) the Most in Need Program ($10,000,000) for severely disturbed children and youth.

Both programs award the bulk of funds to states and territories as grants, contracts, and in cooperative agreement to provide services to individuals at high risk of institutionalization.

5) Adequate funding for mental health planning.

Unless Congress awards a supplemental appropriation for section 314g of the Public Health Service Act, state mental health authorities will receive little or no money to carry out increased responsibilities for mental health planning. We urge a supplemental award of $13,200,000 in FY 80 and an appropriation of $25,000,800 in FY 81.

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I realize even the highlights of our recommendations represent a laundry list of requests. And at a time when you are reviewing many laundry lists and many pleas to limit federal spending. But I would be remiss not to urge that federal health dollars -- tax dollars -- be allocated more in keeping with the health problems that cause disability and non-productivity. We simply must allocate resources to mental health that are commensurate with the depth and scope of the problem.

I remind you that there are persuasive arguments that at least half of our nation's $192.4 billion health bill was spent as the result of mental

and emotional illness. Yet only a fraction of the federal government's investment in health is for mental health.

I know you will give our recommendations careful consideration as you decide spending priorities in health in FY 1981. I challenge you to think about ways to effect: a) an allocation of dollars to mental health proportionate to the scope of the problem, and b) more attention within mental health to preventing disability and promoting mental health.

Thank you.

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION -
NATIONAL INSTITUTE OF MENTAL HEALTH - Research (Sec. 301 of PHS Act;§ Sec.213(d) of CMHC Act)

Appropriation
FY1979 $130,807,000
FY1980 $145,250,000

Authorization
FY1981 Open

President's Request
FY1931 $162,964,000

Coalition Recommendation
FY1981 $185,000,000

CHF Increase Over
President's Request
$22,036,000

Appropriations over the last few years have begun to restore the research capacity of the National Institute of Mental Health--seriously eroded between 1966-76 by level budgets and inflation. The appropriation for FY1980 restores the research budget to only 80% of its purchasing power in 1969. As stated on p. 158 of the ADAMHA 5-year plan "current" funding levels fail to reflect adequately the human and economic tolls of mental illness. "The research budget of the NIMH--the primary federal source for research support for mental illness--is only 4% of DHEW's annual $3.4 billion health research expenditures."

The Coalition recommendations for FY81 build on the increases adopted by the Congress and those recommended by the Administration for FY80 and adjusts for cost escalations in the intramural program (i.e., pass-through of energy and other maintenance costs). In addition, the Coalition believes that additional objectives must be achieved to insure that there are the needed advances made in certain areas, and therefore recommends a higher budget than the one proposed for 1981 by the President.

The following objectives should be achieved with the additional funds recommended by the Coalition over the Administration's research budget request: 1) improvement in the quality of grant and contract monitoring through the provision of additional staff; 2) refinement of existing preliminary findings in the area of schizophrenia, to determine the relative contributions of genetic and environmental factors to this disorders; 3) expansion of investigations of the possibility of biochemical abnormalities in the actions of neuro-transmitters and hormones and expansion of investigations of the possibility of hereditary vulnerability to depression including additional studies of depression among women; 4) additional programs proposed deal with the neuro-behavioral aspects of the major mental illness and dysfunctions, including depression, schizophrenia, and hyperkinesis; 5) expansion of existing research on behavioral health, to include studies of psychosomatic problems; 6) increased studies of the effectiveness of biofeedback in clinical disorders and additional basic research relating to the structure of neuro-transmitters, and the role of neurophysiological functions in mental disorders; and 7) expansion of studies of impact of economic change on mental health development; seeking methodologies to better understand and deal with racist behavior; funding of new studies in the area of domestic violence; and continued work related to identification of factors which cause sexual assault. New projects should address such areas as the effects of institutionalization or death of a spouse upon the elderly; and the impact upon both adults and children of events such as separation, divorce, death, or major illness of a family member.

With increased funding for intramural research over the Administration's request, NIMH would be able to study brain structure and function, involving more precise definition of areas of the brain involved in normal functioning; pursue research in neuro-endocrinology, involving studies of endocrine imbalance on the cyclical alternation of mania and depression, as well as the interactions of naturally occurring hormones with psychoactive drugs.

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION -
NATIONAL INSTITUTE OF MENTAL HEALTH - Training (Sec. 303 & 472 of the PHS Act)

Appropriation
FY1979 $90,400,000
FY1980 $90,354,000

Authorization
FY1981 Open

President's Request
FY1981 $90,354,000

Coalition Recommendation
FY1981 $129,500,000

CHF Increase Over
President's Request
$39,146,000

The 1979 Report of the HEW Task Force on Implementation of the Report to the President from the President's Commission on Mental Health (PCMH) echoed many of the concerns originally discussed by the President's Commission. It recognized that "the quality of mental health care depends ultimately on the knowledge, skills and sensitivity of those persons providing it" and stresses the necessity of assuring that personnel are available to meet the diverse mental health needs of all segments of the population. The Task Force noted that over the past twenty years the demand for and utilization of mental health services has grown rapidly but that even though the number of mental health professionals have grown similarly, there are many people who remain unserved and underserved. In addition significant increases in research training support are urgently needed.

RESEARCH TRAINING

There is a need for significant increases in training support for clinical researchers in the mental health field request. The Coalition recommends that $31 million be appropriated for FY81 in order to: 1) bring mental health research on par with other health research; 2) attract minority undergraduates to science careers in mental health; and 3) develop clinical investigators, especially in areas of childhood, adolescence, and aging, and 4) training of individuals in research management. This Coalition request recognizes that no increases were made in the level of funding received in FY80 over the FY79 base. In addition, greater funding is further justified for FY81 because there is an increased post doctoral emphasis. The OMB-approved 15% stipend increase ($3 million) has had a significant impact on funding increase needs for clinical research training.

CLINICAL TRAINING

The NIMH manpower system provides the mechanism for meeting the needs of the 20-32 million Americans the PCMH identified as in need of these services. The programs provide support for the four core disciplines (psychiatry, clinical psychology, psychiatric social work and psychiatric nursing), as well as paraprofessionals and researchers. The manpower system must develop strategies to offset the loss of FMGs who primarily serve in our state and county mental hospitals. Moreover, the system trains the primary care physician and general medical students, not only to recognize and refer mental health problems for appropriate treatment, but also to detect, diagnose and manage these problems in the general health care setting. This linkage was highlighted in the report of the President's Commission on Mental Health, and the Task Force implementation proposal.

We agree with the Task Force and the PCMH that the three major objectives of a new Federal mental health manpower policy should be to: 1) encourage mental health specialists to work in areas and settings where severe shortages exist; 2) increase the number of qualified minority personnel in the mental health professions, and the number of mental health personnel trained to deal with the special problems of children, adolescents, minorities and the elderly; and 3) assure that the skills and knowledge of mental health personnel are appropriate to the needs of those they serve.

Since 1970, NIMH funds for the support of clinical manpower have fallen by 29 percent (from $96.2 million to $68.3 million), and the real dollar value (adjusted for inflation) has fallen by 62 percent, to $36.1 million. While funds have shrunk, the scope of NIMH manpower programs has grown to include training of paraprofessionals, work with the States to develop comprehensive manpower planning and development systems, increased mental health training for primary health care givers, and a new focus on research in the manpower area. Since funds for new programs have been taken from existing programs, many of these new priorities are underfunded, as are the more traditional training programs.

