INTERNATIONAL HEALTH ACT OF 1980

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

OF THE

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

NINETY-SIXTH CONGRESS

SECOND SESSION

ON

S. 1424

TO AMEND THE FOREIGN ASSISTANCE ACT AND THE PUBLIC HEALTH SERVICE ACT TO PROVIDE FOR THE ADVANCEMENT OF INTERNATIONAL COOPERATION AND ASSISTANCE IN HEALTH, AND FOR OTHER PURPOSES

JULY 2, 1980

Printed for the use of the Committee on Labor and Human Resources

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INTERNATIONAL HEALTH ACT OF 1980

WEDNESDAY, JULY 2, 1980

U.S. SENATE,
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, D.C.

The subcommittee met, pursuant to call, in room 4232 of the Dirksen Senate Office Building, at 9:41 a.m., Senator Jacob Javits, presiding pro tempore.

Present: Senator Javits.

Senator JAVITS. The hearing of the subcommittee will come to order.

Senator Metzenbaum, who was to have presided, has asked me to undertake to open the hearing; he may take over, if he arrives in time. The Chair first would like to acknowledge an opening statement of Senator Metzenbaum's on this hearing on the two bills which are before us, in which he gives his opening views on this subject. The statement, without objection, will be received, and will be the opening statement at the hearing.

OPENING STATEMENT OF SENATOR METZENBAUM

Senator METZENBAUM. The subcommittee will today hear testimony on two bills—the International Health Act of 1979 (S. 1424) introduced by Senator Javits, and an amendment offered by Senator Kennedy as a substitute to that bill, the International Health Cooperation Act of 1980.

This subcommittee has on many occasions heard testimony that points up the growing importance of health-related issues in the relations between nations. Health, in fact, is one of the few areas in which nations that disagree in virtually everything else have found it possible to work with one another toward the common goal of reducing needless human suffering.

Certainly, the need today for cooperation is as great as it ever has been. In many Third World nations for example, population growth is placing enormous strain on medical facilities that are already inadequate to deal with even the rudimentary needs of the people.

Our country has a long and proud record of providing aid to nations that are less fortunate than we. But it is clear that the responsibility for funding this currently needed assistance cannot fall solely upon the United States, or, for that matter, upon the developed nations. We have learned in recent years that progress in improving the health and well being of individuals in the developing world will come about only as a result of the work and

commitment of the Third World governments themselves with the assistance of the United States and donor countries.

We in this country have come to recognize this fact. That our policies have increasingly been directed away from charity and toward constructive, long-term cooperation.

The bills before us today would take important new steps in this direction.

United States efforts in the area of international health originate in a number of agencies, but for many years, the Department of Health and Human Services and U.S. aid have been the focal point in the relationship between the U.S. Government and the organized health agencies of the world. Department personnel have been actively involved in the campaign to eradicate small-pox, in educating United States and foreign nationals in disciplines like public health and preventive medicine, and in providing emergency relief to people around the world who have suffered from natural or man-made disasters.

I believe that we must recognize that the role of these departments in international health has expanded and will very likely continue to do so. It is time, therefore, to reexamine this newly reconstituted department with regard to its legislative authorities and to the relationships that it maintains with the rest of our Government's foreign policy apparatus.

We are fortunate to have with us this morning witnesses with varied backgrounds and experiences in international health. We look forward to their comments on the proposed bills and their advice to the committee.

[The bill and amendment referred to follow:]

96TH CONGRESS
1ST SESSION

S. 1424

To amend the Foreign Assistance Act and the Public Health Service Act to provide for the advancement of international cooperation and assistance in health, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JUNE 27 (legislative day, JUNE 21), 1979

Mr. JAVITS (for himself, Mr KENNEDY, and Mr. BRADLEY) introduced the following bill; which was read twice and referred jointly, by unanimous consent, to the Foreign Relations Committee, the Labor and Human Resources Committee, and the Governmental Affairs Committee, with instructions that when the bill is ordered reported by any committee, the remaining two committees shall have sixty days within which to act

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A BILL

To amend the Foreign Assistance Act and the Public Health Service Act to provide for the advancement of international cooperation and assistance in health, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act be cited as the "International Health Act of 1979".

FINDINGS AND DECLARATION OF PURPOSE

SEC. 2. (a) The Congress declares that—

(1) disease and disability are the common enemies of all mankind;

(2) the survival of mankind in a complex world depends upon a sharing of knowledge with regard to health problems without regard to national boundaries and political subdivisions; and

(3) in the closely linked and interdependent world of today, the health and well-being of the American people is inseparable from that of other peoples.

(b) The Congress finds that—

(1) in order to assure the good health of all people, increased emphasis on the provision of basic environmental health, nutrition, population, and health service, health manpower development, institutional support, medical research and surveillance, especially with regard to the tropical diseases, and experimentation into the organization and delivery of health care, is required;

(2) in order to assure sufficient manpower resources for future United States international health activities, increased Federal support of manpower programs is required;

(3) in order to best utilize limited resources for international health activities, the United States needs to increasingly utilize multilateral mechanisms for assist-

ance to developing countries, and also needs to implement international health programs in the context of overall country development planning formulated in cooperation with the country hosting such programs;

(4) so that current and future international health programs may be more effectively administered, reorganization of international health responsibilities within government is required; and

(5) for the purpose of furthering private, small-scale and cost-efficient health projects in developing countries, and to better relate the international health programs of the United States Government with those of private voluntary organizations, an independent nongovernmental entity is needed.

(c) It is the purpose of this Act to establish mechanisms to manage and support international health activities.

TITLE I—INTERNATIONAL HEALTH SUBCOMMITTEE OF THE DEVELOPMENT COORDINATION COMMITTEE

AMENDMENT TO THE FOREIGN ASSISTANCE ACT OF 1961

SEC. 101. The Foreign Assistance Act of 1961, as amended, is amended by renumbering section "640C" as "640D", and by inserting the following new section 640C:

"SEC. 640C. INTERNATIONAL HEALTH SUBCOMMITTEE OF THE DEVELOPMENT COORDINATION COMMIT-

TEE.—(a) ESTABLISHMENT.—There is hereby established a subcommittee of the Development Coordination Committee to be known as the International Health Subcommittee (herein referred to as the 'Subcommittee').

"(b) MEMBERSHIP.—The Subcommittee shall be composed of members appointed by the President. The President shall appoint—

"(1) as members, the heads of the Department of State, the Department of Health, Education, and Welfare, the Treasury Department, the Commerce Department, the Defense Department, the Department of Agriculture, the Peace Corps, the Office of Management and Budget, the International Development Cooperation Agency, the Agency for International Development, and representatives from other Federal departments or agencies, interested in international health activities; and

"(2) four individual members who are—

"(A) especially qualified to serve on the Subcommittee by virtue of their training, experience, or background in international health, and

"(B) not full-time employees of the Federal Government.

"(c) CHAIRMAN.—The President shall appoint the Chairman from among the members of the Subcommittee.

"(d) DEFINITION.—For the purposes of this title the term 'international health activity' means any collaborative activity in the field of health conducted in two or more countries or any activity carried out in the United States or by the Federal Government for the express purpose of addressing world health problems including those problems articulated by the World Health Organization and other generally recognized international health agencies, through disease control (including projects for safe water supplies, sanitary waste disposal, preventive medicine, biomedical research, and environmental control), projects and programs to promote general health (including nutrition, population, and health education), health services delivery and management, health research, manpower development, and the strengthening of institutions, both domestic and foreign, which contribute to the enhancement of the health status of all people, especially those in the developing countries. For purposes of this title, the term 'international health activity' shall not include any regulatory activities of the Federal Government.

"(e) PURPOSES AND FUNCTIONS.—(1)(A) The Subcommittee shall develop a comprehensive Federal International Health Plan (herein referred to as the 'Plan') for the management of all Federal international health activities.

"(B) In developing the Plan, the Subcommittee shall—

"(1) identify those Federal policies which are being carried out through international health activities and develop a consistent and coordinated Federal international health policy consistent with Federal international development policy;

"(2) develop a comprehensive inventory of all Federal international health activities, including those health, sanitation, nutrition, and population programs affecting other countries, and identify their purposes and how such activities related to the Plan;

"(3) identify, by department and agency, all proposed international health activities, including research priorities;

"(4) develop mechanisms for assuring a comprehensive and coordinated approach, by country or region, for addressing international health care needs, including safe water supplies, sanitary waste disposal, improved nutrition, and the financing of such programs;

"(5) develop procedures for assuring the involvement of other countries, financial institutions, and private international organizations in international health activities; and

"(6) identify all aspects of the Federal budget which involve international health activities and prepare an evaluation of such budget.

"(2) The initial Plan shall include the information and analysis specified in subparagraph (B) of paragraph (1) and shall cover a period of five years from the date of enactment of this title. The Plan shall include those responsibilities of each department and agency for such period under the Plan, including, for each fiscal year within such period, a program and budget analysis.

"(3) The Chairman of the Subcommittee shall simultaneously submit to the President and the appropriate committees of the Senate and the House of Representatives—

"(A) the Plan, not later then one year after the date of enactment of this title; and

"(B) an annual report, not later than February 1 of each year, on Federal international health activities.

"(e) ADMINISTRATIVE PROVISIONS.—(1) The Subcommittee shall establish a centralized information system on all international health activities which shall be developed from information which each department or agency has acquired.

"(2) The Subcommittee may secure directly from any department and or agency information necessary to enable it to carry out it purposes and functions.

"(3)(A) Members of the Subcommittee who are full-time officers or employees of the United States shall serve without additional compensation but shall be reimbursed for travel, subsistence, and any other necessary expenses incurred in the performance of activities of the Subcommittee.

"(B) All other members of the Subcommittee shall receive compensation at a rate to be established by the Subcommittee, but not exceeding for any day (including travel-time) the daily equivalent of the effective rate for level IV of the Executive Schedule (5 U.S.C. 5315) while engaged in the performance of the activities of the Subcommittee, and may be reimbursed for travel, subsistence, and other necessary expenses incurred in the performance of such activities.

"(4)(A) The Subcommittee may appoint and compensate, at a rate not to exceed the annual rate of basic pay in effect for level IV of the Executive Schedule, an executive director, without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and the provisions of chapter 51 and subchapter III of chapter 53 of such title, relating to classification and General Schedule pay rates, who shall administer full time the daily activities of the Subcommittee.

"(B) Other employees shall be selected and appointed by the executive director and shall be vested with such powers and duties as the executive director may determine.

"(C) The Subcommittee may appoint and fix the compensation of such personnel as it deems advisable, without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and the provisions of chapter 51 and subchapter III of chapter 53 of such title, relating to classification and General Schedule pay rates.

"(D) The Subcommittee may procure, in accordance with the provisions of section 3109 of title 5, United States Code, the temporary or intermittent services of experts or consultants. Persons so employed shall receive compensation at a rate to be fixed by the Subcommittee, but not exceeding for any day (including traveltime) the daily equivalent of the effective rate for level IV of the Executive Schedule. While away from home or regular place of business in the performance of services for the Subcommittee, any such person may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703(b) of title 5, United States Code, for persons in the Government service employed intermittently.

"(E) The Subcommittee may utilize, with their consent, the services, personnel, and facilities of other departments and agencies without reimbursement. The head of any department or agency may, at the request of the Subcommittee, detail, assign, or otherwise make available any officer or em-

ployee of such department or agency to serve with, or as a member of the staff of the Subcommittee.

"(f) AUTHORIZATION.—There are hereby authorized to be appropriated for purposes of this Act $2,000,000 for the fiscal year ending September 30, 1981, $2,000,000 for the fiscal year ending September 30, 1982, $2,000,000 for the fiscal year ending September 30, 1983, and $2,000,000 for the fiscal year ending September 30, 1984.".

TITLE II—OFFICE OF INTERNATIONAL HEALTH

AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT

SEC. 201. The Public Health Service Act, as amended, is amended by adding at the end thereof the following new title:

"TITLE XVIII—INTERNATIONAL HEALTH

"DEFINITIONS

"SEC. 1801. For the purposes of this title the term—

"(a) 'international health activity' means any collaborative activity in the field of health conducted in two or more countries or any activity carried out in the United States or by the Federal Government for the express purpose of addressing world health problems, including those problems articulated by the World Health Organization and other generally recognized international health agencies, through disease control (including projects for safe water supplies, sani-

tary waste disposal, preventive medicine, biomedical research, and environmental control), projects and programs to promote general health (including nutrition, population, and health education), health services delivery and management, health research, manpower development, and the strengthening of institutions, both domestic and foreign, which contribute to the enhancement of the health status of all people, especially those in the developing countries. For purposes of this title, the term 'international health activity' shall not include any regulatory activities of the Department;

"(b) 'Office' means the Office of International Health, established under section 1802.

"OFFICE OF INTERNATIONAL HEALTH

"SEC. 1802. (a) There is established within the Department an Office of International Health. The Office shall be headed by a Deputy Assistant Secretary for International Health, appointed by the Secretary.

"(b) The Office shall—

"(1) review and make recommendations on all expenditures of the Department relating directly or indirectly to international health;

"(2) establish policy planning mechanisms and monitor program development activities for all Department programs relating to international health;

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"(3) be responsible for relations with health agencies in other countries with regard to international health activities involving the Department;

"(4) be responsible for coordination of the international health activities of the Department with overall United States international health policy, with the programs of other departments and agencies, and with the activities of the International Health Subcommittee of the Development Coordination Committee;

"(5) provide staff support upon request to the International Health Subcommittee of the Development Coordination Committee;

"(6) establish and maintain information systems adequate to monitor all international health activities within the Department; and

"(7) perform any other activities the Secretary may deem appropriate.

"(c) The Office shall be responsible for the identification and coordination of all international health activities within the Department.

"(d) In carrying out his responsibilities under this title, the Secretary is authorized to—

"(1) use, with the consent of any Federal agency, the services, facilities, and personnel of such agency, with or without reimbursement, and with the consent

of any State or political subdivision thereof, accept and use the services, facilities, and personnel of any agency of such State or subdivision with reimbursement; and

"(2) employ experts and consultants or organizations thereof as authorized by section 3109 of title 5, United States Code, except that contracts for such employment may be renewed annually; compensate individuals so employed at rates not in excess of the rate specified at the time of service for level IV of the Executive Schedule (5 U.S.C. 5315) including traveltime, and allow them while away from their homes or regular places of business, travel expenses (including per diem in lieu of subsistence) as authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently, while so employed.

"SEC. 1803. The Secretary shall establish within the Public Health Service the following programs:

"(a) A program of graduate career awards to be known as International Health Fellowships for study in international health which shall be made to individuals. International Health Fellowships shall be for the support of international health studies (as defined by the Secretary) following other training as a health professional. Priority in the receipt of fellowships shall be given to graduate students in the areas of

study determined by the Secretary to be most in need of additional manpower resources and to returning International Health Service personnel. International health studies shall include studies relating to the organization, management, and delivery of health services as well as to public health, clinical, and research studies.

"(b) A program to be known as the International Health Service, which shall be directed toward the enhancement of public health, clinical, and research capability of foreign governments and institutions engaged in health services training, through the use of an identified group of mid-career health professionals who shall commit to a term of service of no less than two years in foreign nations which request such services from the United States Government and which have been identified by the International Health Subcommittee of the Development Coordination Committee as being in need of such services. Placement of International Health Service personnel shall be subject to the approval of the International Health Subcommittee of the Development Coordination Committee. The Secretary shall establish a preassignment training program for International Health Service personnel which shall prepare such personnel for their specific overseas assignments. The Secretary may assign present Federal employees to the International Health Service for a limited term for the purpose of assuring a sufficient number of personnel in

relation to need by specialty and training. The Secretary may assign present Federal employees or employ new personnel in the International Health Service notwithstanding any provision of law relating to limitations on the total number of Federal employees, or on the total number of positions which may be placed in any grade of the General Schedule, the Executive Schedule, or in the Senior Executive Service.

"(c) A program to establish and provide support for international health centers and international health programs in academic institutions in the United States. Health centers and programs shall train students and conduct research in international health activities in an associated academic institution and shall target their program efforts in one or more selected areas agreeable to the International Health Subcommittee of the Development Coordination Committee. In awarding such support, the Secretary shall give priority to centers and programs organized into cooperative consortia, or which have established a cooperative relationship with a health science institution or public health program located in a developing country.

"(d)(1) There are authorized to be appropriated for the purposes of subsection (a), $3,500,000 for the fiscal year ending September 30, 1981, $4,000,000 for the fiscal year ending September 30, 1982, $4,500,000 for the fiscal year

ending September 30, 1983, $5,000,000 for the fiscal year ending September 30, 1984.

"(2) There are authorized to be appropriated for the purposes of subsection (b), $6,000,000 for the fiscal year ending September 30, 1981, $8,000,000 for the fiscal year ending September 30, 1982, $11,000,000 for the fiscal year ending September 30, 1983, and $15,000,000 for the fiscal year ending September 30, 1984.

"(3) There are authorized to be appropriated for the purposes of subsection (c), $6,000,000 for the fiscal year ending September 30, 1981, $6,500,000 for the fiscal year ending September 30, 1982, $7,000,000 for the fiscal year ending September 30, 1983, and $8,000,000 for the fiscal year ending September 30, 1984.".

TITLE III—THE HUBERT H. HUMPHREY FUND

CONGRESSIONAL DECLARATION OF POLICY

SEC. 301. The Congress finds and declares that—

(a) private voluntary organizations have made substantial contributions to international health;

(b) more assistance has been contributed to other nations for international health activities through private voluntary organizations and other private institutions than through Federal departments and agencies;

(c) private voluntary organizations are an integral part of current international health efforts and should

become an even more valuable component of our Nation's international health activities; and

(d) in order to encourage and support the involvement of private organizations in assisting in meeting our Nation's international health goals, a private corporation should be established to assist these organizations in their international health activities.

SEC. 302. For the purposes of this title the term—

(a) "international health activity" means any collaborative activity in the field of health conducted in two or more countries or any activity carried out in the United States for the express purpose of addressing world health problems, including those problems articulated by the World Health Organization and other generally recognized international health agencies, through disease control (including projects for safe water supplies, sanitary waste disposal, preventive medicine, biomedical research, and environmental control), projects and programs to promote general health (including nutrition, population, and health education), health services delivery and management, health research, manpower development, and the strengthening of institutions, both domestic and foreign, which contribute to the enhancement of the health status of people in the developing countries.

ESTABLISHMENT OF CORPORATION

SEC. 303. There is authorized to be established a nonprofit corporation to be known as the Hubert H. Humphrey Fund for International Health (herein referred to as the "Fund") which shall not be an agency or establishment of the United States Government. The Fund shall be subject to the provisions of this title, and to the extent consistent with this title, to the District of Columbia Nonprofit Corporation Act.

BOARD OF DIRECTORS

SEC. 304. (a) The fund shall have a Board of Directors (herein referred to as the "Board") consisting of fifteen members appointed by the President. The President shall appoint—

(1) seven members of the Board from individuals—

(A) who are officials of the United States Government; and

(B) who are especially qualified to serve as members by virtue of their training, experience, background, or position in the Federal Government involving international health;

(2) eight members of the Board from individuals—

(A) who are not full-time employees of the United States Government; and

(B) who are especially qualified to serve as members by virtue of their training, experience, and background in international health.