Recently the manpower development programs of NIMH received intensive study by the ADAMHA Manpower Policy Analysis Task Force as well as by the PCMH. Similar conclusions were reached by the two groups; additional funds are necessary to implement their recommendations. For FY81, we fully endorse the proposal of the Task Force on Implementation of the report of the President's Commission on Mental Health: that the HEW Secretary increase the funding for NIMH service manpower development and training programs to $85 million in FY80, with annual adjustments for inflation in subsequent years. In addition, adequate funds should be provided for ongoing program support. For FY81, we recommend $98.5 million for clinical manpower training, in keeping with the Task Force proposal to adjust for inflation. This recommendation takes into account a two-year inflation factor and a 15 percent stipend increase ($5 million) approved by OMB and issued by the Department. All additional funds will be allocated according to priority area (child, elderly, minority, linkages with health care, manpower for underserved areas and understaffed facilities, prevention crime and delinquency, systems development, and research and development) as well as by the program branch. Accounting systems will be developed to measure the investment of the total NIMH training budget in these areas, and this will facilitate better program planning, development and evaluation.

Moreover, without any increase over the FY80 appropriation, 922 fewer students will be trained in 1981 than in 1980. The additional objectives which can be met with increased funds are: 1) additional program support funds will provide resources necessary for adequate consultation, site visits and program monitoring; 2) additional funds will enable the Institute to move more rapidly with the training redirection, and thereby have more impact upon underserved population groups; and 3) the number of students trained in 1981 (5,100) will equal the number that could have been trained had the $85 million recommended by PCMH been made available at FY79 stipend and cost-of-living levels. Redirection of training at the higher dollar level will gain credibility for PCMH and Task Force recommendations through support of new projects, chiefly in the areas of minority training, inte-

gration with the general health field, work with children and youth, staffing public facilities, and state manpower development.

Further, the FY80 level for clinical manpower training provides the psychiatric division with only 25% of the funds needed for FY80. It worsens for FY81. Many of the primary care-related programs which were approved but unfunded in FY78 and FY79 will continue unfunded. Social aspects of rehabilitative medicine, impact of chronic illness on children and their families (both needs recognized in P.L. 95-602), primary prevention and intervention and issues of growth and development in pediatrics, and other psycho-socio-behavioral interfaces in the process of medical care will not be taught to those who will be delivering direct services to the nation's citizens.

The FY80 Senate Appropriations Committee report noted that it "continues to be concerned about shortages of trained psychiatrists, psychologists, psychiatric social workers and psychiatric nurses." The shortfall in personnel across the four core disciplines is most severe for psychiatry because of a rising utilization rate and a decline in the supply of both United States and foreign medical graduates in the field of psychiatry.

If the nation is to maintain the same ratio of professionals to clients/patients as existed in 1975, (not even 1970), NIMH indicates this will--in 1980--require an additional 10,100 psychiatrists, 6,600 psychologists, 4,400 psychiatric social workers, and 3,400 psychiatric nurses. The demand is caused primarily by a rising utilization rate. The shortfall for psychiatrists is because of declines in the supply of U.S. and foreign medical graduates and the increased need for psychiatrists to work with primary care providers and in additional setting and areas. Over 3,200 vacancies in understaffed public facilities have been identified in a recent survey. At the same time because of the shortage of new psychiatrists, NIMH must support projects which will make specialization in psychiatry a more attractive career chioce for American medical graduates, as well as projects designed to give greater mental health skills and knowledge to primary care physicians so that they can better handle some of the demand for psychiatric services.

The American Psychological Association reports 1) that there is a current shortage of at least 2,000 psychologists to serve the mental health needs of the elderly and that another 3,000 to 5,000 will have to be trained over the next decade, 2) that there is a current shortage of 5,000 fully trained child psychologists and that another 5,000 such psychologists should be trained over the next decade and 3) that there is a current shortage of at least 3,600 ethnic minority doctoral level providers of psychological services to achieve parity with minority representatives in the general population. We believe that the funding level of $98.5 million for clinical manpower training is the minimum necessary to reduce these shortages and that the FY81 budget request totally disregards the charge to address the shortage problem adequately by not requesting funding commensurate with documented need.

The Task Force on Personnel of the President's Commission on Mental Health recommended that the federal government maintain the present level of the number of mental health professionals in proportion to the population by increasing the funding of training programs to the 1970 level (adjusted for inflation), and recommended that priorities include rectifying maldistribution, increasing the number of mental health professionals with special competence in the care of children, the elderly and minorities, increasing the numbers of minority professionals, and training primary care physicians in the area of mental health and psychiatric skills.

In addition, the Coalition believes the President's budget does not devote sufficient attention to the pressing needs of our nation's minorities. Members of minority populations continue to have problems in the alcohol, drug abuse, and mental health areas far in excess of their proportionate numbers. The Committee was especially concerned that inadequate attention has been given to increasing the number of relevant health care professionals of minority background. Again, the increases can ameliorate these problems by funding programs already formulated and approved but unfunded or underfunded.

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION -
NATIONAL INSTITUTE OF MENTAL HEALTH

I. Community Programs

A. Linkage of Community Mental Health Centers to Community Health Centers
(330 PHS Act)

Appropriation	
FY1979	$0
FY1980	$0

Linkage program was developed to respond to the need to have individuals with mental health training placed in Community Health Centers. NIMH

Authorization
FY1981 $463,000,000

President's Request
FY1981 $10,600,000

Coalition Recommendation
FY1981 $11,500,000

CHF Increase Over
President's Request
$900,000

and the Bureau of Community Health Services have made some internal resource allocations to fund this program in FY1979 and FY1980.

Coalition recommendation of $11,500,000 will fund 232 linkage grants providing mental health personnel in Community Health Centers around the country. Research has demonstrated that mental health problems often accompany or even underly physical symptoms. Providing Community Health Centers with individuals trained to recognize and treat mental illness helps provide the most appropriate and cost-effective care for presenting problems.

B. Community Mental Health Centers
(PHS Act - 202(d), 203(d)(1), (2), 203(e)(3), 204(c), 213)

Appropriation
FY1979 $306,800,000
FY1980 $295,200,000

Authorization
FY1981 Continuations open; other programs $87,000,000

President's Request
FY1981 $277,600,000

Coalition Recommendation
FY1981 $347,900,000

CHF Increase Over
President's Request
$70,300,000

The Community Mental Health Centers Program is designed to make community-based treatment of mental and emotional illness available to the entire country. Currently 50% of the population has access to CMHC services through the Centers initiated under CMHC Act (P.L. 94-63) and its amendments (P.L. 95-83 and 95-622). Over 700 federally funded CMHC programs bring services within reach of nearly 100 million people and treat over 2 million individuals each year. CMHCs offer a complete range of services including prevention and early intervention, halfway house services, screening, inpatient, and follow-up care. Specialized services for children, the elderly and alcohol and drug abusers are also offered.

Several grant programs are offered through the Federal CMHC effort:

1) New and continued operations grants (including old staffing and child mental health grants) - Declining 8-year grant to help communities provide comprehensive mental health services to all in need in a defined geographic area.

2) Consultation and education grants - Available to Centers completing 8 years of operational support. C&E funds provide preventive and early intervention services to public agencies e.g., schools, police, minimizing the need for more costly and intensive clinical care.