(b) The members of the initial Board shall serve as incorporators and shall take whatever actions are appropriate and necessary to establish the Fund under the District of Columbia Nonprofit Corporation Act.

(c) The term of office of each member of the Board shall be four years; except that (1) any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term; (2) the terms of office of members first taking office shall begin on the date of incorporation and shall expire, as designated at the time of their respective appointments, four at the end of one year, six at the end of two years, and five at the end of four years; and (3) a member whose term has expired may serve until his successor has been appointed. No member shall be eligible to serve in excess of two consecutive terms of four years each.

(d) Any vacancy in the Board shall not affect its power, but shall be filled in the manner in which the original appointments were made.

(e) The President shall designate one of the members first appointed to the Board under subsection (a)(2) as Chairman; thereafter the members of the Board shall annually

elect one of their number appointed under subsection (a)(2) as Chairman. The members of the Board shall also elect one or more of them as a Vice Chairman or Vice Chairmen.

(f)(1) The members of the Board shall not, by reason of such membership, be deemed to be employees of the United States.

(2)(A) Members of the Board who are full-time officers or employees of the United States shall serve without additional compensation but shall be reimbursed for travel, subsistence, and any other necessary expenses incurred in the performance of activities of the Board.

(B) All other members of the Board shall receive compensation at a rate to be established by the Board but not exceeding for any day (including traveltime) the daily equivalent of the effective rate for level IV of the Executive Schedule (5 U.S.C. 5315) while engaged in the performance of activities of the Fund, and may be paid per diem in lieu of subsistence at the applicable rate prescribed in the standardized Government travel regulations, as amended from time to time, while away from home or usual place of business in the performance of activities of the Fund.

OFFICERS AND EMPLOYEES

SEC. 305. (a) The Fund shall have a president, and such other officers as may be named and appointed by the Board

for terms and at rates of compensation fixed by the Board. All officers shall serve at the pleasure of the Board.

(b) No political qualification shall be used in selecting, appointing, promoting, or taking other personnel actions with respect to officers, agents, and employees of the Fund.

NONPROFIT AND NONPOLITICAL NATURE OF THE FUND

SEC. 306. (a) The Fund shall have no power to issue any shares of stock or to declare or pay any dividends.

(b) No part of the income or assests of the Fund shall inure to the benefit of any member, officer, employee, or any other individual except as salary or reasonable compensation for services and expenses.

(c) The Fund may not contribute to or otherwise support any political party or candidate for elective office.

PURPOSE AND GOALS

SEC. 307. (a) In carrying out the purpose and goals of the Fund, the Board, officers, and employees of the Fund shall be guided by the—

(1) policies of the International Health Subcommittee established in section 640(C) of the Foreign Assistance Act of 1961, as amended; and

(2) policies set forth in sections 101, 102, and 104 of the Foreign Assistance Act of 1961, as amended.

(b) To facilitate the improvement in the health status of the people in developing countries, the Fund shall carry out the following:

(1) The Fund shall establish communications with, provide a forum for the involvement of, and seek the advice and support of, private organizations, agencies, and groups involved in international health activities. The Fund shall review and analyze the need, and the public and private resources available, both within the United States and throughout the world for international health activities and determine which methods, programs, and activities offer the best opportunities for improving the health status of the people in the developing countries. Specifically, the Fund shall—

(A) provide a forum for a structured international exchange between government and private voluntary organizations on international health issues, problems, and financing opportunities;

(B) support the development of new international health activities in which both public and private organizations and agencies can participate;

(C) develop policy recommendations which are supportive of long-range approaches to improving the health status of the people in developing countries and which emphasize the coordinat-

ed and comprehensive approaches to addressing international health problems, including safe water supplies, sanitary waste disposal, and

(2) The Fund shall provide financial support to specific international health programs and projects sponsored by AID—qualified private voluntary organizations.

(3) The Fund shall assist the incorporation of improved and appropriate technology into international health activities by supporting systems of technical assistance and training.

ADVISORY PANEL

SEC. 308. The Board may appoint an advisory panel comprised of individuals with appropriate competencies and abilities. The principal function of the advisory panel shall be to provide advice for members of the Board.

ANNUAL REPORTS

SEC. 309. At the conclusion of fifteen months after the date of appointment of all members of the Board, and annually thereafter, the Board shall simultaneously submit a report to the President and the appropriate committees of the Senate and the House of Representatives on the Fund's progress, operations, activities, financial condition, and accomplishments and may include such recommendations as the Board deems appropriate.

SEC. 310. There are authorized to be appropriated to the Fund to carry out the provisions of this title, $10,000,000 for the fiscal year ending September 30, 1981, $10,000,000 for the fiscal year ending September 30, 1982, $10,000,000 for the fiscal year ending September 30, 1983, and $10,000,000 for the fiscal year ending September 30, 1984. Funds appropriated under this section are authorized to remain available until expended.

RECORDS AND AUDIT

SEC. 311. (a) The accounts of the Fund shall be audited annually in accordance with generally accepted auditing standards by independent certified public accountants or independent license public accountants certified or licensed by a regulatory authority of a State or other political subdivision of the United States. The audits shall be conducted at the place or places where the accounts of the Fund are normally kept.

(b) The report of each such independent audit shall be included in the annual report required by section 308. The audit report shall set forth the scope of the audit and include such statements as are necessary to present fairly the Fund's assets and liabilities, surplus or deficit, with an analysis of the changes therein during the year, supplemented in reasonable detail by a statement of the Fund's income and expenses during the year, and a statement of the sources and applica-

tion of funds, together with the independent auditor's opinion of those statements.

○

AMENDMENT NO. 1892

Purpose: To amend S. 1424 to provide international support for health services and personnel development.

IN THE SENATE OF THE UNITED STATES—96th Cong., 2d Sess.

S. 1424

To amend the Foreign Assistance Act and the Public Health Service Act to provide for the advancement of international cooperation and assistance in health, and for other purposes.

June 13 (legislative day, June 12), 1980

Referred jointly, by unanimous consent, to the Committees on Foreign Relations, Governmental Affairs, and Labor and Human Resources, and ordered to be printed

AMENDMENTS intended to be proposed by Mr. KENNEDY (for himself, Mr. JAVITS, Mr. WILLIAMS, Mr. PELL, and Mr. METZENBAUM)

Viz:

Strike all after the enacting clause and insert in lieu thereof the following:

"That this Act may be cited as the 'International Health Cooperation Act of 1980'.

"FINDINGS AND PURPOSE

"SEC. 2. (a) The Congress finds that—

"(1) the promotion of world health is an important humanitarian concern and an integral part of United States international policy;

"(2) the improvement of the health of the populations of developing countries will contribute to the economic and social development of such countries;

"(3) research, training, and application of appropriate levels of medical technology can be important factors in improving health abroad;

"(4) the United States has the resources, both human and technical, to provide such research, training, and medical technology to developing countries;

"(5) the efforts of developing nations to strengthen their internal health care systems and institutions should be supported by the United States;

"(6) the international health programs of the United States should include participation by universities, private voluntary organizations, and private industry;

"(7) the international health programs of the United States should be coordinated through multinational efforts; and

"(8) present United States international health efforts are insufficient both in their scope and coordination.

"(b) It is the purpose of this Act to assist developing and other nations to strengthen their health care systems and institutions by making available additional health care re-

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sources, encouraging multinational health-related activities, and improving coordination among the United States international health programs.

"AUTHORITY OF THE SECRETARY

"SEC. 3. The Secretary of Health and Human Services (hereafter referred to as the 'Secretary'), in carrying out the responsibilities of the Department of Health and Human Services (hereafter referred to as the 'Department') in the area of international health, shall—

"(a) support health sciences training programs in the United States and abroad;

"(b) participate in cooperative endeavors in biomedical and health services research, including participation with multinational organizations;

"(c) make grants or enter into contracts to support international health research;

"(d) identify, train, and assign such personnel as may be necessary to carry out research, training, and direct care delivery programs;

"(e) conduct necessary and appropriate investigations to assess the needs for disease control programs in other countries; and

"(f) provide resources to support emergency assistance in the case of natural or manmade disasters adversely affecting the health of individuals.

"OFFICE OF INTERNATIONAL HEALTH

"SEC. 4. (a) There is established within the Department an Office for International Health (hereafter referred to as the 'Office'), which shall be directed by a Deputy Assistant Secretary for International Health, who shall be appointed by the Secretary.

"(b) The Office for International Health shall be under the supervision of the Assistant Secretary for Health, and the Secretary shall provide the Office for International Health with such full-time professional and clerical staff and with the services of such consultants as may be necessary for the Office to carry out its duties and functions.

"(c) The Secretary, through such Deputy Assistant Secretary and in cooperation with other Federal health agencies, shall—

"(1) promote and coordinate international health activities within the Department;

"(2) be responsible within the Department for overall international health policy and planning, establishment of long-range international health goals and program assessment;

"(3) serve as the representative of the Department of Health and Human Services to the International Governmental Coordinating Group for International Health;

"(4) serve as the Department's contact with the World Health Organization, UNICEF, and other private international health organizations and groups; and

"(5) supervise the functions of the Fogarty International Health Center and the International Health Service Corps.

"(d) The Deputy Assistant Secretary may make grants and enter into contracts for the purpose of carrying out this section.

"(e) There are authorized to be appropriated to carry out the purposes of this section, $5,000,000 for the fiscal year beginning October 1, 1981, $5,000,000 for the fiscal year beginning October 1, 1982, and $5,000,000 for the fiscal year beginning October 1, 1983, provided that not less than 75 per centum of the amounts appropriated under this section shall be allocated by the Deputy Assistant Secretary for expenditure by agencies of the Department other than the Office.

"ESTABLISHMENT OF THE FOGARTY INTERNATIONAL HEALTH CENTER

"SEC. 5. (a) There is established within the Department the Fogarty International Health Center (hereinafter in this section referred to as the 'Center'). The Center shall—

"(1) undertake programs to facilitate the international exchange of biomedical and health-related information;

"(2) establish programs of fellowships and scholarships in the medical and health related fields; and

"(3) develop methods and procedures to assist in the planning and assessment of international health activities within the Department.

"(b)(1) The Center shall make grants and enter into contracts with educational institutions for the purpose of providing citizens of the United States and other nations, who have received training in medical and health-related fields, with graduate and post-graduate training related to problems of international health. Such training shall take place in the United States, and shall be in one or more of the following fields:

"(A) community medicine;

"(B) primary care medicine;

"(C) tropical medicine;

"(D) parasitology and other basic biomedical tropical disease research;

"(E) epidemiology and health information systems; and

"(F) public health, environmental health, health planning, health care organization and management, and health policy.

"(2) Such training may, as determined by the Secretary, include short-term field experience, long-term intensive academic and field experience, or initial work experience with international organizations or academic institutions.

"(c) The Center shall establish international health research and training centers for the purpose of establishing linkages with research and training activities being carried out by or within other nations. Each such center shall be based in the United States, shall establish an agreement with one or more research or educational institutions in a developing country, and in conjunction with such institution or institutions shall develop a program of applied research and training relating to the health problems of highest priority of such country. Each agreement shall provide for—

"(1) research and training activities, including field research and training, directed toward strengthening the capability of the host country to solve its principal health needs, with special emphasis on needs in the area of primary health care, human reproduction, public health, and tropical diseases; and

"(2) developmental assistance designed to strengthen the national health research and training systems of the host country.

"(d)(1) In coordination with the international health research training centers established pursuant to subsection (c), the Center shall establish a program to encourage private industry involved in multinational activities to focus resources and activities on the health problems of people in the developing world. Such program shall include—

"(A) a study of the health impact of multinational corporations, and the future impact such corporations might have;

"(B) recommendations regarding the planning, development, and evaluation of model health programs provided by multinational corporations for employees, their families, and the local community;

"(C) recommendations relating to the role of pharmaceutical companies in conducting research and developing products designed to control or eliminate the major causes of mortality or morbidity in the world, including methods of family planning; and

"(D) establishment of programs, including conferences and seminars, to educate and involve corporate executives in international health problems.

"(2) Within two years after the date of enactment of this Act, the Secretary shall report to Congress on the study and recommendations required by this subsection.

"(e) There are authorized to be appropriated to carry out the purposes of this section $10,000,000 for the fiscal year beginning October 1, 1981, $10,000,000 for the fiscal year beginning October 1, 1982, and $15,000,000 for the fiscal year beginning October 1, 1983.

"ESTABLISHMENT OF INTERNATIONAL HEALTH SERVICE CORPS

"SEC. 6. (a) There is established within the Department an International Health Service Corps (hereafter referred to as the 'Corps') under the supervision of the Deputy Assistant Secretary for International Health. The Corps shall—

"(1) provide health care services to developing countries with severe health personnel shortages; and

"(2) assist such countries in the organization and development of health care delivery and educational systems responsive to the health care needs of such countries.

"(b) The Corps shall be composed of—

"(1) practitioners in the health professions of medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, public health, nursing, and in other appropriate health professions; and

"(2) individuals whose principal expertise is in the planning, organization, management, delivery of health services, or health personnel development and training, provided that such individuals compose not more than 25 per centum of the Corps.

Members of the Corps shall be assigned tours of duty of up to three years, provided that the first such tour of duty shall be no less than twelve continuous months.

"(c) The selection of sites for members of the Corps shall be coordinated with the Agency for International Development and the Peace Corps, and first priority shall be given to sites at which Peace Corps members are already active and effective.

"(d) Corps members shall be organized into health service teams and each team shall participate in a training program prior to beginning work at an assigned site. The training of each team shall focus on the indigenous health care problems of the country to which the team will be assigned, and shall include instruction in such country's customs and languages. The Secretary may make grants to and enter into contracts with appropriate government or private entities for the provision of such training.

"(e) The Secretary may permit up to 10 per centum of the individuals providing and being reimbursed for obligated service (under section 331 of the Public Health Service Act)

pursuant to the National Health Service Corps Scholarship program (established under subpart IV, part c, title VII of the Public Health Service Act) to volunteer for service in the Corps in any given year if the Secretary determines that the domestic health needs of the United States would be otherwise adequately met.

"(f) There are authorized to be appropriated to carry out the purposes of this section, $5,000,000 for the fiscal year beginning October 1, 1981, $7,000,000 for the fiscal year beginning October 1, 1982, and $9,000,000 for the fiscal year beginning October 1, 1983.

"UNITED STATES MEDICAL EMERGENCY MISSION

"SEC. 7. (a) The Secretary is authorized to contract with a private voluntary organization for the purpose of establishing a mobile medical disaster relief service to be known as the United States Medical Emergency Mission. Such service shall be made available to any country experiencing a medical emergency upon the request of the country, and shall consist of such epidemiological survey assistance and medical care as may be needed as the consequence of a natural, manmade, or civil disaster. Such service shall be available within forty-eight hours following a request and may be continued in the requesting country for up to three months.

"(b) In order to enter into a contract to establish an international medical emergency relief service pursuant to this section, the sponsoring organization shall assure the Secretary that it has sought a high degree of multinational participation among the health care volunteers composing the Corps and broad based funding from both United States and international sources.

"(c) The President of the United States may, upon request of the sponsoring organization described in subsection (b), provide such emergency air transport, bulk medical supplies, and food as necessary.

"(d) There are authorized to be appropriated to carry out the purposes of this section, $1,000,000 for the fiscal year beginning October 1, 1981, $2,000,000 for the fiscal year beginning October 1, 1982, and $2,000,000 for the fiscal year beginning October 1, 1983. The Secretary is authorized to request additional appropriations as necessary to support ongoing major medical disaster relief projects.

"INTERGOVERNMENTAL COORDINATING COMMITTEE FOR INTERNATIONAL HEALTH

"SEC. 8. (a) There is established an Intergovernmental Coordinating Committee for International Health, to be composed of the Deputy Assistant Secretary for International Health, the Administrator of the Agency for International Development, the Director of ACTION, the Secretary of

State, the Secretary of Defense, the Secretary of Commerce, the Secretary of Agriculture, and the Secretary of the Treasury, or their designees, and a representative of private voluntary organizations active in international health matters. The chairman of the committee shall be selected by the members of the committee.

"(b) The committee established pursuant to subsection (a) shall review and promote coordination of the international health activities of the various agencies of the United States Government.

"(c) The committee established pursuant to subsection (a) shall annually submit to the Senate Committee on Labor and Human Resources and the House Committee on Interstate and Foreign Commerce, by no later than February 1 of each year, a report summarizing its activities for the prior year.".

Amend the title so as to read: "A bill to establish programs in international health, and for other purposes.".

Senator JAVITS. On my own behalf, I welcome this hearing very much and hope very much that we may draw from this hearing the necessary information, cumulative with what we have already received, to enable the committee to act on the bills which are before us.

On a cost-benefit ratio, no aid dollar can be better spent than in improving health, bearing in mind that health is the basic element in the motivation of the people in the developing countries.

Notwithstanding the magnitude of our U.S. international health budget, our responsibilities for international health activities within the Federal Government are not as yet clearly defined, and therefore it is very desirable that we define them to improve our total effort in this area.

I believe that by mobilizing the interest, expertise, and resources of our country we can aid substantially the developing countries to build their own capacity to control disease, train paramedics, plan health systems, and generally to address the serious health problems that now are such a great impediment to their economic and social growth and stability.

I have worked on this matter at least for 10 years, and I like to adopt the words of Dr. Kevin Cahill of New York, who is medical adviser to Governor Carey and a very old friend of mine, a leader in the field of tropical medicine, in which he says—and I quote: "Medicine is our untapped resource."

[The prepared statements of Senators Javits and Hatch follow:]

STATEMENT OF SENATOR JAVITS

Senator JAVITS. I am pleased to welcome our witnesses to these hearings regarding legislation introduced by Senator Kennedy and myself in the area of international health. S. 1424, the International Health Act of 1979 which I introduced last year, and Senator Kennedy's amendment to this legislation, the International Health Cooperation Act of 1980, both seek to strengthen the U.S. contribution to improving health care in developing countries and to emphasize international health as a priority in our development assistance efforts.

The amendment which I recently cosponsored with Senator Kennedy is focused solely on the role of the Department of Health and Human Services in the international health assistance effort, while S. 1424 embodies a more comprehensive perspective. I cosponsored this amendment because I believe that together, these two proposals form a sound basis for hearings before the Subcommittee on Health and Scientific Research to look at the full range of the Federal Government's role in international health assistance. As a result of these deliberations, we will be able to provide a comprehensive proposal for Senate consideration of the need to strengthen our partnership with the developing countries in this critical aspect of humanitarian assistance.

I believe that on a cost-benefit ratio basis, no aid dollar can better be spent than in improving the health and therefore the motivation of the people in developing countries. By improving health conditions, a developing nation's standard of living and overall economic development will improve, thus fostering an increased demand for U.S. products. This expansion of U.S. markets

in developing countries is essential for the U.S. economy. Hence, the United States also has a tremendous amount to gain economically by supporting developing countries health efforts. When economic growth is joined with the humanitarian objective of improving the health and the enjoyment of life of tens of millions in developing countries, it is almost inconceivable that we have not made this effort the centerpiece of our foreign aid to lesser developed nations.