3) Planning grants - 1-year grant enabling communities to determine unmet mental health needs, set priorities, and design appropriate services to meet needs.

4) Conversion grants - Centers having met minimum federal requirements to provide a basic core of community mental health services may apply for a conversion grant to offer more comprehensive services needed in the community.

5) Distress grants - At the end of the 8-year federal operations grant, some CMHCs are still unable to achieve total self-sufficiency. Those which fail can apply for a financial distress grant to maintain services while seeking alternative sources of funds.

Currently there is a large backlog of applications for all grant categories in the CMHC Program. By the end of FY1980, it is anticipated that a total of 142 approved applications in the amount of $51,480,000 will be unfunded. This total does not include new applications that will be approved in FY1981.

	No.	Estimated Amount
Planning	19	$ 1,059,000
Initial Operations	13	13,672,000
Consultation & Education	62	7,667,000
Conversion	5	1,364,000
Financial Distress	43	13,863,000

Federal participation in the CMHC program continues to encourage state and localities to match and even expand the federal initiative. In a large cohort sample of federally funded CMHCs, it was apparent that the federal share of support for Centers has declined from 38% in 1971 to 29% in 1975. State and local dollars continue to provide the largest share of support--35% and revenues from direct services have increased from 23% in 1971 to 32% in 1975. Centers are still not eligible for medicare reimbursement.

For FY1981, the Coalition recommends the following appropriations for the Community Mental Health Centers Program, totalling $337,562,000.

CMHC Grants	Amount
1. Operations	
Continuations including converted staffing	$258,900,000 or SSAN
New (initial operations)	42,000,000
Old staffing	11,336,000
Contin. Old Child Mental Health	13,133,000
2. Consultation and Education ($9,276,000 continuations and $9,724,000 new)	19,000,000
3. Planning (new only)	1,000,000
4. Conversion (new only)	2,000,000
5. Financial Distress	25,000,000

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION - NATIONAL INSTITUTE OF MENTAL HEALTH

II. State Programs

A. The Community Support Program - Chronically Mentally Ill
(PHS Act 301, 303, 340, 340A)

Appropriation
FY1979 $7,600,000
FY1980 $7,600,000

Authorization
FY1981 OPEN

President's Request
FY1981 $33,400,000

Coalition Recommendation
FY1981 $28,500,000

CHF Increase Over President's Request
under by $4,900,000

The Community Support Program (CSP) is a services development program to assist states and localities in planning, developing, and implementing deinstitutionalization programs for the mentally ill. This program followed the Hospitalization Improvement Program (HIP) and Hospital Staff Development Program (HSD) dealing with problems of hospitalized patients returning to the community.

Awards are made for funding of state strategy development projects to help states plan a coordinated effort using available resources, and of state and local demonstration projects to help develop model programs which might be implemented elsewhere.

The closing of state mental hospitals and units in a number of states has, in some cases, led to the neglect and abuse of discharged patients in the community. Where careful planning does not precede the deinstitutionalization of large numbers of individuals, neither the community nor the patients benefit. Increased federal support of the CSP Program is needed to continue efforts to address the complex interagency and intergovernmental nature of problems of the long-term mentally disabled in the community.

Due to level budgets over the last few years, no new projects have been funded since FY1977. 7 to 10 states are waiting to begin needed CSP projects, in addition to the 19 states with funded programs to date.

The Coalition recommends the CSP Program be funded at $28,500,000 in FY1981 ($15,000,000 for continuations and $13,500,000 for new projects).

Contact: Lynn Robinson, National Mental Health Association, (703) 528-6405

B. Children and Youth - The Most in Need Program (MIN)
(PHS Act 301)

Appropriation
FY1979 $0
FY1980 $0

Authorization
FY1981 Open

President's Request
FY1981 $6,700,000

Coalition Recommendation
FY1981 $10,000,000

CHF Increase Over President's Request

This program seeks to coordinate and improve the quality and availability of existing human services for severely disturbed children and youth.

The bulk of funds are awarded to state and territories as grants, contracts, and in cooperative agreements for service programs. Remaining funds support collaborative activities with other human service agencies as well as evaluation activities.

The President's Commission on Mental Health singled out seriously disturbed children and youth as a high risk group needing priority service.

The Coalition recommends a $10,000,000 budget for the Most in Need Program in FY1981 to fund about 30 projects in states across the country.

C. Prevention (PHS Act 301)

Appropriation
FY1979 $0
FY1980 $0

Authorization
FY1981 Open

President's Request
FY1981 $5,400,000

Coalition Recommendation
FY1981 $10,000,000

CHF Increase Over
President's Request
$4,600,000

In response to public pressure for greater attention to prevention and health promotion in mental health and at the recommendation of the President's Commission on Mental Health, the NIMH recently established a Prevention Office. Its role is to coordinate prevention activity within NIMH and with other agencies engaged in prevention activities.

Prevention activity to date in the NIMH has primarily been in research and planning, with small sums allocated internally in FY1979 and FY1980.

As Mrs. Rosalynn Carter stated in recent Congressional testimony: "The history of public health in the last century has shown repeatedly the effectiveness of sound preventive strategies in improving the overall physical health of all people. There are arguments that the complex causes of mental illness make it difficult to develop effective prevention programs. But we already know, for examole, that proper prenatal and perinatal care and periodic checkups and the immunization of young people can prevent serious mental disabilities...Our Commission was struck by the insufficient attention at the federal, state and local levels given to prevention."

The Coalition suggests that $10,000,000 be appropriated for prevention activities at NIMH in FY1981. We suggest money be spent:

1) to continue building a strong central Prevention Office in NIMH, giving leadership and focus to prevention activities across the country,

2) to make grants, contracts, cooperative agreements to states through NIMH to fund prevention programs where appropriate.

Priority targets for prevention services include groups at high risk of developing mental and emotional problems, including single parents and elderly widows, families mourning the death of a child or the loss of a spouse, teenage mothers, and hospitalized children.

ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION -
NATIONAL INSTITUTE OF MENTAL HEALTH

III. Formula Grants for Mental Health Services and Mental Health Planning (PHS Act 314(g))

Appropriation
FY1979 $13,500,000 (314d)
FY1980 $0 (314g)

Authorization
FY1981 $25,000,000

President's Request
FY1981 $12,100,000

Coalition Recommendation
FY1981 $25,000,000

CHF Increase Over
President's Request
$12,900,000

Prior to FY1980, formula grants were awarded to States under Section 314(d) of the Public Health Service Act to assist in meeting the costs of providing public health and mental health services. 314(d) required that at least 15% of each State's allotment of 314(d) be set aside for mental health activities. Effective in FY1980, Congress eliminated the requirement for a minimum set aside for mental health, enacting a new program under 314(g) of the same Act to support formula grants to State mental authorities for services and planning.

The President's FY1980 budget request to Congress did not include funds for this revised mental health formula grant program. Instead the Administration proposed to consolidate the program with Alcohol and Drug Abuse formula grants to States. This legislative proposal, which the Coalition supported, was not enacted. 314(g) was not included under the 1980 Continuing Resolution of Congress in spite of Administration support for the purpose of the program. The Administration has not requested supplemental appropriations for the program to date.