Despite the magnitude of the total U.S. international health budget, responsibilities in this area are not clearly defined, Government-wide priorities and coordinated planning is lacking, and perhaps most problematic, clear leadership responsibility does not vest in any one agency; the legislation proposed by Senator Kennedy and myself seeks to remedy these shortcomings.

Besides improving the coordination and leadership of our current international health programs, our bills would direct additional resources to the key areas of manpower development, research, and private voluntary organization involvement. By mobilizing the interest, expertise, and resources of our country, I believe the proposed legislation can substantially aid the developing countries to build their own capacity to control disease, train paramedics, plan health systems, and to address the serious health problems that now impede their economic growth and stability.

My own interest and commitment in this area is rooted in my many years of involvement in both health issues and international matters as a member of both the Health Subcommittee of the Labor and Human Resources Committee and the Foreign Relations Committee. I introduced similar legislation in 1971 and 1978. I believed then, as I continue to believe now, that as a country preeminant in medical knowledge and skills, in the words of the distinguished Dr. Kevin Cahill, "medicine is our untapped resource." It can be called neither political nor military. It has the inherent capacity to rise above idological, political, or economic differences. It is an area that has long called for an increased commitment on our part to share our vast knowledge with the peoples of the Third World in cooperative and expertise relationships.

I would encourage those witnesses who are with us this morning to offer constructive suggestions with regard to the legislation proposed by Senator Kennedy and myself apart from the immediate restrictions in current budgetary limitations. It is our purpose today to consider structural improvements to the Federal Government's long-range capability to respond to the health problems of developing countries and to build a record to support a stronger role for the United States in the field of international health.

Statement of Senator Hatch

Senator Hatch. I believe we owe a special expression of gratitude to our colleague, Senator Javits, for his instigation in the holding of this hearing as well as for his continuing and unending promotion of better quality health care for everyone. The international character of today's hearing topic and the Javits' bill, "The International Health Cooperation Act," highlight an attitude I know all of us share.

This attitude is our common view that given our country's wealth, resources and incomparable abundance of international good will; it is natural, and it is proper that the United States should lead a worldwide effort to foster health care, especially among the poorer and developing nations of the world. Even if our country were prepared to isolate itself from the rest of the world, we would not be able to do so. The age in which the two oceans served as effective geographical fences is as obsolete as is the mistaken notice that the economic, political or in this case health policies or lack of such, in foreign nations would not affect us. Of our world's 4.1 billion people, more than a fourth live in indigent poverty. This number is increasing, outpacing even the population rates of the developing countries. This problem's configuration cannot help but to adversely affect the economic and political stability of the industrialized nations of the world, and especially our own.

All of us agree on the severity of the problem and support a national commitment contributing to the solution. Where we individually share differences is over the means. Speaking only for myself, I have many questions about how money can be used most effectively, how much of it can be used and how we should organize the specific international health mechanism to be authorized. Reading the preliminary outlines for the testimony to be delivered to the subcommittee, this morning, I was struck by the interrogative analysis of Dr. Joseph of AID, and Dr. Morgan for the National Council for International Health.

Their questions are also my question. That is, before committing myself to either the legislation or the omnibus amendment which are subject of today's exposition, I would like to know whether or not there is unnecessary administrative duplication between what is offered in the new proposals, and what is already available through the Agency for International Development, HHS, the Peace Corps and several other Federal auxiliary agencies. Would we in other words be creating new legislative authorities for areas in which existing U.S. agencies already have mandates? Despite the good intentions concerning the proposals' support for voluntary and private sector activity, how specifically would these independent, nongovernment efforts be affected?

To repeat, the goals stated in both S. 1424 and the proposed amendment to the legislation by Senator Kennedy are shared by all of us. Where there are questions concerning the means, perhaps today's hearing will provide the answers to these questions.

Senator JAVITS. Now, I hope the witnesses this morning will not be inhibited or backward in offering us suggestions, recommendations for change, as well as whatever criticism they feel is justified—I welcome it, and I consider it a distinctive contribution to the hearing, if without any concern about hurting anybody's feelings the witnesses are very direct and very pointed in their testimony.

Our first panel consists of Dr. John H. Bryant, Deputy Assistant Secretary for International Health, and Dr. Stephen Joseph, Deputy Assistant Administrator, Development Support Bureau, AID.

May I suggest, gentlemen, that if you do have an extensive statement that it be submitted for the record and that you confine your remarks in brief, each of you, to 10 minutes.

Dr. Bryant, would you be kind enough to proceed.

STATEMENTS OF JOHN H. BRYANT, M.D., DEPUTY ASSISTANT SECRETARY FOR INTERNATIONAL HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND STEPHEN C. JOSEPH, M.D., DEPUTY ASSISTANT ADMINISTRATOR, DEVELOPMENT SUPPORT BUREAU, AGENCY FOR INTERNATIONAL DEVELOPMENT

Dr. BRYANT. Thank you very much, Mr. Chairman. I am pleased to appear before you today on behalf of the administration in regard to S. 1424, the proposed International Health Act of 1979, and the proposed amendment to that bill, the International Health Cooperation Act of 1980.

The administration appreciates your support for international cooperation and assistance in health programs. We believe that the work of our Government, in cooperation with other countries and international organizations in health-related activities, is making and can continue to make significant contributions to the well-being of people throughout the world.

I have prepared a statement that I would like to submit for the record. At this time, I would like to summarize those major comments.

Senator JAVITS. Without objection, the statement will be included in full in the record.

Dr. BRYANT. My prepared statement includes a description of some of the more important health needs of developing countries, and particularly those that are related to the poorest countries.

But in summary I would like to go beyond that and emphasize my view that the nature of health and development problems in the developing countries varies greatly from country to country and is changing. The time scale of rates of development, for example, is changing. Some developing countries are now moving through health development phases in 5 to 10 years that took 25 to 50 years in the past. For example, while historically the more developed countries have generally proceeded sequentially through the spectrum of communicable diseases and chronic noncommunicable diseases and the health problems associated with social alienation, the developing countries must often deal with these problems simultaneously. Even the perception of health development in the more developed countries is changing as they recognize the health problems associated with a more advanced stage of development.

Therefore, while we must continue to focus on the pressing problems of the present, particularly of the poorest people in the poorest countries, increased attention is needed to the dynamics of health development of the sort that I have just referred to. Indeed, these challenges constitute a major reason for insuring that our agencies and universities are able to continually renew their capabilities for dealing with this changing international health scene.

With this context in mind, I would like to comment briefly on the provisions of the two legislative proposals, concentrating on

those that directly affect the Department of Health and Human Services. We appreciate the intent of the bills, to provide increased support for the role of Health and Human Services in international health and to establish a clear legislative mandate for this Department's international health activities. However, because of the urgent present need for budgetary restraint, we cannot support increased health and human services funding commitments at this time. In addition, we believe that the organizational provisions of the bill are not necessary to accomplish their purposes. I will briefly discuss the provisions of the proposed bills in order to illustrate these points.

Both bills under consideration would establish by law an interagency committee for coordinating U.S. Governmental international health activities. Both bills would also establish an Office of International Health and the position of deputy assistant secretary for International Health. These provisions would require by law the current arrangements that are functioning effectively. With regard to interagency coordination, the International Health Subcommittee of the Development Coordinating Committee, established in 1978, has been operating actively in the major policy and planning areas that would be established by the proposed legislation. The Office of International Health, and the position of Deputy Assistant Secretary for International Health, are also already mandated in regulations under the delegation authority of the Secretary of Health and Human Services.

In addition, we specifically oppose the provision that would make organizational changes with regard to the Fogarty International Center. We are firm in our position that the Fogarty Center should remain integral to the NIH. The Department has recently reviewed and clarified the functions of the center and a search for a new director is now under way.

To go on to the manpower development and institutional support provisions, both proposed bills would provide for expanding HHS legislative authority to include support for the training of U.S. manpower in the various subject areas of international health. They also authorize HHS to provide support for U.S. academic institutions to establish or strengthen international health programs, with emphasis on training and research, including collaborative relationships with institutions in developing countries.

These provisions raise at least two major issues. First, in order to contribute to and benefit from efforts to resolve common health problems, maintaining the quality of U.S. manpower and institutional resources, both governmental and private, is clearly essential. On this issue the Department of Health and Human Services is in full agreement with the intent of the proposals.

The second major issue raised by these provisions is related to the ultimate purpose of supporting U.S. institutions and manpower for international purposes. HHS believes that a major purpose, and certainly the key orientation, must be to assist institutions in developing countries to expand their own manpower resources and institutional capabilities. Thus, a balance must be sought between strengthening institutions and manpower in the United States, on the one hand, and in the developing countries, on the other. And, of course, they are closely interrelated.

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A related issue of balance has to do with the scope of manpower development programs. While the manpower needs of a given developing country can be determined with reasonable accuracy, the need for particular categories of U.S. personnel, trained in international health, cannot be so easily estimated, especially under the changing circumstances I have mentioned.

Thus, provisions for increased training opportunities for U.S. manpower in international health should allow flexibility to meet the changing needs and changing career opportunities.

In general, Health and Human Services believes that while this type of institutional and manpower support is very important, the current legislative authority of other Government agencies is sufficiently flexible to accommodate changing needs for U.S. Government support for academic institutions, both at home and abroad.

Both proposed bills would provide for a new program of a U.S. International Health Service Corps, to be administered by the Department of Health and Human Services in close consultation with AID, the Peace Corps, and the International Health Subcommittee as a whole. Each bill, however, proposes a different purpose for a corps.

S. 1424 emphasizes the use of a corps to promote the capacity of developing countries for meeting their requirements for trained manpower, service delivery, and planning in the health sector. The amendment to S. 1424 proposes that the corps help meet the service delivery needs of developing countries directly, through provision of health and medical services in local settings.

The Department of Health and Human Services has had a long-standing interest in the concept of an International Health Service Corps, and the Department supports the concept of using U.S. health professionals more effectively in relation to health needs in developing countries, and we believe the United States itself could benefit more substantially from the experiences of our health professionals in dealing with health development problems.

At this time, however, we cannot support the specific legislative proposals under consideration that would establish a new, permanent organizational entity with specified functions. Our reasons are not only the need for fiscal restraint, but also that the purposes and the functions of the proposed International Health Service Corps are not yet clearly worked out.

We have recently been reviewing the possibilities of the further use of U.S. health professionals in health development efforts in developing countries through collaborative interagency arrangements, building on their respective expertise in health and development, and using their diverse authorities. We believe that a period of exploration of the subject, including some practical field trials, could be useful in later specifying the appropriate scope and orientation of a larger-scale effort.

Finally, with regard to the proposed Humphrey Fund and the U.S. Medical Emergency Mission, the Department of Health and Human Services concurs with the intent of these provisions to support the valuable work of the private and voluntary organizations, and to maintain a high degree of readiness to respond to medical emergencies. However, we must point out again that legislative authority for these purposes already exists.

In summary, the Department of Health and Human Services is in accord with the purpose of these bills to give further support to international health. We are convinced that the United States can contribute through its involvement in international health to the well being of people throughout the world, as well as in the United States.

We also believe these activities can have a positive impact on U.S. foreign policy. Indeed, we encourage those interested in the field to maintain a broad and future-oriented perspective in order to encompass the variety of issues involved and the rapid changes that are taking place. While favoring the purposes of the legislation, the Department of Health and Human Services cannot support the specific proposals because they are, as described above, duplicative of existing authority and because they would preempt some of the Secretary's authority for departmental organization and delegation of responsibility.

At the same time we appreciate that the reasons for putting the bills forward have to do not only with legislative authority, but also with wanting these activities to have the priority and resources necessary to support strong programs. In these latter matters we also have difficulty, since we cannot support legislation that would either be inconsistent with the need for fiscal restraint or compete with our Department's existing domestic and international priorities.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions. Thank you.

[The prepared statement of Dr. Bryant follows:]

STATEMENT OF JOHN H. BRYANT, M.D.

DEPUTY ASSISTANT SECRETARY FOR INTERNATIONAL HEALTH

I. Introduction

Mr. Chairman and members of the Committee, I am pleased to appear before you today on behalf of the Administration in regard to S.1424, the proposed International Health Act of 1979, and the proposed amendment to that bill, the International Health Cooperation Act of 1980.

The Administration appreciates your support for international cooperation and assistance in health programs. We believe that the work of our Government in cooperation with other countries and international organizations in health-related activities is making and can continue to make significant contributions to the well-being of people throughout the world.

I would like to describe briefly my Department's major activities and initiatives in international health. My comments on the proposed legislation can then be placed in a perspective that takes account of our current contribution and priorities.

II. Current HHS Activities in International Health

The Department of Health and Human Services (DHHS) has a broad involvement in international health. While these activities often consist of individual, scientist-to-scientist collaboration, most of the international health activities of the Department are pursued through

specific organizational arrangements, either through multinational organizations, such as the World Health Organization (WHO), or through binational arrangements with other countries. In both instances we coordinate carefully with the Department of State and with the Agency for International Health (AID) as appropriate.

With respect to WHO, the U.S. is, of course, a member nation of the Organization, and the DHHS has responsibility for coordinating U.S. governmental relationships with WHO. I serve as the U.S. Member on the Executive Board.

The United States is by far the largest contributor to the regular budget of WHO (25 percent) and also contributes earmarked funds on a voluntary basis.

In addition to fiscal contributions, substantive U.S. participation in the programs of WHO, has been of major proportions. An American scientist led the WHO program to eradicate smallpox. Another American, from the Center for Disease Control (CDC),directs WHO's expanded program on immunization, which is of such worldwide importance. Still another plays a key role in the international program to control diarrheal diseases.

Another important channel for our international health activities is through binational arrangements. Some of these

arrangements are long standing, such as those with Japan, the Soviet Union, Poland,and Egypt, while others are only recently developed or renewed, such as those with China, Israel, Nigeria, and India. As a further example, DHHS is now planning, in conjunction with the State Department, cooperative health programs with Oman and Kuwait. Plans are also under way with the Office of Science and Technology Policy (OSTP) and various agencies to visit selected African countries as part of science and technology initiatives, including health. As a follow-up to Secretary Harris' recent visit to Africa, a high level delegation from Nigeria will be visiting next month to develop further plans for collaboration with HHS to strengthen several components of their national health plan.

The binational cooperative activities carried out by HHS are much more than ceremonial. Considerable sharing of scientific knowledge is involved, with a continuous building of professional friendships and mutual trust. These activities become essential components of stable international relationships.

In these binational relationships, DHHS calls extensively on the resources and capabilities of the various agencies of the Department. It is in the National Institutes of Health (NIH), Alcohol, Drug Abuse and Mental Health

Administration (ADAMHA), Center for Disease Control (CDC), Food and Drug Administration (FDA), Health Resources Administration (HRA), Health Services Administration (HSA) and the various centers for policy, planning, research, and statistics, that the capabilities for international health of the Department reside.

Apart from the formal governmental relationships in international health, the work of our scientists in the field and in their laboratories contributes importantly to the resolution of international health problems. Examples include:

- the isolation and identification of the rota virus, one of the major causes of infantile diarrhea, with the highly likely possibility of a vaccine being developed against that virus;
- striking advances in the immunology of malaria, with the possibility drawing near of vaccine protection against that persisting disease in the developing world.

These are only brief examples of the extensive involvement of DHHS in international health and how we pursue those activities through multiple channels and in close coordination with relevant departments and agencies of Government and the private sector.

It is appropriate at this point to place the activities of HHS more generally in the context of the health needs of developing countries.

III. Health Needs of the Developing Countries

The Administration believes that priority must be given to the poorest countries, and to the poorest and most vulnerable populations wherever they are.

In the less developed countries (LDC's), the most pressing needs are for assistance in developing basic health services (also referred to as primary health care) with emphasis on the following areas:

- health system development, including health planning, health data systems and management;
- disease control, including epidemiological surveillance, expanded programs of immunization, and other approaches to controlling tropical diseases;
- programs for dealing with population growth and overly large families;
- malnutrition, particularly as related to maternal nutrition, low birth-weight babies and protein energy malnutrition in young children;
- water and environmental sanitation; and,
- manpower development and training relating to these areas.

Additionally, LDC's are increasingly calling attention to their needs in the areas of:

- foods, drugs and potentially hazardous products, including related legislation and regulation, standards and quality control, and production and distribution;
- occupational health and safety; and,
- broader environmental concerns, including environmental spoilage and chemical toxicity.

As nations look toward the turn of the century, keeping in view WHO's goal of Health for All by the Year 2000 (HFA/2000), it is increasingly clear that every country, whatever its stage of economic development, is confronted with health problems that arise from its particular phase of development. Historically, health problems have come in three phases:

1. infectious and parasitic diseases compounded by nutritional deficiencies. Currently, these diseases are usually associated mainly with the least developed tropical countries;
2. chronic degenerative diseases, particularly cardiovascular diseases and cancer, and accidents, which become more prevalent as the infectious and parasitic diseases subside; and,

3. health problems associated with changing social norms and often with social alienation. Such problems include alcoholism, drug abuse, teenage pregnancies, homicide and suicide, and extreme absenteeism from work. This group of problems tends to be most prevalent in those societies that are most developed economically.

A curious and important phenomenon is that while the more developed countries have generally proceeded through these three phases sequentially, many of the LDC's are now having to deal with them simultaneously. Further, as the LDC's look ahead to the health problems of the more developed countries, they are asking: must we all proceed through the same development phases? Botswana is asking, "Is it inevitable that we acquire the prevalence of cardiovascular disease and carcinoma of the lung of Europe, and the adolescent health problems of the U.S.?" And the U.S. might well ask if it is headed toward the health situation of the Netherlands: total coverage of the population with modern health services but, nevertheless, 20 percent absenteeism from work, mostly for reasons that have obstensibly to do with health.

Thus, the nature of health and development problems in the LDC's varies greatly and is changing. The time scale

of rates of development is changing: some LDC's are now moving through health development phases in five years that took 25 or 50 years in the past. Even the perception of health development in the more developed countries is changing. Therefore, while we must continue to focus on the pressing problems of the present, increased attention needs to shift to various aspects of the dynamics of health development. These emerging issues constitute major challenges to global health efforts,and certainly to U.S. agencies and institutions. Indeed, these challenges constitute a major reason for ensuring that our agencies and institutions are able to continually renew their capabilities for dealing with this changing international scene.

IV. Comments on Provisions in the Bills

General

With this context in mind, I would like to comment briefly on the provisions of the two legislative proposals, concentrating on those that would directly affect HHS authorities. As I have mentioned, we appreciate the intent of the bills to provide increased support for the role of HHS in international health and to establish a clear legislative mandate for HHS international health activities.

However, because of the urgent present need for budgetary restraint, we cannot support increased HHS funding commitments at this time. Related to this "same" reason, the proposed expansion of HHS international program authorities might also jeopardize the Department's ability to maintain its commitments in meeting domestic health needs, as well as the current international health commitments and priorities that I have just summarized. In addition, we believe that the organizational provisions of the bills are not necessary to accomplish their purposes. I will briefly discuss the provisions of the proposed bills in order to illustrate these points.