314(d) funds has been reallocated to other public health functions expecting that 314(g) would cover mental health formula grants previously in 314(d). This has not happened. In the absence of a supplemental appropriation, no money will be available for mental health formula grants in FY1980. This in spite of the fact that with the Health Planning Act Amendments of 1979, state mental health authorities have an increased responsibility for mental health planning.

The Coalition recommends a minimum of $13,700,000 to fund 314(g) in FY1980 and no less than $25,000,000 in FY1981.

64-129 O - 80 - 71

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION
NATIONAL INSTITUTE OF MENTAL HEALTH --

Program Support

Appropriation

FY1979 $31,173,000
FY1980 35,000,000

Authorization (301,303 PHS)

FY1981 Open

Suggested Coalition Recommendation

FY1981 $42,210,000 and
1096 positions (748 extramural
448 intramural)

History - This activity supports the Regional Office and Headquarter staff responsible for the planning, development and administration of the grants and contract program of the National Institute of Mental Health. Included is funding for th information services of NIMH and re paid to the General Services Administration for building space in the Central and Regional Offices.

In the past, programmatic increases have been made by Congress without proportionate increases in the program support budget.

Justification - The coalition recommends $42,210,000 and 1096 postions for program support and the National Institute of Mental Health (Headquarters and Regional Offices). We feel these figures represent what is needed to assure the responsible administration and monitoring of program responsibilit

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LETTER FROM BESS CENTER, CHAIRMAN, ALLIANCE FOR THE MENTALLY ILL, SAVANNAH, GA.

4 March 1980

Mr. Terry L. Lierman
Staff Director
Senate Labor-HEW Appropriations Subcommittee
1108 Dirksen Senate Office Bldg.
Washington, D.C. 20510

Dear Mr. Lierman:

I am replying to your 21 February letter regarding the public witness testimony hearing scheduled 13 March. Because I will be unable to attend this hearing, the following recommendation is furnished by my group concerning assistance for the Schizophrenia Patient.

The time has come for the Schizophrenia Patient to receive more consideration, medically speaking, than he/she has received in the past.

For years the mentally ill patient has been hidden in the "closet" - families have been too ashamed to admit that mental illness is present. "Stigma" always reared its ugly head when any mention of mental illness prevailed. What should have been done years ago is just beginning to surface.

Parent support groups are forming all over the country, and I represent the Alliance for the Mentally Ill, Savannah Area. We are members of the National Alliance for the Mentally Ill which was organized in Madison, Wisconsin, September 1979.

Research will be the "key" to open the door for schizophrenia illness. It is frustrating to think that $14 million was spent on research pertaining to schizophrenia as compared to cancer, heart or any other major illness. More interesting than the above is the fact that $10 million was spent in one city to house prisoners with a rehabilitation program that would make any psychiatric hospital green with envy.

New drugs, which have been used in the past few years, have enabled many schizophrenia patients to be released from the hospital with their condition stabilized, but not cured. This alone should be an incentive for more research funds in order for the National Institute for Mental Health to determine why these drugs have a good effect on some patients. This is not the time to stop, but time for action!

The "revolving door" syndrome of the '70's should be a good learning experience. Nothing was gained by deinstitutionalizing the schizophrenia patient. Report after report has proven this was not the answer. Namely, once a stabilized patient was released from the hospital, where was he going and what was he going to do?

Families having to cope with this illness become "burnt" out, thereby creating more mental illness. The development of innovative programs to enhance the quality of life for chronically ill patients is a goal all communities should work toward, but funding is a necessity. Families need to look forward to hope, and this can only come when they are aware that more funding for research and after-care systems will be forthcoming.

Families have the core of resiliency to take the bitterness of this illness, but it can only be sweetened with the hope and faith our government will come forward and provide the necessary funds for research and supportive living.

We can look back with pride at the many wonderful achievements which have been accomplished in the field of medicine over the last two decades - polio has been whipped; new heart operations for the cardiac patient; more hope for cancer. All this was accomplished with research funding.

Won't you add this disease to your list of medical accomplishments by funding and giving hope to families?

Sincerely,

Bess Center

BESS CENTER
Chairman
Alliance for the Mentally Ill
Savannah, GA

STATEMENT OF EDWARD J. CARELS, PH. D., COMPREHENSIVE CARE CORPORATION

Mr. Chairman, members of this subcommittee, I appreciate this opportunity to present my views on the Fiscal 1981 health budget.

I am Dr. Edward Carels, Director of Communications for the Comprehensive Care Corporation, a nationwide private health care management organization which operates the largest system of inpatient alcoholism treatment programs in this country. We also own and operate six psychiatric hospitals and a free telephone crisis intervention and referral center. Last year we received approximately 84,000 phone calls from persons, needing or living with others, experiencing alcohol or mental health problems. We treated 27,375 persons in our facilities, largely for alcoholism problems. Those persons whom we could not assist were referred to more appropriate care elsewhere.

To begin with, may I applaud the members of this subcommittee and others responsible for recognizing the need to increase the 1981 budget to support grants to state and community organizations for mental health and alcoholism. This

suggests an awareness of the growth in these health problems and a recognition of how the stigma attached to these maladies can delay needed treatment.

The need for cost containment is apparent to even the most casual observer of the health care industry. What is not so apparent, however, is the degree to which proposed solutions to rising costs have become part of the problem. My research has uncovered at least 36 factors which contribute to rising health care costs. These can be categorized in three ways:

(1) factors outside the health care system (inflation, increased longevity, and population growth account for two-thirds of the health care cost increases).

(2) factors within the health care system (increased medical specialization, new medical technology, etc.)

(3) Government legislation or regulation (increased paperwork and accountability, knowledge that health providers could be singled out for sanctions - such as wage price controls).

What many fail to appreciate is the tremendous complexity created by the cross impact of these 36 factors. Together, they create a multivariate problem which many are trying to rectify by univariate solutions. These solutions most often appear in the form of amendments to existing legislated programs or new regulations of the kind being promulgated by the Health Care Financing Administration. Curiously, I can find little or no research support for the notion that regulation reduces costs. In fact, there is substantial evidence to suggest that imposing legislation and regulation upon the health care delivery system has contributed to rising costs, stifled innovation, retarded the growth and development of free standing facilities and reduced competition.

Before I detail a few concerns with the 1981 budget, permit me to briefly review the cost to society of one disease - alcoholism. There are an estimated 12 to 15 million alcoholics in the United States. The cost to this nation, for Americans afflicted with alcoholism, was estimated in 1976 at $44.2 billion and we estimate it at $54.1 billion today. The economic consequences of alcohol abuse for the 1976 figures were broken down as follows:

Cost Category	Millions of Dollars Lost
Lost Production	$ 20,587
Direct Health Care Costs	11,929
Fire Losses	375
Motor Vehicle Accident Losses	6,587
Cost of Violent Crime	2,061
Alcohol Related Programs (highway safety, criminal justice, etc.)	2,654
	$ 44,193

Please note that the second highest cost figure is that of direct health care costs. It is known that alcoholics, and those afflicted with drug abuse and mental illness, use a high level of medical care services. The morbidity and mortality of alcoholics is high compared to other diseases. Research has further shown substantial cost savings following appropriate treatment for alcoholism. No doubt, it was with a realization of these cost savings in mind that a $51 million budget increase for mental health and alcoholism programs has been requested.

Our concern is that embodied in the same budget are a number of cost control measures which may undo much of the progress made in the field of mental health and alcoholism treatment over the years. I'm nervous about promises of $125 million savings by imposing "efficiency limits" on routine hospital costs. I'm very concerned about proposed HCFA savings in the area of reimbursement. The net effect of some of these reimbursement charges has been to deny access to care for Medicare and Medicaid recipients when the hospital decides to regard them as non-pay patients and refer them elsewhere. In addition, the cost of conforming to a constantly changing set of regulations is passed on to all hospital patients.

The budget further suggests that PSROs will receive greater funding so they can reduce hospitalization by $23 million and Medicare and Medicaid payments by $70 million. Physicians are being asked to make cost effectiveness decisions. This creates two problems. First, physicians aren't trained to make cost effectiveness decisions. Second, they are being pressured to include cost effectiveness as a therapeutic treatment rationale. This is good strategy up to a point. But there is an optimum level of hospitalization above and below which money is wasted and costs will go up. The prevailing cost containment wisdom is that anyone in a hospital be removed as soon as possible. Unlike most other disease areas, over two-thirds of the mentally ill and alcoholic patients are already being treated on an outpatient basis. The remainder who are in a hospital bed need the controlled medical environment of a hospital to get better. The PSRO can and should monitor exceptions to this general rule and act accordingly.

Additionally, most physicians have little or no training in alcoholism. Consequently, they may further question the efficacy hospitalizing patients with this disease. Research studies have demonstrated a cost offset following appropriate treatment for alcoholism including hospitalization. Can we justifiably expect PSRO physicians to avail themselves of this literature and make decisions based upon it? I don't think so! A nationwide educational campaign with PSROs is required. PSROs were installed to improve the quality of care being rendered. They are being pres-

sured to contain costs. While the two are not mutually exclusive, a program's effectiveness must be kept in the decision equation. That is, a more costly hospital treatment program with a 65% rate of recovery will, in the long run, be more cost effective than a less expensive outpatient program which has a 40% recovery rate. If an alcoholic or mentally ill person gets the treatment they need (either inpatient or outpatient), they will ultimately use fewer dollars of insurance coverage (less gastritis, cirrhosis, etc.); have fewer accidents; become more productive, etc.

An excellent example of how the cost control movement can precipitate "solutions" which raise costs is embodied in the proposed Section 211 of H.R. 934, entitled "Reimbursement for Inappropriate Inpatient Hospital Services". The intent of the section is to rectify abuses in the treatment of alcoholism. The wording of the section would encourage PSROs to question any hospital treatment of alcoholism beyond detoxification. From just a cost effectiveness standpoint, this is a mistake. From a quality of care standpoint, this would sentence a number of problem drinkers to a revolving door of pain, misery, and possibly death which are the inevitable accompaniments to unresolved alcohol abuse. Research conducted by insurers has demonstrated that shifting benefits from the inpatient to the outpatient area does not necessarily result in cost savings. This is too simple a solution to such a complex problem. Other factors must be taken into consideration.

Let me summarize:

1. We commend the subcommittee for continued grant support of mental health and alcoholism programs. Alcoholism is the nation's third leading killer. It needs adequate funding because it was denied appropriate recognition until several years ago.

2. We urge greater consideration be given to funding prevention as well as treatment programs. The rate of alcoholism is increasing by an estimated 200,000 to 500,000 persons each year. Treatment alone cannot solve this major health problem.

3. We support cost containment initiatives which are based on a complete understanding of the factors contributing to rising costs. We are opposed to cost control proposals which fail to recognize cost offsets for appropriate treatment regardless of location; assume that shifting insurance reimbursement from inpatient to outpatient will automatically save money; or do not take into consideration a program's rate of recovery in making cost considerations.

4. There are doubts about legislation or regulation as solutions to the problem of rising costs. It seems, as in physics, for every action there is an equal but opposite reaction. The record of government regulations in stemming the

rise in health care costs is not impressive. With the possible exception of HMO, the contribution of CON, PSRO, UR guidelines, Medicare-Medicaid reimbursement reforms, HSA, and wage and price controls in controlling costs has been minimal. In fact, there is some data to suggest that some of these have contributed to rising costs.

My concerns about regulated solutions are nicely summarized by Feldstein commenting on regulation of non-health industries. He states "....regulation in non-health industries led to higher, not lower prices; to cross subsidization of services; to greater non-price competition, which in turn led to increased costs in the regulated industry; to protection of the regulated firms, thereby lessening their incentives to strive for efficiency; and to a reluctance to introduce innovation in the delivery of services because such innovation threatens the revenues of the regulated industry." We would support legislated solutions provided there was concrete research information which supported its effect on costs.

Regulation fails to provide a basic ingredient in all behavior change -- motivation. It is a disquieting, but nonetheless true fact, that people are unlikely to do something unless provided a sound reason for doing so. The government would probably further its objective if it mandated incentives toward cost containment and prevention.

5. Cost effectiveness should not be regarded as the sole criterion for reimbursement of certain forms of treatment. The key question is whether cost controls contribute to increases in morbidity and mortality. There is an optimum level of cost control and quality assurance. Too much emphasis on cost control can ultimately lead to cost escalation the same as too little.

In alcoholism, this can be illustrated by the fact that problem drinkers right now are being treated in acute care hospitals for a wide range of diseases that are the indirect result of their drinking. Alcohol has an adverse physiological affect on every system in the human body. In 1977, the American Hospital Association estimated that 55% of the patients in hospital beds had alcohol related problems. Because of stigma and insurance language which excludes coverage for alcoholism, many of these patients are never treated for their problem - - drinking too much alcohol. As a result, a lot of dollars get spent treating symptoms or consequences rather than the cause.

6. Persons over 65 and poor people appear to need mental health and alcoholism services in greater proportion than the population as a whole. Although they account for 11% of the population, 25% of all suicides are committed by the

elderly. Loneliness, loss of spouse, lack of employment, and chronic health and financial problems all contribute to mental health difficulties.

The elderly get into problems with alcohol and prescribed drugs because their bodies can no longer tolerate toxic chemical after-effects as was once the case.

In short, there is a tremendous need for appropriate alcoholism and mental health treatment among Medicare and Medicaid recipients. We hope the proposed HCFA cost control initiatives take these needs into account.

7. Freedom of choice characterizes the American heritage. The effects of 11 years of regulations and legislation in health care has had many effects. One which troubles me is that of denying Medicare and Medicaid recipients access to care. Some hospitals and physician offices have grown weary with government protocols and simply refer these patients elsewhere.

As the spectre of NHI looms with us, I am uncomfortable with this potential loss of freedom of choice. In Britain, one of the leading industries today is the sale of private health insurance. This suggests to me that some people are willing to pay for the freedom to choose when and where they will get treatment.

8. There is a need to get more uniformity and better representation of alcoholism and mental health treatment in existing insurance contracts. I would urge the appropriation of funds to encourage a more standard benefit package for all insured to follow. Hopefully, it could be based on cost effectiveness studies. I urge consideration of this because presently many state legislatures are passing laws to mandate insurance coverage for mental health and alcoholism. As stated previously, we question the long range effect of legislated solutions. Voluntary education of the insured, using data from government funded studies would probably be more effective.

There really is no good substitute for honorable people working collectively toward a commonly agreed upon social goal.