Organizational Changes

Both bills under consideration would establish, by law, an interagency committee for coordinating U.S. Governmental international health activities. Both bills would also establish an Office of International Health and the position of Deputy Assistant Secretary for International Health in HHS. These provisions would require by law the current arrangements that are functioning effectively.

With regard to interagency coordination, my Department and indeed all the member agencies of the International Health Subcommittee of the Development Coordination Committee (IHS/DCC) have shown a strong commitment to maintaining

an effective and continuing coordination mechanism for all major U.S. Government international health programs. Thus, the existing IHS, established in 1978, has been operating actively in the major policy and planning areas that would be established by the proposed legislation.

The Office of International Health and the position of Deputy Assistant Secretary for International Health are also already mandated in regulations under the delegation authority of the Secretary of HHS.

Thus, since these provisions would establish by statute mechanisms that are functioning under current authorities, we question the need for new authorities.

In addition, we specifically oppose the provision that would make organizational changes with regard to the Fogarty International Center (FIC). We are firm in our position that the Fogarty International Center should remain integral to NIH. The FIC provides a focus for enhancing the role of NIH in promoting and coordinating international cooperation in all aspects of biomedical research. The Department has recently reviewed and clarified the functions of the Fogarty International Center and a search for a new Director is now well under way.

In general, we believe that to establish such organizational changes by law unnecessarily limits the flexibility of the Secretary in determining program management arrangements in the context of the Department's overall needs.

The merits of establishing new program authorities for manpower training and academic institution support, which are proposed in one of the bills in association with the Fogarty International Center, ought to be considered separately from the issue of their organizational placement. I want to turn now to these more substantive program issues.

Manpower Development and Institution Support

Both proposed bills would provide for expanding HHS legislative authority to include support for the training of U.S. manpower in the various subject areas of international health. They also authorize HHS to provide support for U.S. academic institutions to establish or strengthen international health programs, with emphasis on training and research, including collaborative relationships with institutions in LDC's.

These provisions raise at least two major issues. First, in order to contribute to and benefit from efforts to resolve common health problems, maintaining the quality

of U.S. manpower and institutional resources - both governmental and private - is clearly essential. On this issue, HHS is in full agreement with the intent of the proposals.

The second major issue raised by these provisions is related to the ultimate purpose of supporting U.S. institutions and manpower for international purposes. HHS believes that a major purpose and certainly the key orientation must be to assist institutions in developing countries to expand their own manpower resources and capabilities. Thus, a balance must be sought between strengthening U.S. and LDC institutions and manpower.

A related issue of balance has to do with the scope of manpower development programs. While the manpower needs of a given developing country can be determined with reasonable accuracy, the need for particular categories of U.S. personnel trained in international health cannot be so easily estimated, especially under the changing circumstances I have mentioned. Thus, provisions for increased training opportunities for U.S. manpower in international health should allow flexibility to meet changing needs and changing career opportunities.

In general, HHS believes that, while this type of institutional and manpower support is very important, the current

legislative authority of other Government agencies is sufficiently flexible to accommodate changing needs for U.S. Government support for academic institutions, both at home and abroad. Thus, it appears to us that the more basic legislative issue is funding, rather than legislative authority. Although I cannot speak to the funding needs of programs administered by other Government agencies, I can address the impact that the proposals would have on HHS.

In a time in which priorities must be very carefully chosen, HHS believes that its commitment to fulfilling its domestic mandate must receive highest priority. In this regard, I must emphasize that this commitment does not deter us from carrying out our current responsibilities in international health, or from increasing those efforts as far as possible without additional resources.

International Health Service Corps

Both proposed bills would provide for a new program of a U.S. International Health Service Corps, to be administered by the DHHS, in close consultation with AID, the Peace Corps, and the International Health Subcommittee as a whole. Each bill, however, proposes a different purpose for a Corps. S.1424 emphasizes the use of a Corps to

promote the capacity of developing countries for meeting their requirements for trained manpower, service delivery and planning in the health sector. The amendment to S.1424 proposes that the Corps help to meet the service delivery needs of developing countries directly, through provision of health and medical services in local settings.

The DHHS has had a long-standing interest in the concept of an International Health Service Corps. We have held numerous discussions over the past two years regarding the specific needs for such a Corps, types of manpower that would be required relative to the willingness of such manpower to serve overseas, alternative organization and administrative arrangements, and cost implications.

One of the major conclusions that we have reached is that a "single purpose" Corps that offered one predominant set of skills to developing countries would not seem to serve the varied and broad scope of LDC needs. Further, we have concluded that the activities proposed by either bill are possible now under the collective authorities of the relevant Federal agencies, and are in various ways being carried out now.

DHHS supports the concept of using U.S. health professionals more effectively in relation to health needs in developing countries, and we believe the U.S. itself could benefit more substantially from the experiences of our health professionals in dealing with health development problems.

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At this time,however, we cannot support the specific legislative proposals under consideration that would establish a new permanent organizational entity with specified functions. Our reasons are not only the need for fiscal constraint, but also that the purposes and the functions of the proposed International Health Service Corps are not clearly worked out. We have recently been reviewing the possibilities of the further use of U.S. health professionals in health development efforts in developing countries through collaborative interagency arrangements, building on their respective expertise in health and development and using their diverse authorities. We believe that a period of exploration of the subject, including some practical field trials, could be useful in later specifying the appropriate scope and orientation of a larger scale effort.

Now I would like to comment briefly on two other provisions in the bills, though these would affect HHS international program authorities less directly.

Humphrey Fund

S.1424 would establish a fund, administered by a private corporation, that would support small scale international health projects sponsored by non-profit organizations.

HHS concurs with the support of this provision for the private voluntary organizations (PVOs),which have made significant contributions to meeting international health needs through their responsiveness, creativity and use of highly varied approaches to service delivery, training, and health system development. However, we question the need for creating additional legislative authority in this area, since mechanisms for funding PVOs' activities already exist in other Government agencies.

U.S. Medical Emergency Mission

Finally, the amendment to S.1424 proposes a U.S. Medical Emergency Mission, to be administered by a private organization under contract with the DHHS. The Mission would consist of a voluntary cadre of U.S. health professionals willing to accept short-term assignments at short notice to provide assistance to countries requesting emergency medical and related services to deal with national, man-made, or civil disasters.

Again, we are in agreement with the intent of maintaining a high degree of readiness to be able to respond to needs for emergency medical assistance. Here, too, there is no doubting the essential role that is now being played and will continue to be played by the PVOs. In addition, we agree that there may be a need for strengthening

coordination of emergency medical assistance in the private sector and that private sector efforts must be carefully coordinated with established governmental arrangements. However, since mechanisms to do this exist under current legislative authority, we question the need for new authority.

V. Concluding Remarks

In summary, DHHS is in accord with the purpose of these bills to give further support to international health. We are convinced that the U.S. can contribute through its involvement in international health to the well-being of people throughout the world, as well as in the U.S. We also believe these activities can have a positive impact on U.S. foreign policy. Indeed, we encourage those interested in the field to maintain a broad and future-oriented perspective in order to encompass the variety of issues involved and the rapid changes that are taking place.

While favoring the purposes of the legislation, the DHHS cannot support the specific proposals, because they are, as described above, duplicative of existing authority, and because they would preempt some of the Secretary's authority for Departmental organization and delegation of responsibility. We appreciate that the reasons

for putting the bills forward have to do not only with legislative authority, but also with wanting these activities to have the priority and resources necessary to support strong programs. It is in these latter matters that we have the greatest difficulty. We cannot support legislation that would either be inconsistent with the need for fiscal constraint or compete with our Department's existing domestic and international priorities.

Mr. Chairman, this concludes my prepared Statement. I will be happy to answer any questions you may have.

Senator JAVITS. Thank you very much. I think we will hear the whole panel and come back.

Dr. Joseph?

Dr. JOSEPH. Thank you. Mr. Chairman, I am pleased to appear today to testify on behalf of the Agency for International Development regarding Senator Javits' international health bill, S. 1424, and the amendments to it introduced by Senator Kennedy.

My colleagues and I in the field of international health are deeply appreciative of the support given over the years by the sponsors of this legislation to the important issues of the health and well being of the populations of developing countries, and for your sustained encouragement of a greater and more effective U.S. role in relieving the burdens of disease and malnutrition which are borne by such a large proportion of those populations.

I will not take the time in my verbal statement to detail the health needs of the developing world with which you are quite familiar. But before commenting specifically on the proposed legislation, I would like to review my agency's efforts in this field.

AID, and the International Development Cooperation Agency (IDCA) of which AID is now a part, have given recognition to the importance of the problems of health in the developing world by designating population and health as one of the priority areas for AID assistance, along with food and nutrition, and energy.

AID, as the principal U.S. Government agency that provides health assistance to developing countries, has established a health sector policy that recognizes four priority areas, as I will describe below.

Since 1977, funding in AID health and population accounts has doubled from about $150 million to a level of around $300 million. Congress authorizes AID's assistance program in an annual International Development and Food Assistance Act, and has declared that assistance should be concentrated on poor countries, particu-

larly those countries prepared to make effective use of such assistance.

In health our four priority areas are: One, basic health, nutrition, and family planning services (primary health care); two, safe water and sanitation; three, disease prevention and control; and four, health policy, planning, and management.

Primary health care is AID's first health sector priority. The agency will continue to place principal emphasis on this health-promoting strategy. AID is funding approximately 47 primary health care projects in 1980 at a cost of approximately $83 million. Our major objective here is to assist countries to extend access to primary health care to larger and larger proportions of their rural population, with the ultimate objective of total population coverage. The specific mix of health services that is most feasible and necessary in a given country will, of course, vary.

In addition to assistance with country-specific health projects, we have been closely involved with the World Health Organization in furthering the goal of health for all by the year 2000, which was agreed upon by virtually all nations in Alma Ata in 1978, especially with regard to the need for larger scale donor coordination.

In water and sanitation, the goals of the administration's current initiative for the International Drinking Water and Sanitation Decade were enunciated at the U.N. Water Conference held at Mar del Plata in Argentina in 1977. There we joined with the developing countries and other donors in establishing the 1980's as the decade for expanding the availability of drinking water and sanitation. The goal of the decade is to provide safe drinking water and adequate sanitation for all by 1990. Here again, AID is the primary U.S. agency responding to the global effort and supporting safe drinking water and adequate sanitation programs in the poor countries.

In our assistance in this area, we will place major emphasis on training and institutional development in the developing countries rather than on heavy capital infrastructure. This assistance will complement the infrastructure development efforts of other donors, especially the World Bank, which is now spending $1 billion annually in this area.

AID's funding for water and sanitation was approximately $200 million in 1979, and, although lower in 1980, is again planned for about $200 million in 1981.

With regard to tropical diseases, again I won't repeat the statistics of the toll this takes in the developing world with which you are familiar. Our research efforts in this field are in response to the lack of adequate methods of prevention, diagnosis, and treatment which would be applicable to mass populations in the developing countries.

AID is supporting an international research network to develop an effective vaccine against malaria. Support is being given to about 12 different grantees, and recently several major breakthroughs have occurred. Future development of a vaccine is a real possibility in the coming years of the eighties.

We are also supporting a multidonor effort to find more effective and more economical means for diagnosis, treatment, prevention and control of six major tropical diseases. This support to the

World Health Organization in tropical disease research is planned for approximately $20 million over 6 years. We are in the mid-stream of that activity.

We are also contributing to the International Center for Diarrheal Disease Research in Bangladesh for their program of research and training. ICDDR was established in June of 1979 following 18 years of operation of a cholera research laboratory in which the United States was the major donor.

In health policy, planning, and management, our fourth area of emphasis, we support a health planning program that emphasizes three types of activities: One, training of country personnel to design, implement, and evaluate strategies, particularly integrated low-cost primary health care to increase the availability of health services to the rural and urban poor; two, the collection, analysis, and utilization of information from health projects in the field; and three, collaboration with other donors and developing countries in special studies to advance the state of knowledge of the health and nonhealth interventions most effective in improving health in developing countries.

Since health depends not only on health sector programs but also on agriculture, nutrition, education, economic policies, and population growth, AID, through its broad range of development activities, is in a unique position among U.S. agencies to effectively promote health status in developing countries. We think especially important in that regard is the presence of overseas resident staff in AID missions who are able to work with their counterparts in health ministries on a sustained basis.

Now, with regard to the legislative proposals under consideration today, I would like to make a few general comments and then speak to specific provisions of S. 1424 and the proposed amendments. Though many of the proposals refer to legislative authorities of the Department of Health and Human Services, I shall address them as they relate to the Foreign Assistance Act. In addition, my colleague, Jack Bryant, and I are cochairmen of an interagency coordinating committee on international health, of which I will have more to say in a moment. My remarks will also reflect the position taken on S. 1424 by that group.

AID and IDCA appreciate the intent of the proposed legislation, and fully agree that international health deserves greater attention, particularly in the field of primary care. We conclude, however, that the proposed legislation may not be the most appropriate way to increase the attention we devote to international health, because it would duplicate a number of existing authorities already available to AID, HHS, and Peace Corps. We also believe that interagency coordination in this field is now working well and thus needs no additional legislative authority.

We perceive, Senator Javits, three major reasons why we cannot support the legislation as currently proposed.

One. S. 1424 and the proposed amendments introduce significant additional budgetary requirements at a time when resources are extremely limited.

Two. The legislation would establish new authorities in areas where U.S. agencies already have existing mandates.

Three. Underlying the proposals is a concept of filling the gaps, of deploying Americans to fill in where LDC personnel are unavailable. This could conflict with AID's philosophy of development, helping LDC's to create independent mechanisms at appropriate levels of technology, in order to meet the health needs of their people.

As to specific provisions of the proposed legislation directly relevant to AID, we believe that legislative provision for an intragovernmental coordinating committee for international health is unnecessary. This function is currently fulfilled by the International Health Subcommittee of the Development Coordination Committee—this DCC is chaired by the Administrator of IDCA—The International Health Subcommittee includes representation from all major U.S. Government agencies involved in international health, meets on a regular monthly basis, and not only performs an information-sharing function, but also serves as a forum for cross-agency programs and policy concerns. A system of interagency cross-tabulation of international health budgets has been developed and is being put in place. This committee grew out of a study done under the leadership of Dr. Peter Bourne in 1977-78, and we believe that the existing mechanism is effective and adequate.

The proposed legislation provides for financial support for U.S. institutions to train students and conduct research in international health. The amendments, through the Fogarty International Center, go a step further to support collaborative training and research between U.S. universities and counterpart universities in developing countries. AID acknowledges the need to train a new generation of U.S. specialists in international health, and strongly endorses efforts to develop this expertise in developing countries. In fiscal year 1979, the latest year for which such data are available, AID funded nearly $28 million in grants and contracts to U.S. academic institutions specifically for research and training in the interrelated fields of health, population, and nutrition in developing countries. This figure does not include substantial support given to LDC universities for health research and training carried out in conjunction with AID's projects in health, population, and nutrition.

The proposed legislation calls for establishment of the Hubert H. Humphrey Fund for International Health to coordinate between Government and private voluntary organizations in international health, and to fund PVO international health projects. Over the years AID has developed a strategy for the involvement of PVO's in all fields of endeavor in LDC's, including health. PVO's funded by IAD have very effectively implemented projects that deliver, among other things, primary health care, and water and sanitation to poor communities in many countries. Assigning this function to a new and separate institution could disrupt coordination and prove duplicative and wasteful.

The Kennedy amendments call for the establishment of a U.S. medical emergency mission, organized by a private organization, to send health professionals on a short-term basis to disaster areas. Both AID and the Department of State are at present involved in medical disaster relief activities. The Department of State provides grants principally to international organizations, notably the U.N.,

but also provides disaster relief grants to PVO's. AID depends on the expertise of such U.S. Government agencies as the Department of Defense and the Health and Human Service's Center for Disease Control, who have the experience and facilities needed to respond expeditiously in times of natural and manmade disasters.

Finally, the legislation calls for the creation of an international Health Service Corps as a means of alleviating the shortage of trained public health personnel in developing countries. From its experience helping to develop cadres of trained health workers in LDC's, AID is aware of the severity of this problem. However, the pending legislation concentrates on higher level health personnel and calls for them essentially to fill in for LDC personnel, mostly providing direct health care services. This may be an admirable gesture, but we at AID feel that it can do little to solve the problem, given the magnitude of personnel shortages in LDC's.

U.S. efforts to solve health personnel shortages should aim at developing cadres of workers who can provide primary health care in the villages, consistent with the Alma Ata resolution, endorsed by the United States and developing countries alike. Finally, AID believes that U.S. support for health in LDC's is most effective when we help these countries generate their own legions of personnel, rather than sending our people overseas as a short-term, short-gap measure. Thus, AID endorses the use of U.S. funds principally to train community level health workers, a long-term solution that will enable LDC's to sustain primary health care programs independent of outside assistance.

We do not feel that a clear need exists for a specific legislatively mandated large cadre of U.S. health professionals who would spend 2- or 3-year periods in international work, as described in the proposed legislation. Opportunities and legislative authority for such service currently exist in AID, Peace Corps, and in CDC and elsewhere in HHS. The real need is for a longer term career structure for a relatively small number of U.S. health professionals who could move back and forth across agency lines, and in and out of university, PVO, and foundation settings as well as Government service. The United States has never been able to adequately provide appropriate career patterns—in or outside of Government—in international health, but the problem is not one of the lack of legislative authority.

We would favor, Senator Javits, a small-scale attempt to develop a coordinating activity, based in Health and Human Services, and collaborating with such agencies as AID, Peace Corps, CDC, et cetera, for placement for field service. In our view, this could and should be undertaken on a trial basis under existing legislative authority, so that questions of supply and demand, most appropriate types of skill recruitment and training, career potentials, et cetera, can be carefully worked out.

In closing, I would like to reiterate that while we cannot support the proposed specific legislation, because of the reasons I have detailed, we are grateful for the committee's interest, which has underscored the importance of the United State's continuing involvement in international health.

I would be happy to amplify any points or to respond to any questions you may have.

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Senator JAVITS. Thank you very much, Dr. Joseph, and thank you, Dr. Bryant.

[The prepared statement of Dr. Joseph follows:]

TESTIMONY OF

Stephen C. Joseph, M.D.
Deputy Assistant Administrator for Human Resources

BUREAU FOR DEVELOPMENT SUPPORT
AGENCY FOR INTERNATIONAL DEVELOPMENT

Mr. Chairman and members of the Committee, I am pleased to appear before the Senate Subcommittee on Health and Scientific Research today to testify on behalf of the Agency for International Development regarding Senator Javits' International Health Bill (S.1424) and the amendments to it introduced by Senator Kennedy.

My colleagues and I in the field of international health are deeply appreciative of the support given over the years by the sponsors of this legislation to the important issues of the health and well-being of the populations of developing countries, and for your encouragement of a greater and more effective U.S. role in relieving the burdens of disease and malnutrition which are borne by such a large proportion of those populations.