Again, I thank you for the opportunity to present these views.

STATEMENT OF MANUEL M. CHAVEZ, LA SALIDA, INC.

Comes now Manuel M. Chavez and duly states: that he is the Executive Director for La Salida, Inc., a Methadone Program in Las Vegas, New Mexico (NM 10,027M); that La Salida, Inc. is funded on a 61.58% basis by the National Institute on Drug Abuse and 38.42% from the State of New Mexico.

La Salida, Inc. services the rural counties of San Miguel and Mora in Northern New Mexico, which constitute two of the poorest counties in the United States. With a population of only 28,900, these counties are at an 84.1% Hispanic-American population, 69.5% of which are unemployed or receiving public assistance. In keeping with the national trend, the two counties of San Miguel and Mora have an explosive drug abuse problem. Some reasons for this have been an exodas of people from urban to rural settings and people who returned from military service in Viet Nam where such people had a previous addiction problem. Other communities throughout New Mexico and the United States are also experiencing heroin and poly-drug abuse epedemics in the field.

As an Executive Director for La Salida for almost six years, I must submit that the United States has become a drug oriented society. The rampant use of drugs (legal and illegal) by American citizens have grown in such great proportions that even the smallest of rural communities are being gravely affected. No longer should we only concern ourselves in fighting illegal heroin smuggling by burning heroin puppy fields throughout the world, such actions have only caused the further use of synthetic drugs in its place. The real battle should now begin by the use of correct innovative treatment concepts to resocialize those addicted to respond to what we have found is "anomia" (limitations of life goal expectations) in the client's life. Attitude resocialization in the client's personality is the real weapon against drug abuse. Education criteria in America's schools need revitalization in providing instruction that will develop all aspects of personality to help the individual's leadership ability and future problem solving (technic) training. Testing indicated that 99% of hard-core heroin addicts in this area lack in past ability to communicate and in problem solving abilities. People with these

types of problems also tend to participate more in deviant behavior that leads not only to drug abuse, but other criminal activity. The New Mexico State Penitentiary, for example, has a 69% Hispanic population and 97% of their crimes were committed under the influence of drugs. Throughout the Southwest and the West, the same is true. Poverty, lack of education, lack of occupation, and discrimination are exploding into drug abuse and crime sprees that are really developed from frustration and despair among our population.

Drug abuse has spread from the barrio and gettos to the middle and upper class suburban areas of America, both illegal heroin use and poly drugs are rampant. The problem has not stopped there. Europe, Asia and South America are no longer only suppliers of illegal drug smuggling, their populations are now consumers of drugs. Epedemic disturbances are now producing a need for international conferences to help other world countries deal with their drug abuse problems. Our own American troops in other countries throughout the world are experiencing dangerous drug abuse problems that are not being appropriately solved.

To add to the above problems on drug abuse, the United States (a world leader in combating drug abuse) is further failing to listen to epedemic problems on drug abuse from the field. A few months ago, the House Subcommittee on Health and Environment reduced the Federal Government's support of drug treatment programs by a total of 11.27 million dollars on probable recommendations from un-informed reports not from field directors. During the last few years, the National Institute on Drug Abuse has cut funding from New Mexico's Substance Abuse programs from an 80% funding level to 61.58%. Unresponsive to the worst inflation since the 1929 depression, together with the explosion of drug abuse in the field, these funding cuts are adding to a losing fight against drug abuse throughout America.

As a Program Director, I propose that the Senate's Subcommittee on Appropriations, seriously consider all recommendations to counteract all limitations in funding to substance abuse: That if any doubts of the informed problems on drug abuse remain in the committee members minds, they are hereby invited to visit the programs in the field; that the best way for the subcommittee to get the most accurate and realistic information on issues of drug abuse is to grant more

time on their agenda to the program directors who work with the real clients of Substance abuse and would like to testify publicly.

In conclusion, I must submit that the possibility of me personally testifying before this subcommittee was rejected. As always State Government has again added to the problem of Congress getting personal testimony from field directors of drug abuse in New Mexico. I am therefore sorry to inform the subcommittee that the State of New Mexico rejected my request for Out-of-State Travel monies that would have allowed me to travel to Washington and testify before this subcommittee.

STATEMENT OF THE ASSOCIATION OF AMERICAN VETERINARY MEDICAL COLLEGES

The Association of American Veterinary Medical Colleges (AAVMC) is a non-profit organization whose members include all 24 schools and colleges of veterinary medicine in the United States. Three of the schools are parts of private institutions, and the remainder are in state universities. Schools are located in 23 states.

The AAVMC vigorously opposes the President's request for rescission of funds for capitation grants and Health Professions Student Loan (HPSL) program funds for fiscal year 1980. We urge you to reject this unfair and short-sighted recommendation in its entirety.

The Administration's suggestion that the fiscal year 1980 appropriation for capitation grants should be eliminated at this late date is unconscionable. Less than three months ago, Congress passed and the President signed an appropriations measure that settled on a level of funding. This level was agreed to after months of deliberation by Congress. This level represents a reduction of 20% from the fiscal year 1979 appropriation, and a reduction of 40% from the fiscal 1978 level, for the schools of veterinary medicine, optometry, pharmacy, and podiatry (VOPP).

We were led to believe that there was an acquiescence by the Congress and the Administration in a plan to phase out capitation grants over a period of years. We objected strongly to this plan and still believe that capitation grants play an essential role in pursuing federal health manpower goals. However, any plan, even an ill-conceived one, is superior to the chaotic lack of stability evidenced by the President's rescission request.

This rescission request proposes the elimination of a program that has clearly been extremely successful. During the 1970's, federal assistance encouraged the opening of six new schools of veterinary medicine, a one-third increase. The federal institutional support has encouraged an increase in student enrollments of nearly 60% between 1969 and 1979.

We reject the notion that the capitation grant system has outlived its usefulness. No one can yet predict what effect abolishing capitation grants will have on the opening of new veterinary schools or the enrollments at

veterinary schools. However, it is safe to assume that a number of schools will no longer increase enrollments, and some may reduce enrollments. Without capitation grants, there will clearly be some reduction in the opportunities for students to study veterinary medicine. And there is still a very strong interest in the profession; the schools receive more than four qualified applications for each slot, despite the rapid increases in enrollment.

The impact of withdrawing federal institutional support will probably affect the residents of states without schools most severely. States such as South Carolina, North Dakota, New Mexico,and Wisconsin will find it increasingly difficult to persuade state-supported universities in other states to undertake the exceedingly expensive education of their students in veterinary medicine. Federal institutional support now encourages the states with veterinary schools to expand the enrollment of students from other states; without such federal encouragement, it will be extremely tempting for these states to limit enrollments to their taxpayers' children, who are students more likely to stay in the state to practice veterinary medicine.

Those students who do make it into veterinary school will also suffer from a rescission of capitation grants. The most obvious effect is the inevitable increase in tuition that some schools will be forced to make. A reduction in capitation at this time is more likely to have this impact than a reduction made with more warning. This is because many of the schools' other sources of funds are already "locked up." State budgets for academic year 1980-81 were completed months ago. Nongovernmental sources of funding have already made most, if not all, of their commitments for the coming year.

The other effect on students is less tangible but no less important. In veterinary schools, the grants have been well spent on improving equipment, libraries, and other teaching resources. Without these funds, we will deprive students of important medical knowledge to some degree. In an era when the costs of health professionals are taking an alarmingly-high portion of the Gross National Product, it is extremely short-sighted to take any actions which would impair the accuracy or efficiency of the professionals of tomorrow. We believe that a relatively small investment in improving a

health professional's productivity will pay benefits in the form of reduced costs for years to come.

The request to rescind the appropriation of new funds for the Health Professions Student Loan (HPSL) fund is equally short-sighted. The costs of attending a school of veterinary medicine are comparable to those of attending a medical school. A recent survey conducted by the Student American Veterinary Medical Association found that the average cost of attending the required four years at a school of veterinary medicine ranged between a little over $14,000 and over $41,000. This survey was conducted before the opening of the Tufts University School of Veterinary Medicine last fall, which charges a tuition of $15,000 per year (unless the student is subsidized by the state of his residence).

The students in schools and colleges of veterinary medicine do not come from economic backgrounds that can support educational costs of $10,000, or even $20,000, per year. The student survey found that over 70% of the veterinary students have or will have educational loans to repay when they graduate. Of these students with loans, the national average was nearly $12,000 per student, but one school averaged over $28,000 per student.

In another financial aid survey, it was found that the assistance provided by the HPSL program is extremely important. In a survey of 16 of the veterinary schools, 14 reported that they participate in the HPSL program and that on average, HPSL loans supplied 35% of the students' financial needs (i.e., 35% of the total scholarships and loans received by the students).

Any reduction in HPSL funds must be replaced, and there is little alternative other than the unconscionable Health Education Assistance Loan (HEAL) program. The HEAL loan is extremely burdensome for a veterinary student, because he has nothing near the income potential of his colleagues in human medicine. Starting salaries for 1979 graduates mostly ranged in the $16,000 to $19,000 area, with some as low as $12,000 and as high as $30,000, for private practice, industry, and government jobs. Students entering internships and residencies received salaries as low as $8,000 per year, with most falling in the $11,000 to $14,000 range.

Obviously, recent graduates do not have incomes sufficient to repay substantial educational debts. And the long-term income potential is not very great, either. In a 1977 survey of its membership, the American Veterinary Medical Association found that average income was $30,175 for private practitioners. But, significantly, the true "general practitioner," i.e., one with a mixed practice of treating large and small animals, had an average income of only $26,458. Substantially higher averages were reported by practitioners specializing in companion animals, both pets and horses.

The HPSL program helps students substantially in keeping their educational debts at a managable level. The larger the debts to repay, the greater the pressure on the student to specialize in the most lucrative field of practice. If more students become dependent on HEAL loans to complete their education, more of them will be forced to engage in companion animal medicine. Although companion animals play a very important role in maintaining both the physical and mental health of their owners (a role that is only beginning to be understood), we believe that the public welfare would be better served at this time by policies that encourage graduates of veterinary schools to seek employment and experience without income being an overwhelming factor in the decision-making.

In summary, the schools of veterinary medicine and their students rely heavily on the limited federal financial assistance offered by the capitation grant program. Likewise, the HPSL program is essential in making the cost of veterinary education affordable for hundreds of students. Both the schools and the students have already made plans in reliance upon the levels of federal support contained in the fiscal year 1980 appropriations measure already passed by Congress and signed by the President. It would be extremely unfair to these students and schools and needlessly short-sighted and counterproductive federal policy to rescind these appropriations.

We strongly urge you to reject this rescission request outright. Thank you.

Letter From Roy Morgan, Executive Director, Zero Population Growth

March 11, 1980

The Honorable Warren Magnuson
Chairman
Subcommittee on Labor-HEW
U.S. Senate
Washington, D.C. 20510

Dear Senator Magnuson:

On behalf of ZPG's 7,000 members around the country, I am writing to urge the subcommittee to approve a $4 million appropriation for population education, authorized by the "Population Education Act of 1978," Section 392 of P.L. 95-561, the "Education Amendments of 1978."

Changes in the nation's population are having a tremendous effect on all of us, for which we are uninformed and ill-prepared. As James McIntyre, Director of the Office of Management and Budget, reported last year, "Demographic factors are important in determining the size and composition of much of the federal budget. For instance, today's federal retirement and health care programs would increase from 36 percent of the budget in 1980 to 52 percent in 2030 due to demographic changes alone."

Yet, according to public opinion polls, the majority of Americans are not informed about basic facts of population change, and only a fraction of the nation's teachers spend any time on population education.

The attached fact sheet outlines both the widespread public support for population education and the need for a fiscal 1981 appropriation. A $4 million appropriation will begin to reach millions of the 30 million students who are now in the Kindergarten through eighth grade and will have been through secondary school by the end of the decade. We know through our own population education program's experience of working with 3,000 teachers in 70 workshops in 22 states how valuable this expenditure would be.

Please enter this request for a $4 million appropriation for population education and the attached fact sheet in the subcommittee's hearing record for fiscal 1981 Labor-HEW appropriation requests.

Sincerely,

Roy Morgan

Roy Morgan
Executive Director

POPULATION EDUCATION FACT SHEET:
THE NEED FOR A FISCAL 1981 APPROPRIATION

The United States is entering an era of dramatic population changes, not only around the globe but also here at home. The U.S. population -- now 221 million -- is growing by an estimated two million people every year. We're experiencing a major shift in our urban population to rural areas. And the proportion of the population over age 65 may double in 50 years.

We need to educate ourselves and the generations to come about the tremendous impact these changes will have, and how we can respond to them. Congress authorized the 1978 Population Education Act to do the job. Now, it's time for Congress to get the job started by appropriating $4 million for teacher training and materials in fiscal 1981.

What is population education?

Programs which teach individuals about changes in the population, their causes, and their consequences for everyone are what population education is all about. Population education does not include sex education.

Why is population education important?

Changes in fertility, mortality, and migration can deeply affect the lives of each of each of us. They also can have a profound effect on the country as a whole. Take the federal budget for example. President Carter told Congress this year: "Demography is the most significant factor affecting the budget that is fairly predictable."

James McIntyre, Director of the Office of Management and Budget, states: "Demographic factors are important in determining the size and composition of much of the federal budget. For instance, today's federal retirement and health care programs would increase from 36 percent of the budget in 1980 to 52 percent in 2030 due to demographic changes alone."

Who says we need population education?

* The American Public. Eighty percent of Americans polled in 1971 by the Opinion Research Corporation believed schools "should give special attention to the causes and consequences of population growth." In 1977, 86 percent of the repondents to a Roper poll said people need to be more aware of continued population growth.

* The President's Commission on Population Growth and the American Future. This Congressionally-established Commission recommended in 1972 federal funds for teacher training, materials development, and leadership training in population education.

* The United States Government. In 1974, the U.S. government joined 80 other nations in signing the United Nations' World Population Plan of Action which emphasized the importance of population education.

* The Federal Interagency Committee on Education's Subcommittee on Population Education. In 1976, it recommended that "population education...should be considered a national educational priority and the federal government should provide leadership and support."

* The House Select Committee on Population in 1978 recommended that "federal funds should be available to support population education in elementary and secondary schools."

* The U.S. Congress enacted the "Population Education Act" as part of P.L. 95-561 to authorize a minimum of 10 percent of the Commissioner of Education's discretionary funds be available for population education.