I will not take the time in my statement to detail the health needs of the developing world; your Committee is familiar with the patterns of infectious and parasitic diseases, set against a background of acute and chronic malnutrition that afflict the world's poor, and combined with high birth rates. These patterns are reflected in such statistics as infant mortality rates more than 10 times higher than the affluent industrialized countries, early childhood death rates up to 20 times higher, and maternal mortality rates up to 100 times higher. I have attached to my statement a reference chart which shows mortality and fertility data for each of the world's nations; I would be happy to discuss the details or implications of these data in response to your questions.

Before commenting specifically on the proposed legislation, I will review my Agency's efforts in this field.

The Agency for International Development (A.I.D.), and the International Development Cooperation Agency (I.D.C.A.) of which A.I.D. is a part, have given recognition to the importance of the problems of health in the developing world by designating population and health as one of the priority areas for A.I.D. assistance, along with food and nutrition, and energy.

A.I.D., as the principal U.S. government agency that provides health assistance to developing countries, has established a health sector policy that recognizes four priority areas, as I will describe below.

A.I.D.'s involvement in health assistance to developing countries goes back almost forty years. In the 1940's cooperative health and sanitation programs in Latin America were developed. Beginning in the 1950's as part of the Point IV Program, there was an expansion of these activities including major categorical disease control programs in Asia, Africa, and the Near East.

In the early 1960's when our overall A.I.D. strategy stressed attempts to raise GNP, direct health sector assistance decreased. During this period much of A.I.D.'s large professional health and sanitation staff left the Agency or moved into other fields. In the late 1960's, however, A.I.D. worked with the Communicable Disease Center of H.E.W. in support of the global efforts to control measles and eradicate smallpox. In the 1970's, with the shift in emphasis away from GNP growth to a "basic human needs" approach to development, interest in the social sectors revived, with a particular concern to find ways

to adapt the developed world's expensive high technology health system so as to be relevant to health problems of poor countries.

In LDC situations where resources for health are very limited (generally less than $3-5 per capita per year versus about $800 in the U.S.) and the formal health systems often reach no more than 25 percent of the population, the first concern needs to be for broad population coverage by well-managed low-cost services tailored to the health needs of the population; services that can be delivered independent of physicians and other scarce, highly-trained personnel, and services that are not dependent upon sophisticated technology.

Since 1977, health funding in A.I.D. accounts has doubled from about $150 million to a level of around $300 million; Congress authorizes A.I.D.'s assistance program in an annual International Development and Food Assistance Act, and has declared that assistance should be concentrated on poor countries, particularly those countries prepared to make effective use of such assistance. In health, our four priority areas are: (1) basic health, nutrition, and family planning services (primary health care); (2) safe water and sanitation; (3) disease prevention and control; and (4) health policy, planning and management.

1. Primary Health Care

Primary health care is A.I.D.'s first health sector priority. The Agency will continue to place principal emphasis on this health-promoting strategy. A.I.D. is funding approximately 47 projects in 1980 at approximately $83 million for primary health care. Our major objective is to assist countries to extend access to primary health care to larger and larger proportions of their rural population -- with the ultimate objective of total population coverage. The

specific mix of health services that is most feasible and necessary in a given country will vary, of course.

In addition to assistance with country-specific health projects, we have been closely involved with the World Health Organization in furthering the goal of Health for All by the Year 2000 (agreed upon by virtually all nations in Alma Ata in 1978), especially with regard to the need for larger-scale donor coordination.

2. Water and Sanitation

The goals of the Administration's current initiative, for the International Drinking Water and Sanitation Decade, were enunciated at the U.N. Water Conference at Mar del Plata, Argentina in 1977. There the United States joined with the developing countries and other donors in establishing the 1980's as the decade for expanding the availability of drinking water and sanitation. The goal of the decade is to provide "safe" drinking water and adequate sanitation for all by 1990. Here again, A.I.D. is the primary U.S. agency responding to the global effort and supporting safe drinking water and adequate sanitation programs in the poor countries.

In its assistance in water and sanitation, A.I.D. will place major emphasis on training/personnel development/LDC institutional capability, rather than heavy capital infrastructure. This will complement the infrastructure development efforts of other donors, especially the World Bank, which is spending a billion dollars annually in this area.

Funding from A.I.D. for water and sanitation was close to $200 million in 1979, and although lower in 1980, is planned for about $200 million again in 1981.

3. Tropical Diseases

The magnitude of the communicable disease problem, particularly in the tropics, is staggering. Hundreds of millions of the world's inhabitants suffer the effects of parasitic and other diseases and many more are at risk. Reliable epidemiological data on the prevalance and dynamics of communicable diseases in the developing countries are sparse. Estimates of the population infected by schistosomiasis range from 200 to 300 million, with estimates of 1.5 to 2 billion at risk. Malaria plagues at least 200 million people, and filariasis infects approximately 300 million people around the globe. Many individuals may harbor several diseases simultaneously. The toll of tropical diseases is greatest in Africa, although many of the same diseases, often in the form of local variants, are of significance in the developing nations of the Near East, Asia, and Latin America. Our research efforts in this field are in response to the lack of adequate methods of diagnosis and treatment applicable to mass populations in the developing countries.

A.I.D. is supporting an international research network to develop an effective vaccine against human malaria. Support is being given to about 12 different grantees. Recently several major breakthroughs have occurred, and future development of a vaccine is a real possibility in the coming years of the eighties.

A.I.D. is also supporting a multidonor effort to find more effective and more economical methods for diagnosis, treatment, prevention and control of six major tropical diseases. This support to the World Health Organization for tropical disease research is planned for $20 million over about six years.

A.I.D. is also contributing to the International Center for Diarrheal Disease Research (ICDDR) in Bangladesh for their program of research and training. ICDDR was established in June 1979 following 18 years of operation of a Cholera Research Laboratory in which the U.S. was a major donor. The U.S. participated in the internationalization of the center.

4. Health Policy, Planning and Management

In order to bring about a more efficient, effective and equitable allocation of resources to improve the health of the poor in less developed countries, A.I.D. supports a health planning program that emphasizes three types of activities: (1) training of country personnel to design, implement and evaluate strategies, particularly integrated low-cost primary health care and other programs that increase availability of health services to the rural and urban poor; (2) the collection, analysis and utilization of information from health projects in the field; (3) collaboration with other donors and developing countries in special studies which advance the state of knowledge of the health and non-health interventions most effective in improving health in developing countries.

Since health depends not only on health sector programs but also on agriculture, nutrition, education, economic policies and population growth,

A.I.D., through its range of development activities, is in a unique position among U.S. agencies to effectively promote health status in developing countries. Added to that are many years of experience with the development problems of the Third World, and the presence of A.I.D. staff resident in developing countries and able to work with their counterparts in health ministries on a sustained basis.

With regard to the legislative proposals under consideration today, I would like to make a few general comments and then speak to specific provisions of S.1424 and the proposed amendments. Though many of the proposals refer to legislative authorities of the Department of Health and Human Services, I shall address them as they relate to the Foreign Assistance Act. In addition, my colleague, Dr. Jack Bryant of HHS and I are co-chairmen of an interagency coordinating committee on international health, of which I will have more to say later; my remarks will also reflect the positions taken on S.1424 by that group.

A.I.D. and I.D.C.A. appreciate the intent of the proposed legislation, and fully agree that international health deserves greater attention, particularly in the field of primary health care, including basic health, nutrition, and family planning services. We conclude, however, that the proposed legislation may not be the most appropriate way to increase the attention we devote to international health, because it would duplicate a number of existing authorities already available to A.I.D., HHS, and Peace Corps. We also believe that interagency coordination in this field is now working well and thus needs no additional legislative authority.

We perceive three major reasons why we cannot support the legislation as currently proposed.

First, S.1424 and the proposed amendments introduce significant additional budgetary requirements at a time when resources are extremely limited.

Second, the legislation would establish new authorities in areas where U.S. agencies already have existing mandates.

Third, underlying the proposals is a concept of "filling in the gaps", of deploying Americans to fill in where LDC personnel are unavailable. This could conflict with A.I.D.'s philosophy of development, of helping LDC's to create independent mechanisms at appropriate levels of technology, in order to meet the health needs of their people.

As to specific provisions of the proposed legislation directly relevant to A.I.D., we believe that legislative provision for an intragovernmental co-ordinating committee for international health is unnecessary. This function is currently fulfilled by the International Health Subcommittee of the Development Coordination Committee (the DCC is chaired by the Administrator of I.D.C.A.). The International Health subcommittee includes representation from all major U.S. government agencies involved in international health, meets on a regular monthly basis, and not only performs an information-sharing function, but also serves as a forum for cross-agency programs and policy concerns. A system of interagency cross-tabulation of international health budgets has been developed and is being put in place. The IHS/DCC grew out of a study done under the leadership of Dr. Peter Bourne in 1977-78; we believe the existing mechanism is effective and adequate.

The proposed legislation provides for financial support for U.S. institutions to train students and conduct research in international health. The amendments, through the Fogarty International Center, go a step further to support collaborative training and research between U.S. universities and counterpart universities in developing countries. A.I.D. acknowledges the need to train a new generation of U.S. specialists in international health, and strongly endorses efforts to develop this expertise in developing countries. In fiscal year 1979, the latest year for which such data are available, A.I.D. funded nearly $28 million in grants and contracts to U.S. academic institutions specifically for research and training in the interrelated fields of health, population and nutrition in developing countries. This figure does not include substantial support given to LDC universities for health research and training carried out in conjunction with A.I.D.'s many projects in health, population and nutrition.

The proposed legislation calls for establishment of the Hubert H. Humphrey Fund for International Health to coordinate between government and private voluntary organizations in international health, and to fund PVO international health projects. Over the years A.I.D. has developed a strategy for the involvement of PVO's in all fields of endeavor in LDC's, including health. PVO's funded by A.I.D. have very effectively implemented projects that deliver, among other things, primary health care, and water and sanitation to poor communities in many countries. Assigning this function to a new and separate institution could disrupt coordination and prove duplicative and wasteful.

The Kennedy amendments call for the establishment of a United States Medical Emergency Mission, organized by a private organization, to send health professionals on a short-term basis to disaster areas. Both A.I.D. and the Department of State are at present involved in medical disaster relief activities. The Department of State provides grants principally to international organizations, notably the United Nations, but also provides disaster relief grants to PVO's. A.I.D. depends on the expertise of such U.S. government agencies as the Department of Defense and the HHS's Center for Disease Control, who have the experience and facilities needed to respond expeditiously in times of natural and man-made disasters.

Finally, the legislation calls for the creation of an International Health Service Corps as a means of alleviating the shortage of trained public health personnel in developing countries. From its long experience helping to develop cadres of trained health workers in LDC's, A.I.D. is aware of the severity of this problem. However, the pending legislation concentrates on higher level health personnel and calls for them essentially to "fill in" for LDC personnel, mostly providing direct health care services. This may be an admirable gesture, but we at A.I.D. feel that it can do little to solve the problem, given the magnitude of personnel shortages in LDC's.

United States efforts to solve health personnel shortages should aim at developing cadres of workers who can provide primary health care in the villages, consistent with the Alma Ata resolution, endorsed by the U.S. and developing countries alike. Finally, A.I.D. believes that U.S. support for health in LDC's is most effective when we help these countries generate their own legions

of personnel, rather than sending our people overseas as a short-term, short-gap measure. Thus A.I.D. endorses the use of U.S. funds principally to train community level health workers, a long-term solution that will enable LDC's to sustain primary health care programs independent of outside assistance.

We do not feel that a clear need exists for a specific legislatively-mandated large cadre of U.S. health professionals who would spend two-or three-year periods in international work as described in the proposed legislation. Opportunities and legislative authority for such service currently exist in A.I.D., Peace Corps, and in CDC and elsewhere in HHS -- the real need is for a longer-term career structure for a relatively small number of U.S. health professionals, who could move back and forth across agency lines, and in and out of university, PVO, and foundation settings as well as government service. The U.S. has never been able to adequately provide appropriate career patterns (in and outside of government) in international health, but the problem is not one of lack of legislative authority.

We would favor a small-scale attempt to develop a coordinating activity, based in HHS and collaborating with such agencies as A.I.D., Peace Corps, CEC, etc. for placement for field service. In our view, this could and should be undertaken on a trial basis under existing legislative authority, so that questions of supply and demand, most appropriate types of skill recruitment and training, career potentials, etc. can be carefully worked out.

Mr. Chairman, in closing, I would like to reiterate that, while we cannot support the proposed specific legislation, because of the reasons I have detailed, we are grateful for the Committee's interest, which has underscored the importance of the U.S.'s continuing involvement in international health. I would be happy to amplify any points, or to respond to any questions that you may have. Thank you, Mr. Chairman.

Senator JAVITS. I have a few questions which I would like to ask you. I don't take your testimony as being oppositional, because I believe that whatever results from these measures should be collaborative between the Executive and the Congress. And I would hope, as we refine the subject and receive more testimony on it, to work out an agreed-upon measure, if we need one.

I believe we will need something, but I am not fixed in concrete as to what I propose, and I don't believe Ted Kennedy is either.

But we have raised the subject effectively, and I think we will have to move now to get something out of it.

First, let me lay a few things to rest, so that we are not encumbered with impedimenta.

The provision respecting the Fogarty International Center is not in my bill; it was in a previous draft—it no longer is. So we can, for the moment, lay that aside.

What I would like to ask both of you, either acting together or separately, as you choose, is: Where you have mentioned legislative authority as existing, I would like the reference—the legislative authority—by book and page and section.

Now, I find those assertions, looking now at Dr. Bryant's testimony, at page 10, where you deal with the jobs, that is, Deputy Assistant Secretary and so on—page 10, middle of the page. You say these are functioning undercurrent authority. I want them specific.

I find another reference at page 13, again looking at Dr. Bryant's statement, at the top of the page: "Legislative authority of other government agencies is sufficiently flexible," and so on.

At page 14: "Further, we have concluded that the activities proposed by either bill are possible and are in various ways being carried out now."

Page 16: "However, we question the need for creating additional legislative authority in this area."

And page 17: "However, since mechanisms to do this exist under current legislative authority, we question the need for new authority."

Doctor, would you submit for the record, and supplement it by whatever Dr. Joseph wishes—the particular sections in the particular laws to which you refer?

Second, do you both have one common recommendation? I find that at page 17 of Dr. Bryant's statement, saying that you want to try some small-scale demonstration project; and, Dr. Joseph, at page 11, "We would favor a small-scale attempt," et cetera.

I want from each of you your specific proposition, and I want it costed out, and also tied, if you can, to existing legislative authority.

How long, gentlemen, would you need in order to give us this response?

Dr. BRYANT. Mr. Chairman, I believe on the matter of giving you the detailed references to the legislative authorities involved, this could be done in a matter of a very few days.

With respect to the recommendation for a pilot program relating to an International Health Service Corps, we have had some preliminary discussions on this, and we would have to have some further discussions to iron out the details, in particular the costing effort. This would take a bit more time.

Senator JAVITS. What would you say a bit more, 2 weeks?

Dr. JOSEPH. I think, Senator, for this second activity we would want to use the International Health Subcommittee that we both referred to. We have a meeting of that committee I think next week. I would say within 2 or 3 weeks we can get you——

Senator JAVITS. Well, I would like to set a date. Let's say by July 21 you will submit your information, is that all right? The close of business, July 21.

And, without objection, the record will be kept open until then for this purpose.

Now turning to general questions. Last month, Secretary Harris delivered the commencement address at Harvard, and she came out for an International Health Service Corps which she characterized—and I quote—as "a cadre of prevention-focused medical personnel, capable of responding to health needs in any part of the world."

I appreciate that endorsement of this idea. But what troubles me is that that description does not quite square with the policy both of you endorse, which is a policy of training, et cetera, to enable the LDC's to do their own thing, rather than to use the medical-team idea which is subsumed under Senator Kennedy's measure as the U.S. medical emergency mission.

I am very interested, gentlemen, in the bottom line; I am not interested in giving you tough questions. So tell me what is the policy of your respective departments now, and, if you want to put that in writing, that's all right with me; we just want it definitive so we know what we are talking about.

Dr. Bryant?

Dr. BRYANT. Mr. Chairman, I don't see a conflict between Secretary Harris' statement about a prevention-focused cadre working in countries where the need is so great, and our own position stated here of the importance of the orientation of such a corps toward capacity building in developing countries.

The approach that we would take is that the U.S. health personnel who would be involved in such overseas activities would be experienced and seasoned in the field, to the extent that they could support developing countries as they build their own infrastructure with an emphasis on prevention. This would be in terms of the manpower training, the development of primary care systems that have an intent to cover their total population, epidemiological capabilities and so on, but not providing those services themselves.

Rather, it would be helping those countries to strengthen those services.

But we certainly agree that the major diseases of the developing countries can be approached through a preventive mode, to great benefit.

Perhaps one of the other differences here is that we are speaking of a pilot program at this time to more thoroughly explore the subject under discussion.

Senator JAVITS. Dr. Joseph?

Dr. JOSEPH. I think, Senator, that the point I would like to emphasize, which may or may not be a point of difference between our position and the position of HHS—I don't think it is—is our feeling that the health care needs and the ways the developing countries and the international organizations perceive those needs has changed in recent years. And we do not see the need for large numbers of American health professionals undertaking short and essentially self-limited work experiences in the Third World, as an optimum solution.

As I tried to say in my statement, we do see a need for the development and sustenance in the United States of a relatively smaller number of career professionals who could work through the existing agencies, through the universities and private sector, and who would form that core of support that is needed in the United States.

But this may be different than the concept of large numbers of people going abroad for relatively short and self-limited periods of time.

In addition, I think there needs to be significant clarification as to the benefits that can be provided by U.S. health professionals providing, in essence, direct health services or direct care, as opposed to people who can work either in research support or in planning and administrative support, both in the United States and in the developing countries themselves.

I say that as someone who has had personal experience from the system that I am now describing as not the optimal one. I had my first overseas experience as a physician with the Peace Corps under circumstances very similar to that described in the amendments. And I also was part of a program in the U.S. Public Health Service called the global community health development program, which under existing legislative authorities for a number of years, prepared physicians and other health professionals to work across a broad spectrum in international and domestic community health.

But I have come to feel, and I think the evidence bears out, that what we really do need is a sustained career structure for a relatively limited number of people working in the agencies that currently exist and in the private sector rather than a sort of a crash overseas single tour for larger numbers.

Senator JAVITS. Well, I think that is essentially the thrust of my own bill; that is why I am so interested. Also, I notice that you especially, Dr. Joseph, emphasize at page 9 of your statement: "AID acknowledges the need to train a new generation of U.S. specialists in international health, and strongly endorses efforts to develop this expertise in developing countries."

Now, what do you say about the availability of such international health manpower and the predicted supply, and what could we do about it?

Dr. JOSEPH. Senator, I think if there is one manpower area in which there is, I think, the greatest shortage in the international arena and this country, it's in the area of people who have biomedical research talents. With the various cutbacks in research funding across the entire spectrum of U.S. Government, and natural attrition from the old days of massive malaria investments, et cetera, the numbers of U.S. professionals, whether it's CDC or in the universities, who are capable in tropical disease research has really shrunk dramatically. I think this is the crisis area. I do not believe that there is an equivalent crisis of people who are involved in the delivery system or the health planning area; I think there is still an adequate supply of trained people in this area from the Peace Corps and similar activities.

But I think the area of research is one in which our attention needs to be focused.

Senator JAVITS. And, Dr. Bryant, would you answer the same question?

Dr. BRYANT. I would concur with Dr. Joseph's emphasis on the needs for training and experience in the tropical disease research area. I am perhaps not as close to him on the question of the need for people who work with other countries in basically the development of health services and in the development of training programs. There is a substantial number. But one of the problems, Senator, is that we don't know what the extent of need is. Most of the manpower studies that we see in this country bypass the international health arena. It is an area in which we need to have more information, and I would expect that one of the things that should be pursued in the near term is a study of what those needs are in various fields related to health problems in developing countries.

Senator JAVITS. Well, could each of you go back to your respective agency, then, and advise us of their recommendations in order to do what both of you say needs to be done, and, obviously, if it needs to be done—you haven't been reluctant about claiming you are doing everything and that it is all covered by existing legislation.

What about this, these very matters that you are discussing now? What have you done about them? Or, if you can't do it, tell us why and what we should do, because that is the object of this exercise. This committee deals with health, and generally deals with universities and with the education of health professionals—it covers the whole field.

So we will include that in what you will advise us on by July 21.

Thank you very much, gentlemen. You have been very helpful, and we thank you for testifying today.

Dr. BRYANT. We would like to thank you again for your interest.

Senator JAVITS. Thank you.

Our next witness is Dr. David A. Hamburg, President of the Institute of Medicine of the National Academy of Sciences.

Dr. Hamburg, we will make your statement part of the record, and ask that you be kind enough to sum it up in 10 minutes.

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STATEMENT OF DAVID A. HAMBURG, M.D., PRESIDENT, INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES

Dr. HAMBURG. Yes; thank you very much, Mr. Chairman. It gives me great pleasure, Senator Javits, to appear before you. Whenever I have introduced you in the past I have been lucky enough to have a number of occasions—I stressed your deep and thoughtful interest in improving health in this country and throughout the world. And I am also aware of your broad interest in international relations, and I happen to think that the topic under discussion this morning actually brings those two interests together in a way that is exceedingly important for our country.

I have submitted a longer statement which I hope will be helpful to the members and staff. I will summarize briefly my remarks, and toward the end I would like to add a comment which I regard as of great importance that is not directly dealt with either in my statement or in the legislation under consideration.

Let me say first, Senator Javits, when I became president of the Institute of Medicine in 1975, I put a lot of emphasis on viewing health in worldwide perspective and not confining ourselves to the United States, important as our problems are. Particularly I emphasized the tragic health-related problems in developing countries. And I must say that I found encouragement for that point of view in this town and throughout the country pretty sparse 5 years ago, and I have to say that the first truly emphatic organized response that I got of a positive nature was from this distinguished subcommittee under the chairmanship of Senator Kennedy, and with your very active and creative involvement in it. This subcommittee provided the powerful stimulus to the Institute of Medicine to move into an area which it had not been able to pursue before, and in turn to develop a set of working relations with the various foci in our Government that are crucial to progress in this field: the comparable subcommittee in the House, the Departments of what we now call HHS, and State, and Defense, which has an important role in this field, the International Development Cooperation Administration, and the Office of the President of the United States.

It does seem to me that a number of factors have come together in the past few years to make for considerable progress in what is in fact one of the truly crucial problems in the world today. And I admire the leadership being provided by such people as Dr. Bryant and Dr. Joseph, who have just testified. They have done an absolutely first-rate job. We have made progress; we still have a long way to go; and, in my view, the legislation under consideration, generally speaking, takes us a considerable step in the right direction.

Now, very briefly, a word about the nature and the scope of the problem, just to underline how terribly severe and common these problems are—the tropical diseases and other infectious diseases embedded in the context of widespread malnutrition, in population numbers that in most developing countries exceed the support capacity, and all of that which you are familiar with in this committee, but I regret to say we are not so familiar with throughout the country or even throughout the health professions. Those issues raise serious ethical questions for us in technically advanced

countries, like the United States, and in recent years I think we have come to realize that our attention in research and education and in practice to health problems of developing countries has been much too small.

Because the encouraging thrust that I refer to of the past few years started from a very low baseline, we could hardly go down from the level of attention we were giving to these matters, say, 5 years ago.

These health problems, I wish to emphasize, present a virtually insurmountable obstacle at present to any sustained economic development and social progress in many of the countries of the world. So this is not a marginal issue in national policy or a hobby of do-gooders; it is really a fundamental problem of the nature of the world we live in, and, indeed, its future existence.

Now, in my view, both altruism and self-interest dictate that this country do more in helping developing nations address their pressing health problems. Altruism, I say, because our Judeo-Christian values will not permit indifference in the face of such enormous suffering anywhere in the human family. Self-interest, and I would underscore self-interest—I think altruists tend to function more effectively if their altruism is articulated with self-interest—and I say self-interest, because we have a lot to learn about what is applicable to our own health needs from work in developing countries. Bacteria or viruses do not respect national boundaries, Mr. Chairman, and there is a great deal that turns up in our work abroad that feeds back to the well-being of the U.S. people.

More than that, it will not be beneficial for the United States, surely, to have a kind of constant turmoil in disease-ridden and population-overwhelmed and malnourished people in developing countries. This kind of problem poses grave risks to the industrialized nations, and it is certainly a major factor in the despair and instability and even fanaticism in many developing countries.

Now, we are talking about long-term efforts. These are not problems that will go away very quickly, surely; there has to be a better balance between resources, especially food and population—and I would like to emphasize a point that has not been widely understood, though it is now coming to be better understood. That is that health improvements are probably a prerequisite for effective population control. It's all too easy to say if you improve health, they are just going to have lots more people around, you are going to compound the population problem. In fact, health has to be seen in close juxtaposition with population and with nutrition issues. In cultures where large families have always been the primary source of social and economic support, it's very difficult to sell family planning. When you have, say, 40 or 50 percent of children dying before age 5, parents are not very amenable to arguments about how nice it would be to have a small family and space children out. So the health care and family planning programs go together, they reinforce each other. Improved health tends in time, not immediately, but in time to reduce fertility, and reduced fertility contributes to improved health.

Now, what is needed? It's important to be clear about the priorities of what's needed, because there is no single way of meeting the needs, there is no royal road to accomplishment in this very

difficult effort. But it is an historic effort, and we have to be flexible in trying to find ways to meet these needs.

I would put the first priority on institution building or institution strengthening in the developing countries. This task involves the development of human resources, trained and competent personnel, and workable institutional arrangements to support those competent people at every level of the system, from the basic health community workers, to hospital administrators, to research scientists.

To make the point vivid, about 1½ million people, mostly children, young children, die every year from measles, of course a preventable disease—and millions more suffer complications and disabilities of measles in developing countries, for example, encephalitis. We have a very good vaccine, but such a vaccine and a number of others are of no value sitting in a warehouse in the United States or in Europe; they must be delivered, stored, distributed, administered. And human skills are essential at each step along the way, from manufacturer to patient, and in large part those skills will have to be developed with our help in a cooperative mode in the developing countries themselves.

The second priority is that of primary care networks, or a mechanism for providing some decent minimum of basic health services. You've heard about that already this morning. Although there is enormous cultural variation, there is a common need to create such networks that will provide a decent minimum of preventive and therapeutic services, and I would, like Dr. Bryant, put some emphasis on the preventive services, particularly early in life.

The content of these services, of course, will vary a lot, as well as the organization, according to their specific health needs, and social-economic conditions. But there are basic services that are more or less common to all, which include immunizations, maternal and child health services, coupled with family planning, simple treatment of acute conditions, especially the childhood diarrheas, and health education. This last component is very important, particularly focused on nutritional and sanitary measures, if the kinds of developments sketched by Dr. Joseph this morning are really to be effective.

Now, the third priority is in research. And really this calls for intensive research across the entire spectrum of the health sciences and services. From epidemiology to biomedical research to health services research and studies in health promotion, research is an essential tool to obtain maximum benefit from the minimal resources that will be available. And I should add that the United States has—I think we can say without any chauvinism that the United States has simply outstanding capabilities in the research field, and this capability is recognized and deeply respected worldwide, even in the most remote and distant developing countries.

The experience of the recent successful worldwide program to eradicate smallpox shows the importance of incorporating a research element even into a disease control program which is based on a century or more of prior knowledge. As a matter of fact, it was my privilege to be with Dr. Bryant and Dr. Joseph at the World Health Assembly one month or so ago in Geneva when a ceremony took place observing the worldwide eradication of small-

pox. And Secretary Harris gave a beautiful, elegant speech, not about the U.S. contribution but about the history of smallpox in the Americas, the nature of this disease in the developing world, and the different factors that contributed to its eradication. I am not saying that eradication of any other disease is going to come soon, but I am saying that it is within our power to diminish considerably the burden of illness in developing countries, if we use our intelligence and our resources.

Now, you have heard something briefly about the prospects for progress with the tropical and infectious diseases. I think it is fair to say—not only the ones that have been mentioned, like malaria and schistosomiasis, which are tremendous burdens, but also other diseases common in the developing world, like dengue, hepatitis, various viral hemorrhagic fevers—all are amenable to significant gains from research in the foreseeable future. So, too, is fertility control; this has to move not only toward safe, effective, low-cost convenient methods of birth control but also to a deeper understanding of what constitutes cultural acceptability in different cultures and why people start and then stop, and how they can continue with effective fertility control measures where they want to do that.

Nutrition is also a clear focus for research, particularly in more effective use of indigenous foods.

Now, Mr. Chairman, the Institute of Medicine has done two studies directly stimulated by this subcommittee, and I want to say just a word about those two studies, because the thrust of the studies speaks to the present legislative proposals to a considerable extent.

One was a study published in 1978, called "Strengthening U.S. Programs To Improve Health in Developing Countries," and the second was a study called "Pharmaceutical Innovation and the Needs of Developing Countries." You yourself, Senator Javits, spoke at the second conference, Senator Kennedy did, Senator Schweiker did—all three of you made important contributions which were published in the volume.

We have done a number of other studies for the Office of Science and Technology Policy in the White House and AID and other units of our Government, but these two studies stimulated by the subcommittee I think were particularly important.

In the first of these, on the general overview of strengthening the U.S. role in this field, after looking at a statutory policy and the organizational framework, the distinguished committee with their broadly composed and diverse perspectives identified four major problems, which I shall very briefly state: inadequate access by the U.S. Government to the major sources of American health science expertise; too little support for research and development on the major health problems of the developing countries; inadequate arrangements for U.S. participation in international agency health programs; and inadequate organizational arrangements for policy development, planning, and coordination of U.S. international health activity.

It seems to me the intent and the main thrust of the present legislation speaks to those problems. Indeed, the committee made recommendations to resolve these problems, one of which was that

Congress should authorize what is now the Department of Health and Human Services to undertake broad research and development in international health, make possible serious commitments by the various agencies, and especially the NIH and CDC, to the problems of developing countries wherever it was necessary to do so. And then a mechanism for assuring coordination between HHS, AID, and other interested agencies was suggested. And ways were suggested in which the budgets could be coordinated both in the executive branch and in the appropriations committees of the Congress.

As I interpret the current legislative proposals, they speak constructively to these recommendations.

There was also a recommendation to provide the U.S. foreign aid program with authority to enter into long-term flexible relationships with U.S. academic institutions, and that seems to me important for the future also—and an organizational mechanism in the executive branch for policy development, program planning, and coordination.

The only thing I would want to say about the second report—on pharmaceuticals for developing countries—which to some extent goes beyond the scope of the present legislative proposals is that there are new scientific opportunities for developing drugs and vaccines aimed at the diseases of developing countries, and we soon may be able actually to invent rather than to discover drugs and vaccines in light of current advances, for example, advances that permit a much more specific differentiation of the human host and the parasitic organism. And the question is how we can get the best out of those efforts, not only for developing countries, Mr. Chairman, but for orphan diseases in the United States, neglected diseases. And it does seem to our committee that the Congress really ought to mandate a study in depth on ways of taking advantage of those new opportunities. And I am glad to see that this matter is addressed to some extent in the present legislative proposals.

Now, I would like to add just a closing word about a larger issue. It's not in my testimony, and it's only in the bills by implication. But, Senator Javits, I think there are wider implications of the U.S. health capability for our international relations. In my view, we have a great opportunity to improve our relations with many developing countries. They are important to our future as well as their own. We have lots of reasons now in our national interest, broadly conceived, to be concerned with developing countries—social progress, natural resources, many other reasons why we should be concerned about what happens there.

Now, my point is that in the developing countries throughout the world there is an extraordinary degree of respect for U.S. health capability, both in medical care and in research. There are solid ties that have been and can be engendered by joint efforts in health, focused on problems of a specific nation or region. And what I am advocating in very short form is something like this, Senator: wherever the flag goes, there U.S. health capability should go as well, and a serious interest in the health of those people, bearing in mind that probably, as you indicated in your opening remarks, probably no single matter in the life of people everywhere is more sacred than health. There is a worldwide desire to improve

health. And we have the capability of tapping into that desire and fostering it in a way that actually no other country has.

Such cooperative efforts—and I emphasize cooperative—between the United States and developing countries in the long run tend to build respect for the United States, to increase knowledge useful for health of Americans abroad and indeed for people in this country. Such efforts tend to increase knowledge of each country even beyond the health sphere, and we need that knowledge. And such efforts tend to build a network of human relationships with highly respected people in each country where we work cooperatively.

So I close, Senator Javits, by saying that in a world of widespread U.S. commitments, such knowledge and goodwill is clearly a vital national interest of ours. The investment for this is quite modest in comparison with most of the other activities we undertake abroad, and indeed with our other health activities in this country. So that for the future I think we should develop strongly our ability to work cooperatively, to build indigenous capability in health and related matters in the developing countries.

Thank you very much.

[The prepared statement of Dr. Hamburg follows:]

STATEMENT OF

DAVID A. HAMBURG, M.D.

OPENING REMARKS

Mr. Chairman and Members of the Subcommittee:

When I became President of the Institute of Medicine in 1975, I emphasized the importance of viewing health in a world-wide perspective and especially of paying more attention to the tragic health-related problems of developing countries. At that time, this was hardly a fashionable subject, and I found encouragement pretty sparse. The first truly emphatic response came from the distinguished members of this remarkable subcommittee under the Chairmanship of Senator Kennedy. I am personally deeply grateful, especially since your interest gave a powerful stimulus to the work of the Institute of Medicine in this field. This in turn greatly facilitated the working relations that have developed in international health between the Institute and major foci of our government: the comparable subcommittee of the House, the Department of Health and Human Services, the Department of Defense, the Department of State, the International Development Cooperation Administration, and the Office of the President of the United States. In my judgment, this nation has made encouraging progress on one of the world's truly crucial problems in the past few years. But we have a long way still to go. In my personal view, the present bill takes a long step in the right direction.

NATURE AND SCOPE OF THE PROBLEM

The burden of early death and long-term disability in most developing countries of the world today is exceedingly heavy. Severe and common tropical diseases, and a much wider range of infectious diseases, are embedded in the context of widespread malnutrition and population numbers that exceed the support capacity of most developing countries. Susceptibility to a wider range of diseases is heightened by the marginal character of subsistence. This raises ethical questions for countries with strong scientific capability. In recent decades, we Americans have given too little attention--in research, education and practice--to some of the most important disease problems of the developing countries.

The most urgent challenge in the sphere of international health unquestionably lies in the developing countries, home of approximately three-fourths of the world's population and even more of its human suffering. Across Africa, Asia and Latin America, explosive population growth and abject poverty have combined to produce devastating health problems that stand as a virtually insurmountable obstacle at present to any sustained economic development and social progress.

Throughout the developing world, a population explosion unprecedented in human history is overwhelming all available resources, exacerbating already widespread malnutrition and lowering resistance to the multitudinous diseases that are either common to poverty pockets everywhere or specific to tropical climates. And as this staggering burden of illness is sapping the productive energy of developing societies, rapid urbanization is shattering life styles and value systems that go back for millenia, replacing certitude with confusion and adaptation with anguish. It is customary to regard cities as the

exception rather than the rule in developing nations, but the reality no longer conforms to the stereotype. Indeed, it is anticipated that 42 percent of all people in the developing nations will reside in cities within the next 25 years. In the context of current conditions, the implications of this trend are not promising. Crowding and competition for scarce resources tend to trigger aggression and promote the kind of social and political instability which too often leads to violence both within and among nations.

Both altruism and self-interest dictate that the United States help the developing nations address their crushing health problems. Altruism because our Judeo-Christian values will not permit indifference in the face of such manifest suffering anywhere within the human family. Self-interest because we learn much that is applicable to our own health needs from work on problems of specific concern to developing countries, and because constant turmoil in developing countries poses grave risks to the industrialized nations.

In recent years, the focus of U.S. foreign assistance programs has shifted away from high-visibility, high-technology development projects towards programs aimed at meeting the basic needs of the poor majorities in developing countries. But this new emphasis, while both welcome and wise, does not yield quick results. The problems are both complex and deeply rooted. Efforts to increase food production are often overwhelmed by uncontrolled population growth. Population control programs sometimes fail to win enough public acceptance to make them effective. Water and sanitation projects fall short of their objectives when maintenance and repair capabilities are lacking.

It has become increasingly evident that development progress will remain a frustratingly distant goal in most of the developing countries until a better balance can be achieved between resources, especially food, and

population. But it has also become clear that health improvements are quite probably a prerequisite for effective population control programs, for in cultures where large families have always been the primary source of social and economic support, it is difficult to "sell" family planning as long as up to 40 percent of all children die before reaching the age of 5. Health care and family planning programs reinforce one another; improved health tends to reduce fertility, and reduced fertility contributes to improved health. And as Benjamin Disraeli observed more than a century ago:

> "The health of the people is really the foundation upon which all their happiness and all their powers as a state depend."

Over the past three years, the Institute of Medicine has undertaken a half-dozen studies in international health, all of which were focused on problems of the developing countries. Emerging from these studies has been a gradually sharpening picture of the health needs of developing countries, ways in which the United States can be most helpful in meeting those needs, and the various obstacles--bureaucratic, legislative, institutional--which make it difficult to provide appropriate assistance. My remarks today are partly based on some of the main themes which emerged from those IOM sutdies.

WHAT IS NEEDED?

1. Institution-Building

The most urgent need in the developing countries today is the development of human resources--trained and competent personnel and the institutional arrangements to support them--at every level of the system, from minimally skilled community workers to hospital administrators and research scientists. Even more than the lack of financial resources, a

very real limitation, it is the lack of an adequate infrastructure which is most directly frustrating significant health progress in developing countries.

The knowledge and technology necessary to prevent or control many of the diseases rampant in developing nations has been available for years; what is missing is the manpower and means to deliver the relevant services. An estimated 1.5 million people, most of them children under the age of 5, die each year from measles--a disease which can be prevented by a single dose of vaccine. But vaccine is of no value sitting in a warehouse in the United States or Europe. It must be delivered, stored, distributed and administered in order to protect anyone, and human skills are essential at each step along the way from manufacturer to patient.