What is the need for population education?

There is still tremendous ignorance about even the most basic facts about population change. In 1971, the ORC poll found 63 percent did not know the U.S. population size. In 1976, a Roper poll found that 39 percent thought the population either had stopped growing or was declining. In 1978, another Roper poll found only 50 percent thought the population is likely to increase.

Schools are not equipped to do something about this for the next generation. Only 35 to 40 percent of secondary school teachers offer population education,

according to a 1977 University of Cincinnati survey, and even in those cases, the instruction is only a brief unit within a curriculum.

The major obstacle is not teachers' interest. Instead, it is the cost and lack of materials as well as inadequate classroom time. Model workshops, funded by the U.S. Office of Education, have found that training, simple materials, and activities which can be incorporated into existing curricula successfully bridge these obstacles.

What can the "Population Education Act" do about this?

Funds under the "Act," which is part of the Elementary and Secondary Education Act," are intended for "pre-service and inservice training programs and projects," and "development and dissemination of teacher and student education, training, and instructional materials..."

The law was enacted in November 1978, following the beginning of the new fiscal year 1979. No funds were appropriated in fiscal 1979, and in fiscal 1980 a $4 million appropriation passed by the Senate was dropped in the Labor-HEW conference. The Administration has not requested a fiscal 1981 appropriation.

What will be a $4 million appropriation buy?

$4 million is only 1/140,000 of the federal budget. But by building on existing programs and materials and adapting existing curricula, these funds can make an enormous difference for teachers and students around the country. Model programs, with funds no longer available from the Office of Environmental Education, have reached an estimated 1,000 teachers and 10,000 students for every $100,000 spent on teacher training. With each successive year, the original investment continues to bring population education to thousands of additional students.

Today, there are an estimated 30 million students in Kindergarten through eighth grade; by 1990 there are projected to be more than 34 million. A fiscal 1981 appropriation of $4 million for population education will reach millions of these students in the next decade.

Statement of Arthur S. Flemming, Chairman, U.S. Commission on Civil Rights

Mr. Chairman, Members of the Committee, I am Arthur S. Flemming, Chairman, United States Commission on Civil Rights. I am grateful for the opportunity to appear before your subcommittee today to express the views of the Commission with respect to appropriations for the new Department of Education. Specifically, I wish to comment on the possible attachment of the "Eagleton-Biden" amendment to this appropriations bill.

The amendment states that Federal funds may not be used to coerce any school districts to force the busing of students or the abolishment of any segregated school, or the transfer or assignment of students to particular schools over their parents' objections. In addition, no funds can be used to transport students or teachers to overcome racial imbalance or to carry out school desegregation plans.

The Commission on Civil Rights has consistently and vigorously opposed the Eagleton-Biden amendment from the time it was first proposed and has repeatedly urged its repeal. After the initial battle over Eagleton-Biden, its attachment to subsequent appropriation bills became almost routine. But now, at the inception of a new Department of Education, the opportunity is

presented to establish a renewed commitment to school desegregation. We strenuously oppose the attachment of this provision to the appropriations bill here under consideration.

The Commission was gratified that in the consideration of the legislation establishing the new Department of Education many proposed limitations on the new Department's authority to promote school desegregation were not enacted. The consideration and rejection by the Congress of those proposed limitations reflected a commitment to the goal of equality of educational opportunity for all Americans, and an affirmation of the need for a Department of Education with the requisite authority to accomplish that goal.

Attaching Eagleton-Biden would negate this congressional affirmation by effectively undermining the new Department's authority - by stripping it of the enforcement mechanism for obtaining compliance with the mandates of the Constitution and of Title VI of the Civil Rights Act.

In a brief filed with the U. S. Court of Appeals for the District of Columbia by attorneys for the plaintiffs in the recent case of Brown v. Califano, the following statements were included, based on deposition testimony of Mr. David Tatel, former director of the Office of Civil Rights at HEW:

> Data supplied by Mr. Tatel confirm the effectiveness of the aid termination power. Thus whereas 158 voluntary plans involving student assignment issues were secured by OCR in the last five calendar years [1973-78], it became necessary to initiate fund termination proceedings in only 37 cases. Mr. Tatel underscores that conclusion by testifying that in [those] five years only a single school district [had] gone as far as actual fund termination rather than comply with Title VI. He similarly concedes that comparing the single district that went to fund termination with the 1,025 districts which agreed to compliance plans in the same period is 'a fair reflection of the efficacy of the fund termination threat.'

Mr. Tatel, in this same testimony, concluded, referring to the Esh, Byrd and Eagleton-Biden Amendments, that HEW's "primary or principal method of achieving desegregation is barred by these amendments."

It is clear that in the three years that Eagleton-Biden has been in effect, and this fund cut-off mechanism has therefore been unavailable, enforcement has dwindled. Only seven cases have been referred to Justice, and of those, suit was brought in but one instance.

From the evidence available to us, we believe that Eagleton-Biden has had a chilling effect on federal enforcement and has given encouragement to

local districts who wish to unlawfully resist and delay the constitutionally mandated desegregation of their schools.

Furthermore, in considering the impact of this amendment, we believe it is important to keep in mind that often there is no meaningful alternative to the transportation of students beyond the nearest school if unconstitutionally segregated schools are to be broken up. A case in point is the unlawful segregation of the schools of Chicago. Secretary Patricia Harris has said that HEW was forced to refer the case to the Justice Department last October because nothing short of busing would accomplish desegregation in that city's schools. To date no action has been taken by Justice, despite assurances from Assistant Attorney General Drew Days that suit would be brought within 90 days of the referral.

Finally, Eagleton-Biden as applied may prevent the Executive branch of the Federal Government from fulfilling its constitutional obligations. The Executive branch has been commanded to see that the laws are faithfully executed and is obligated by the Fifth Amendment and by Title VI to achieve equality in federally funded schools. The referral of cases to the Justice Department, as required by Eagleton-Biden, and the resulting delays that attend such referrals, may constitute unlawful avoidance by the Executive Branch of its obligation to dismantle unconstitutionally segregated schools without delays that deprive generations of young people of equal access to educational resources. The recent decision in Brown v. Califano, while holding the challenged amendment constitutional on its face, affirmed the opinion of the District Court that further attacks on the provision as applied should be entertained "if further proceedings show the litigation option is not a 'workable instrument for effecting equal educational opportunities.'"

This committee has an opportunity to reaffirm this nation's commitment to the principle of equality of educational opportunity by assuring that the new Department has the capability to achieve that goal. The Eagleton-Biden amendment should not be permitted to hinder the progress of school desegregation by tieing the hands of the new Department. Action by Congress to attempt to limit school desegregation through such actions as the Eagleton-Biden Amendment contributes to the belief that desegregation can be avoided and fuels opposition to desegregation. In short, the Eagleton-Biden measure aids and abets obstructionists in the field of desegregation. The Commission on Civil Rights urges you to reject any proposal to attach Eagleton-Biden to the Department of Education appropriations bill.

Thank you.

CONCLUSION OF HEARINGS

Senator WEICKER. I agree. This concludes our public witness testimony. The subcommittee will stand in recess, subject to the call of the Chair.

Thank you all very much.

[Whereupon, at 2:47 p.m., Thursday, March 13, the hearings were concluded and the subcommittee was recessed to reconvene at the call of the Chair.]

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