It would be difficult to overemphasize the necessity for appropriate training and institution-building in every aspect of the health sciences and services. All the expertise in the world will be of little help in alleviating the awesome burden of illness in the Third World unless those countries have scientists available to collect and analyze data about the incidence and distribution of various diseases, health planners to devise cost-effective programs to combat specific problems, administrators and managers to organize such programs, technicians to operate and maintain necessary equipment and health workers of every skill level to deliver the services.

It must be stressed that training alone is not enough; there is little point to educating, at great effort and expense, a biomedical researcher, epidemiologist, paramedic or community health administrator if there is no career ladder available for that individual to climb once trained. The developing countries need an <u>institutional</u> capability to define and address the health needs of their people, not educational opportunities for an elite handful.

2. Primary Care Networks

Although there is enormous variation among nations, they share a common need for the creation of primary care networks that can be gradually extended to provide at least a bare minimum of preventive and therapeutic services to all of their citizens. In some instances, this will require construction of physical facilities such as health clinics, roads, landing strips and the like. But the universal first priority is the development of appropriate human resources.

The content of primary health care services will vary considerably within an among nations according to specific epidemiological, social and economic conditions. But needed services that are pretty much common to all include immunizations against preventable diseases, some mix of maternal and child health services coupled with family planning, simple treatment of some acute conditions, and a health education component focused on nutrition and sanitary measures.

Like content, the organization and delivery of primary care services will vary widely to suit cultural, social and economic realities. Such service cannot be either "prepackaged" or imposed from outside if they are to be effective, but rather must be developed on site with the active involvement of community personnel.

3. Research

Intensive research is needed across the entire spectrum of the health sciences and services if the developing countries are to make sustained progress. From epidemiology to disease-oriented biomedical research to health services assessment and studies in health promotion, research is an essential tool to insure that maximum benefit is obtained from the often

minimal resources available. This is an arena in which the United States has simply outstanding capability--and this is deeply respected worldwide.

The value of research is not always self-evident. Especially when resources are limited, it is often tempting to go with technology known to be effective rather than setting aside some portion of those resources to search for new knowledge. But the experience of the recent successful worldwide program to eradicate smallpox illustratesthe importance of incorporating a research element into a disease control program.

In that instance, studies of vaccine production helped produce both maximum yield and standardization of vaccine. Epidemiological studies demonstrated that smallpox was concentrated in focal areas and that outbreaks could be more effectively combatted by efforts targeted on such areas than by countrywide measures. Research also indicated that immunity conferred by primary vaccination lasts as long as 20 years, dictating a change in the previously accepted practice of revaccination every three years. Introduction of a bifurcated needle, the product of research outside the smallpox eradication program, greatly improved and simplified smallpox vaccination techniques. From start to finish, in other words, research contributed immeasurably to the program's success. Conversely, the malarial eradication program wich began in 1955 was adversely affected by a decision to stop almost all research on the disease because DDT, then thought to be the ultimate weapon, became available.

An obvious target for intensified biomedical research are the infectious and parasitic diseases which are among the most important causes of death and disability in the developing countries. The development of vaccines for malaria, schistosomiasis, African and American trypanosomiasis

would be a major advance in international health. Since these diseases are included in the Tropical Disease Research program of the World Health Organization, they are already receiving increased attention. But there are other important diseases for which vaccines are needed which are not included in the TDR program, such as dengue, hepatitis A & B, and the viral hemorrhagic fevers. In addition, there is an even longer list of diseases for which drug therapies are badly needed.

Complicating the research problem are some special requirements that should be met if new drugs and vaccines are to be of maximum usefulness in developing countries. Health care systems that wil l necessarily be based upon the delivery of services by personnel with limited skills and training require: 1.) Highly effective pharmaceuticals that can be easily administered with few or minor side effects. 2.) Drugs that minimize reliance on patient compliance or frequent visits to health clinics, which are likely to be few and far between; and 3.) Drugs and vaccines that can be shipped and stored without stringent requirements for refrigeration and the like.

Another high priority target for research is fertility control. Safe, effective, low cost, convenient methods of birth control that are culturally acceptable are critically needed throughout the Third World and indeed, in developed societies as well.

Basic research should not be overlooked in this context. Never before have the scientific opportunities been so great yet so poorly exploited for human benefit, according to participants at a conference on "Pharmaceuticals for Developing Countries" held by the Institute of Medicine in January 1979. Despite great advances in basic biological knowledge, relatively little has been done to advance our understanding of host-parasite

interactions which are central to the infectious disease problems of developing countries. What is needed is a heightened awareness within the U.S. scientific community of the opportunities that exist, for even a modest shift of attention to such problems could yield sizeable payoffs.

When basic research produces results of potential significance to disease problems of developing societies, U.S. clinical investigators can serve as a vital link between the scientific community here and health care professionals in developing countries. If the expertise of the United States is to be directed toward the development of agents to control diseases which occur primarily in developing countries, then clinical research must be undertaken in those nations. If pursued on a collaborative basis, such research can help strengthen host country research institutions and provide valuable training to host country personnel as well as producing new knowledge needed to control or treat endemic diseases. But it is important to acknowledge the difficulties of conducting clinical research in developing nations, for the complexities inherent in such activities under the best of circumstances are multiplied by language and cultural differences. Considerable sensitivity and flexibility are needed to adapt western scientific concepts and processes to the differing value systems, beliefs and behavior patterns of traditional societies.

INSTITUTE OF MEDICINE STUDIES IN
INTERNATIONAL HEALTH: SOME RECOMMENDATIONS

The Institute of Medicine's Division of International Health has done two studies directly stimulated by this Subcommittee. The first was a study entitled, "Strengthening U.S. Programs to Improve Health in Developing Countries," completed in April 1978. The second was a study on pharmaceuticals for developing countries which produced two publications in 1979: a report, entitled, "Pharmaceutical Innovation and the Needs of Developing Countries," and the proceedings of the conference held at the National Academy of Sciences in January 1979, entitled, "Pharmaceuticals for Developing Countries." The latter publication contained papers by Senators Kennedy, Javits and Schweiker of the Subcommittee. The division also did a study on health problems in Egypt; and reviewed the Agency for International Development's world-wide health strategy. Both projects were sponsored by AID. It recently completed a study, sponsored by the White House Office of Science and Technology Policy entitled, "U.S. Participation in Clinical Research in Developing Countries." Copies of all of these reports have been made available to the members and staff of the Subcommittee.

Allow me to take a few moments to review the major findings and recommendations of the two Institute of Medicine reports that were commissioned by this committee. I believe they are sound and particularly relevant to the bill being considered today.

Our April 1978 report, "Strengthening U.S. Programs to Improve Health in Developing Countries, " classified U.S. government programs addressing health problems of developing countries into three categories:

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- Programs authorized and funded explicitly to improve the health of people of less-developed countries. Only AID and Peace Corps operate such programs.
- Those portions of assessed contributions to international organizations (such as WHO, UNDP, UNICEF, and World Bank) that are used for health-related projects in less-developed countries. The State and Treasury Departments have primary responsibility for U.S. decision-making related to the programs--the former for the UN specialized agencies; the latter for the World Bank and other international lending institutions.
- Programs undertaken primarily to solve health problems important to Americans, whether at home or abroad, that also are of primary importance to developing countries. The Departments of Defense and of Health and Human Services (particularly NIH and CDC) operate such programs.

The committee concluded, after examining the statutory policy and the organizational framework being used by the U.S. Government to operate these international health programs, that these are four major problems that require resolution if U.S. international health activities are to be strengthened and made more effective:

1. Inadequate access by the U.S. government to the major sources of American health science expertise. This is attributable primarily to two factors: first, AID's statutory base and funding uncertainties have forces it to adope a very short-term outlook; second, the health agencies in DHSS do not have a statutory

mission that permits them to make a significant commitment to address the health problems of the developing countries. The primary sources of relevant health science expertise are in U.S. universities—especially the medical schools and schools of public health--and the HHS health agencies, particularly NIH and CDC. AID's statutory constraints have sharply limited its ability to form stable relationships with academic institutions. Its relationships tend to be ad hoc, relatively short term, and discontinuous. Consequently, AID has not been able to recruit sufficient numbers of talented American health professionals who are willing and able to make career commitments to international health.

2. Too little support for research and development on the major health problems of the developing countries. This is a major deficiency in U.S. international health efforts. The U.S. biomedical, epidemiological, and social science research and development capabilities are very large, and have hardly been tapped to address the health problems of the developing countries. AID has invested very little in research, primarily because of its short-term outlook. Other sources of U.S. government funding are not available, hence the biomedical research community has been sharply limited in its ability to address these problems. The academic institutions are heavily dependent on NIH funding, which is currently authorized to address disease problems of importance to the American people. The pharmaceutical industry operates on the basis of market incentivies and those are clearly not strong enough in low income countries to prompt the industry to undertake risky and expensive drug development research for diseases affecting primarily low income countries.

3. Inadequate arrangements for U.S participation in international agency health programs. This stems from the fact that four U.S. agencies--the State Department, Treasury, AID, and DHHS--now have some responsibility vis-a-vis international agency programs. The decision making arrangements do not appear adequate to insure consistent U.S. positions on international health

matters.

4. Inadequate organizational arrangements for policy development, planning, and coordination of U.S. international health activity. At present there is no U.S. government organizational unit responsible for gathering information on international health activities flowing through a large number of bilateral and multilateral channels. There is no U.S. policy to guide the U.S. direct, bilateral, and multilateral programs in international health. There are no policies and no mechanism to plan and coordinate program decision-making across agencies and to take account of the program actions of other governments and or private organizations.

The committee made three general recommendations designed to resolve these problems so that the U.S. government international health activities can be effectively broadened and strengthened. The first recommendation was that the Congress should authorize DHHS to undertake broad research and development and related activities in international health. The committee noted that authorizing HHS to undertake the research and development programs in international health would complement the foreign aid authority in two respects: it would make possible serious committments by NIH and CDC (and other agencies of HHS) to some of the major health problems o of developing countries, and it would permit these agencies to address these problems wherever it was necessary to do so--for example, in countries without a U.S. bilateral foreign aid program if appropriate.

To assure coordination between the HHS international health programs and those of AID, the Institute of Medicine committee suggested that the HHS international health budget be presented to the Congress as a separately authorized component of the foreign aid budget (more or less the way Peace Corps budget is presented to the

Congress). Alternatively, it could be part of the HHS budget, but reviewed together with the foreign aid budget. The desirable feature is that both budgets be coordinated in the executive branch, and in the appropriation committees of the Congress.

The draft legislation this committee is considering now provides additional authority to accomplish these purposes; this is encouraging, but it may not yet be fully adequate. The Subcommittee may wish to explore this problem further with the health leadership of HHS to determine whether the NIH, CDC, and ADAMHA find the language in the bill as currently drawn gives them a clear statutory mission to undertake a major commitment to research on diseases that are important world-wide, regardless of their present status within the United States.

The second recommendation made by the Institute of Medicine committee was that the Congress should provide the U.S. foreign aid program with authority to enter into long-term flexible relationships with U.S. academic institutions. I note that the committee has addressed this question in the legislation and authorizes these relationships to be administered by the Fogerty International Center. This could work out very well, although it is clear that the programs would have to be coordinated with activities funded and managed by AID. Finally, the Institute of Medicine Committee recommended that the Exeuctive Branch should establish an organizational mechanism to be responsible for international health policy development, program planning, and coordination. I note that section eight of the bill is designed to establish such a mechanism.

The Institute of Medicine report entitled, "Pharmaceutical Innovation and the Needs of Developing Countries," examined the problems inherent in development of

the development of new drugs and vaccines, specifically aimed at the diseases of developing countries. It found that the scientific knowledge acquired in recent years in modern biology have begun to make possible fundamental understanding of many of the vital processes in various living systems and have revealed opportunites for rational development of techniques to attack pathogens chemically or biologically without harming the host organisms. Comparative biochemistry, immunology, molecular genetics, physical and synthetic organic chemistry have advanced so much in recent years that we now seem to be on the verge -- at least for infectious diseases, and possibly for some others--of an era of rational chemotherapy and vaccine development that could produce some new and very effective drugs and vaccines. That is , we soon may be able to "invent" -- rather than "discover"--drugs. The infectious and parasitic diseases of developing countries offer an inviting target for such research efforts.

In the judgment of a number of leading scientists, the organization of major,long-term targeted research efforts would probably result in discovery by rational process of effective and safe drugs to treat many infectious diseases for which therapeutic agents are now inadequate or unavailable. At present, however, neither the pharmaceutical companies nor academic reserach centers are in a position to mount such efforts. The amount of research in the non-profit sector is limited because NIH funds for biomedical research--the principal source of support for such research--are appropriated to study diseases of direct importance to the American people. Research on diseases of developing countries has a low priority and therefore receives very little support. Other sources of federal

support for such research are also very limited. AID, which has the statutory authority to support such research, for the most part has focused on short-term research problems. Department of Defense funding for work on diseases of importance to developing countries is likewise quite limited. The drug companies, on the other hand, are not making a major effort to develop drugs aimed at diseases important primarily to developing countries, because of two factors. First the likelihood of substantial utilization of new drugs and vaccines is not easily forecast and past experience is not encouraging with markets in developing countries. Consequently, research directors of pharmaceutical companies of wary of investing in such projects. Second, some FDA regulations pose disincentives to American pharmaceutical companies to do research in this country on drugs which must be studied clinically in developing countries. These regulations make it difficult to send investigational drugs out of the country for clinical trial, and they make it difficult to manufacture a product in this country when the sole market is elsewhere, such as in developing countries.

The committee called attention to the gap in public policy that affects development of drugs for developing countries, but also for drugs for "orphan" diseases. Present public policy in the United States affecting development of new drugs has two important characteristics : one, it relies almost entirely on market influences to shape research investment of the pharmaceutical companies; and two, it imposes extensive regulatory constraints on drug research conducted by the pharmaceutical industry which are especially significant in relation to problems of developing countries. The committee was not suggesting that these constraints be

relaxed in ways that would jeopardize determination of efficacy and safety of drugs and vaccines. But the committee did note that the federal regulatory role is not balanced by any federal mandate to foster development of new drugs in those instances where market signals do not stimulate action by the pharmaceutical companies. This is a significant gap in public policy. Although these circumstances affect all research and development conducted by pharmaceutical companies, there are special constraints affecting research and development aimed at diseases important primarily to developing countries:

--the likelihood of substantial utilization of new drugs and vaccines is not easily forecast in these countries and past experience has often been difficult. Consequently research directors are wary of investing in such projects. These are long-term investments whose outcome is is difficult to predict in market terms.

--FDA regulations pose disincentives to American pharmaceutical companies to do research in this country on drugs that must be studied clincally in a developing country. These regulations make it difficult to send investigational drugs out of the country for clinical trial and they make it difficult to manufacture a product in this country when the sole market for this product is elsewhere, such as in developing countries.

The study therefore recommended the following: 1) that the Congress commission a study to determine the consequences of the absence of clear federal policy to foster the development of new pharmaceuticals and make specific recommendations for strengthening public policy in this area. The committee believes it important to specify appropriate federal responsiblity for fostering development of effective new drugs and vaccines. A public mechanism may be necessary to determine whether intervention in needed to

stimulate drug research and development, in what specific scientific areas, and what specific intervention arrangements are needed. Devising a realistic policy will involve studying such issues as appropriate adjustments of the regulatory framework, direct public subsidy of industrial research, government drug purchasing policies, tax policy, patent policy, fostering drug development research by academic groups financed by the pharmaceutical industry and or government, and coordination of academic and industrial research groups in long-term targeted research efforts. This study should make specific recommendations about development by American research groups of drugs and vaccines of primary importance to developing countries. The powerful scientific research and development capacity in this country, if it were able to give somewhat more attention to disease problems of developing countries, could very likely produce some powerful new technologies that would improve health throughout the world.

The second recommendation of this Institute of Medicine committee reinforces a recommendation made in the earlier study: that Congress authorize DHHS to conduct and support biomedical and epidemiological research and training on diseases important anywhere in the world, not merely those of direct interest to the United States. It also noted that additional funds will have to be made available--either in the foreign aid appropriation or in the DHHS appropriation--to act on such new authority.

CLOSING COMMENTS

The improvement of health in developing countries is surely a superordinate goal of a high order in today's world. How can we possibly alleviate the crippling burden of illness that so profoundly undermines the quality of life and the productivity of developing countries without international scientific cooperation for health? This means deep and enduring cooperation beyond anything we have known before--transcending boundaries of geography, ideology, religion, and politics. What is at stake here is human misery of a profound and pervasive nature--indeed survival itself.

To meet this crucial set of tasks will require the mobilization of the sciences over their entire range. Attitudes, emotions, and beliefs from our past may hinder such efforts to enhance our understanding, and even impede the utilization of scientific knowledge when it is available. But our motivation for survival is strong, our problem-solving capacities are great, and the time is not yet too late.

Mr. Chairman, I will be happy to answer questions to the best of my ability.

Senator JAVITS. Well, thank you, Dr. Hamburg; it was very illuminating and deeply appreciated, and will be very helpful.

Now, I am going to ask you to join us in something of a little experiment in this matter. I notice the three recommendations that you have made in your testimony and from your studies as follows: One, Congress should authorize the Department to undertake broad research and development and related activities in international health; two, Congress should provide the U.S. foreign aid program with authority to enter into long-term flexible relationships with U.S. academic institutions; and three, the executive branch should establish an organizational mechanism to be responsible for international health policy development, program planning, and coordination.

Now, both previous witnesses said, sorry, Senator, this is all covered by existing law. So on July 21 I would like to submit to you all of their recitals as to what is existing law, and I want you to tell me whether you agree or disagree, and, if you disagree, what law is recommended according to your work in order to give the necessary authorities to implement your recommendations.

I don't want to in any way exacerbate relations between your Institute and the Department, but it's the only way we are going to get anywhere. I'm a lawyer, and the only way you get anywhere is by opposing briefs; otherwise you don't know where you are at.

Dr. HAMBURG. Senator, I'll be happy to do that. Our relations with those agencies and with those individuals are very good indeed, and I suspect they will survive the strain of this matter. But, if I may briefly comment on it right now, just very briefly, I understand their point, I think; it seems to me, from watching

them, as a nongovernmental fascinated spectator, they have indeed interpreted broadly, wisely, and constructively the ambiguous authority they now have. That was also true for some years when there was a President's Scientific Advisory Committee—you remember that. There was no specific legislative authorization for it, but we had very good committees until a President decided he didn't want that anymore, and it was abolished.

And I don't know what will happen 5, or 10, or 15 years from now, but I think the probability of doing what these gentlemen are doing now 5, or 10, or 15 years down the road will be greater if there is an explicit legislative mandate than if there isn't.

When Congress came back to the PSAC matter, it was decided not to leave it to the discretion of individual Presidential interpretation, but rather to pass legislation creating an Office of Science and Technology Policy in the White House. I favored that then and I favor it now.

Senator JAVITS. Now, one other thing you testified to that interests me, is the vividness of the United States activity. The difficulty I find with the testimony which preceded yours is that we spend a fortune and it gets all fuzzed over so that it has no character and no personality. Now, I couldn't agree with you more, that if there is one thing about the United States that is absolutely revered in the world, it's U.S. medicine. And by being in AID and in this agency and that agency and relying upon generalized statutory authorities, it lacks any kick, and nobody even knows it's coming or they have got it; it has no real identity, which is a critically important point to me because it is the perception of the United States which we are deeply interested in in this world.

So when you do make your comments, I hope that you will also give us some indication of the views of the Institute on that as well, though that is a question far more up to us than to any of the professionals in the field. But it is one thing that has struck me about this whole effort. You know, you can turn up your nose at the International Health Service Corps, but if there is anything to it, it will become pretty well known, and that is a big asset for the United States.

Well, thank you, Doctor, you have been very helpful, and I deeply appreciate your personal references to me.

Our next witness is Dean Banta of the School of Public Health and Tropical Medicine at Tulane, and president also of the Association of Schools of Public Health.

I am well acquainted, Dr. Banta, with Tulane, I have been there I think at least twice for lectures, and we are very happy to welcome you here.

Will you let us put your statement in the record, and then, if you could, though it seems quite short—it probably wouldn't take any longer to read—but let us put it in the record and ask us if you could give us the essence of it in 10 minutes.

STATEMENT OF JAMES E. BANTA, M.D., M.P.H., DEAN, SCHOOL OF PUBLIC HEALTH AND TROPICAL MEDICINE, TULANE UNIVERSITY, ON BEHALF OF THE ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH

Dr. BANTA. Thank you, Mr. Chairman. It is indeed an honor to present our views on your international health bill and Senator Kennedy's amendments.

The Association of Schools of Public Health is aware of your continuing championship of the cause of health for which we all owe you a great debt, and your bill, introduced for yourself and your colleagues nearly a year ago in the Senate, is another example I think of your wisdom and dedication in seeking to articulate in legislative terms a mechanism to help assure the good health of all people.

And we would like to particularly commend you for your great support of health administration and management in other bills.

We applaud also Senator Kennedy's efforts in the field of international health, especially his attempts to focus national attention and resources on the plight of the world's refugees. We therefore strongly support his amendment to S. 1424 which seeks to strengthen the original bill.

We would like to point out that international health activities are not a one-way street in which the wealthy donor country gives all but receives little in return. One recent dramatic and concrete example of the mutual benefit inherent in international health programs is the successful smallpox eradication program of the World Health Organization in which the U.S. Government was a major participant.

One other very important benefit was an economic one. The savings accruing to our national economy by not having to immunize people against smallpox is considerable, and we estimate it to be about $225 million annually in present dollars. As long as epidemic infectious disease exists anywhere in the world, it remains a potential threat to the United States. This is true of the epidemic diseases such as dengue, yellow fever, other vector-borne diseases, and cholera. And we are ever mindful of these threats in our part of the world in Louisiana, and hence any effort to control these diseases internationally is of direct domestic benefit to us in our part of the Nation. But indeed this is true throughout the Nation, especially in this age of rapid air transport.

So international health transcends the interests of AID, Department of State, and the socioeconomic development fraternity as articulated in the Foreign Assistance Act. The bills recognize this by virtue of the fact that they seek to amend both the Foreign Assistance Act and the Public Health Service Act, and I believe appropriately so, Mr. Chairman.

An important aspect of the bills is the strengthening of the coordination of international health activities which are now fragmented and scattered through a number of Government agencies. The Director of the Office of International Health and others have sought from time to time to coordinate their efforts. Unfortunately, this has been without an official mandate or legislative authority. The establishment of an international health subcommittee of the development coordination committee and the clear legislative es-

tablishment of an Office of International Health directed by a deputy assistant secretary will greatly strengthen coordination, communication, and cooperation.

Invigorating the Fogarty International Health Center will go far toward establishing a focal point within the Public Health Service for the conduct of meaningful international health programs. International health is an endeavor requiring continuing research, as pointed out by Dr. Hamburg. We are pleased to see emphasis on the need for a close collaborative relationship between academic institutions and the Fogarty International Health Center in carrying out both research and academic training relating to the solution of international health problems.

We feel, however, Mr. Chairman, that the bill fails to address adequately the special resources available in the Center for Disease Control in Atlanta. The special expertise of CDC has long been utilized by the international health community. It was the principal agency of the U.S. Government that provided manpower for the WHO worldwide smallpox eradication program. CDC for a number of years provided the manpower for the AID malaria control program. And because of CDC's special relationship with the schools of public health, departments of preventive medicine, and State health departments, it would be very appropriate for the act to contain a section which mobilizes the resources of CDC in a manner similar to the Fogarty Center as a resource for international health activities.

The need for collaboration between the U.S. Government and the academic community and a source of continuing stable financial support are absolutely vital and essential to the successful consummation of this act. Speaking for the Association of Schools of Public Health I can state unequivocally that the schools stand ready to cooperate in this endeavor. There have from time to time been international biomedical research activities conducted under the auspices of the National Institutes of Health. But these efforts, with AID, NIH, et cetera, while not insignificant, have been disparate and have lacked the cohesion, continuity, and flexibility which an ongoing, adequately funded, legislatively recognized program would afford. And I believe the present bills address this problem.

Successful international health effort depends principally upon the quality and dedication of the people engaged in the enterprise. Unfortunately, there has not been an established clear and consistent career pattern for international health workers; efforts have been ad hoc, fragmented, obscure, and devoid of the possibility of long-term career planning. The International Health Service Corps is a concrete mechanism for addressing this needed health manpower tool to provide the kind of international health leadership required and expected of a great nation. There is no question that such a corps will also produce individuals who can provide effective leadership to the domestic health problems of the United States. From personal experience, as a former medical director of the Peace Corps over 15 years ago, I know many of the young medical officers who were then posted overseas as Peace Corps physicians that are now in positions of major responsibility and leadership in public health in the United States, whether in the academic com-

munity, in Government, at whatever level. One was sitting here at the table testifying earlier this morning, Mr. Chairman.

On a personal note, I would like to see the Corps emphasize public health activities like health promotion, disease prevention, and health administration, in contrast to medical care.

Section 6 of Senator Kennedy's bill proposes to establish a U.S. medical emergency mission. We think this should go a long way toward correcting some of the wasted energy and effort in the past by effectuating the kind of coordination required in a disaster situation and insuring the participation of both the public and the private sector.

In conclusion, Mr. Chairman, the Association of Schools of Public Health stands ready, willing, and able to assist in the implementation of this act. It can be said that schools of public health have a long record of involvement in international health activities. And these efforts will continue, with or without the act, because many of us in schools of public health are committed to international health as an important function of our institutions. However, instead of the somewhat disjointed, discontinuous, and catch-as-catch-can financing that we are presently subsisting upon, this new act should provide ongoing resources and enhance our efforts to respond more effectively.

On behalf of all the deans of the 21 U.S. schools of public health, Senator Javits, I wish to thank you and the members of the subcommittee for giving us the opportunity to comment on these bills.

[The prepared statement of Dr. Banta follows:]

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STATEMENT OF

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UNIVERSITY

ON BEHALF OF

THE ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH

BEFORE

THE LABOR AND HUMAN RESOURCES
SUBCOMMITTEE ON HEALTH AND SCIENTIFIC RESEARCH

ON

THE INTERNATIONAL HEALTH COOPERATION ACT OF 1980
AND
THE INTERNATIONAL HEALTH ACT OF 1979

Washington, D.C.
July 2, 1980

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STATEMENT OF THE ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH TO THE SUBCOMMITTEE ON HEALTH AND SCIENTIFIC AFFAIRS OF THE SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES ON A BILL WITH AMENDMENTS (S. 1424) TO AMEND THE FOREIGN ASSISTANCE ACT AND THE PUBLIC HEALTH SERVICE ACT, JULY 2, 1980, WASHINGTON, D.C.

Mr Chairman, Members of the Subcommittee, I am Dr. James Banta, Dean of the School of Public Health and Tropical Medicine at Tulane University. I am also President of the Association of Schools of Public Health (ASPH)* on whose behalf I am appearing today.

Senator Jacob Javits in a speech before the American Public Health Association meeting in November, 1979 quoted the British statesman Benjamin Disraeli as saying, "The health of the people is really the foundation upon which all happiness, and all their powers as a state, depend." These sentiments which apply not only to the nation state, but to the world, were given substance by Senator Javits when he introduced Senate Bill 1424 to amend the Foreign Assistance Act and the Public Health Service Act to provide for the advancement in international cooperation and assistance in health and for other purposes. The Association of Schools of Public Health is aware of Senator Javits' continuing efforts in championing the cause of health for which we all owe him a great debt, and his bill introduced for himself and his colleagues nearly one year ago in the Senate is another example of his wisdom and dedication in seeking to articulate in legislative terms a mechanism to help assure the good health of all people.

Mr Chairman, we also applaud your efforts in the field of international health, especially your attempts to focus national attention and resources on the plight of the world's refugees. We, therefore, strongly support your amendment to S. 1424 which seeks to strengthen the original bill.

*ASPH is the only national organization representing the Deans, faculty and students of the twenty-one Schools of Public Health. The Schools represent the primary educational system that trains personnel needed to operate our Nation's public health, disease prevention and health promotion programs. ASPH's principal purpose is to promote and improve the education and training of professional public health personnel.

Several strengthening sections have been added. The bill clearly articulates the importance of world health, not only as an important humanitarian concern, but as an integral part of United States international policy and seeks to establish mechanisms by which national goals may be achieved through concrete policy, programs, and actions.

Health has been recognized for some time as being an important and integral part of the socio-economic process and as such has received some consideration from several US development assistance agencies through the years. However, health transcends purely socio-economic developmental interests and foreign assistance to developing countries because achievement of health is a true international enterprise. This very fact makes it a particularly valuable vehicle for the United States to project its humanitarian concerns, transcending politics and ideology and building thereby a bridge of international communication and cooperation across which other matters may later travel.

International health activities are not a one way street in which the wealthy donor country gives all but receives little in return. On the contrary, it is a good use of taxpayers funds and a sound investment for all. One recent dramatic and concrete example of the mutual benefit inherent in international health programs is the successful smallpox erradication program of the World Health Organization in which the United States government was a major participant. Not only did many United States Public Health Service Officers receive valuable field experience in epidemiologic control, knowledge which is now being used by our own National Center for Disease Control in the furtherance of its domestic responsibility in the United States, but one other very important benefit has been an economic one. The savings accruing to our national economy in not having to immunize people against smallpox is considerable and estimated at some 150 million dollars annually. As long as epidemic infectious disease exists anywhere in the world, it remains a potential threat to the United States. This is true of the epidemic diseases such as dengue, yellow fever, other vector borne diseases, and cholera. We are ever mindful of these threats in our part of world in Louisiana and hence any effort to control these diseases internationally is of direct domestic benefit to us in our part of the nation, and this is true throughout the nation as well, especially in this age of rapid air transport. International health therefore transcends the interests of A.I.D., Department of State, and the socio-economic development fraternity as articulated in the Foreign Assistance Act. The present proposed Act recognizes this by virtue of the fact that it seeks to amend both the Foreign Assistance Act and the Public Health Service Act and I believe appropriately so.

An important aspect of the Act is the strengthening of the coordination of international health activities by the United States government which are now fragmented and scattered through a number of agencies. The Director of the Office of International Health and others have sought from time to

time to coordinate their efforts and to strengthen interdepartmental and interagency cooperation and communication. Unfortunately, this has been without an official mandate or legislative authority. The establishment of an international health sub-committee of the development coordination committee and the clear legislative establishment of an Office of International Health directed by a Deputy Assistant Secretary for International Health will greatly strengthen coordination, communication, and cooperation.

By invigorating the Fogarty International Health Center and providing it with operational capability, it will go far toward establishing a focal point within the Public Health Service for the conduct of meaningful international health programs. International health is an endeavor for which there are many unanswered questions and which will require considerable continuing research, development, and administrative imagination for their solution. We are pleased to see a clear articulation of this principle in the Bill with the emphasis on the need for a close colloborative relationship between academic institutions and the Fogarty International Health Center in carrying out both research and academic training relating to the solution of international health problems.

The bill fails to address adequately the special resources available in the National Center for Disease Control, (NCDC), Public Health Service, in Atlanta, Georgia. The special expertise of NCDC has long been utilized by the international health community, its officers have been assigned to the World Health Organization. It was the principal agency of the US government that provided manpower for the WHO worldwide smallpox eradication program. NCDC for a number of years provided the manpower for the AID Malaria Control Program. Because of NCDC responsibility with the Schools of Public Health, departments of preventive medicine, and state health departments, it would by very appropriate for the Act to contain a section which mobilizes the resources of NCDC in a manner similar to the Fogarty Center as a resource for international health activities.

This need for collaboration between the United States government and the academic community and a source of continuing stable financial support are absolutely vital and essential to the successful consummation of this Act. Speaking for the Association of Schools of Public Health I can state unequivocally that the Schools of Public Health stand ready to cooperate in this endeavor. Indeed, we have a long history of such cooperation and if one were to poll the members of most Ministries of Health throughout the world one would find a significant number of graduates from United States Schools of Public Health. For example, at the Tulane University School of Public Health and Tropical Medicine approximately one-fourth of our annual student body, that is some 100 students, are foreign nationals and at Johns Hopkins approximately 13 percent are foreign nationals. Over 18 and 12 percent, respectively, of the students at the UCLA School of Public Health and Columbia University School of Public Health are specializing in international health affairs. In addition, many of the Schools have had contractual obligations with the U.S. Agency for International Development for the conduct of health activities both domestically and abroad

pursuant to the mandate of the Agency. There have from time to time been international biomedical research activities conducted under the auspices of the National Institutes of Health. But these efforts, with A.I.D., N.I.H., etc., while not insignificant, have been disparate and have lacked the cohesion, continuity, and flexibility which an ongoing, adequately funded legislatively recognized program would afford. I believe the present Bill addresses this problem.

Successful international health effort depends principally upon the quality and dedication of the people engaged in the enterprise. It requires individuals who are not only very well trained technically, but who also have the ability to communicate and work across cultural barriers, to be good listeners, to be change agents, while coping with considerable frustration. Such health professionals are not a common breed. Having many of the characteristics of the classical Peace Corps volunteer, they are the heart and soul of a successful international health program or indeed any health program seeking to help the alienated, and the socially and economically disadvantaged. There are many Americans interested in a career in international health whether physicians, nurses, veterinarians, health administrators, or in fact virtually all the health professions. Unfortunately, there has not been an established, clear and consistant career pattern for international health workers; efforts have been ad hoc, fragmented, obscure, and devoid of the possibility of long term career planning. The International Health Service Corps is a concrete, practical and cost effective mechanism for addressing this desperately needed health manpower tool to provide the kind of international health leadership required and expected of a great nation. There is no question that such a Corps will also produce individuals who can provide effective leadership to the domestic health problems of the United States. From personal experience as a former Medical Director of the Peace Corps over fifteen years ago, I know that many of the young medical officers who were then posted overseas as Peace Corps physicians are now in positions of major responsibility and leadership in public health in the United States, whether in the academic community, in government, at the local, state, and federal level.

The United States is called upon often to respond to some major international emergency resulting from natural catastrophe or social upheaval. Our response as a people has been motivated by the highest humanitarian concerns and our response has usually been positive, if too often characterized by ad hoc, disorganized, or inadequately coordinated effort. Section 6 of the Bill proposes to establish a United States Medical Emergency Mission which should go a long way toward correcting some of the wasted energy and effort of the past. This section of the Act will affectuate the kind of coordination required in a disaster situation and insure the participation of both the public and the private sector by providing a focus to which all may turn in a time of disaster for guidance, communication and coordination, thereby insuring a cost effective relief effort.

From my own past experience in the government, Mr. Chairman, I can assure you of the great need for appropriate intergovernmental coordination of

United States international health efforts. Present activities are indeed fragmented and uncoordinated. As a taxpayer I fully support the efforts of our government in international health, but I believe that these efforts should be the most cost effective possible to maximize the impact of the tax dollars spent. There seems little excuse for the present uncoordinated efforts. The intergovernmental coordinating committee for international health addressed in Section 7 of the Act and in Title I of the original submission should go a long way toward solving this problem of coordination, thereby helping to assure maximum impact from our international health efforts and dollars, not only the efforts of official government agencies, but also those of the private volunteer organizations, including the academic community.

In conclusion, the Association of Schools of Public Health stands ready, willing and able to assist in the implementation of this Act. I would not presume to speak for the sister professional schools of the Association, such as medicine, nursing, dentistry, veterinary medicine, etc. However, I would venture that they too will find much to applaud in the Act which will enable them to carry out programs in international health, especially health manpower training and research, thereby mobilizing their considerable talents on behalf of the United States effort in international health. It can be said that Schools of Public Health have a long record of involvement in international health activities. In fact, a number of the Schools have as a major focus international health, especially the training of health administrators, specialists in tropical medicine, nutrition, family planning, and maternal and child health. They also present a substantial resource in terms of technical assistance capacity to be provided to developing countries, as well as research and development capability to address the health problems confronting developing countries. These efforts will continue with or without the Bill because many of us in Schools of Public Health are committed to international health as an important function of our institutions. However, instead of the somewhat disjointed, discontinuous, and catch-as-catch-can financing that we are presently subsisting upon, this new Act should provide ongoing resources and enhance our efforts to respond more effectively, particularly in the areas of tropical medicine, epidemiology, health planning, health care organization and management, and health policy. Our capacity can be enhanced with regards to developing countries and we can thereby become a more viable and cost effective instrument for achieving United States government policy goals in international health.

On behalf of all the Deans of the 21 U.S. Schools of Public Health, I wish to thank the Chairman and Members of the Subcommittee for giving us the opportunity to comment on S, 1424.

Senator JAVITS. Well, thank you very much, Dr. Banta, we really appreciate that and appreciate your great services in this field, as I expressed to Dr. Hamburg our appreciation for his great efforts.

Now, I think the degree of dependence, in view of your university background—the stability of the dependence which the schools of public health can have upon the Government agencies concerned is an important question.

Could you give us any evaluation of that? It may be our fault in the Congress—but, in any case, an evaluation of that from your point of view would be helpful.

Dr. BANTA. Well, schools of public health are by their very nature public sector institutions. The vast majority of our graduates assume positions in government or in nonprofit organizations—but mostly in government. Hence, historically, we have been very dependent upon, and I think we have also been responsive to, Congress in terms of our educational activities and in terms of responding to the mandate of the public for health personnel in the various health disciplines.

And this is certainly true of international health, particularly in the institutions which are part of State universities. In justifying their budgets to the State legislatures, they have to make a very strong case indeed in order to justify international health activities as part of their educational budget.

It is true that in spite of this the schools have been very active in training health manpower for the developing countries, sponsored by AID, sponsored by WHO. As a matter of fact, in our school, one-quarter, or 100 students, of our total student body of 400 are international students, are foreign students, sponsored by WHO, AID, or by their own governments. This is true of a number of other schools. Our proportion is perhaps a bit higher, but on the average for all the schools I think we can say that at least 10 percent of our student body are international students, and out of an annual student body of some 6,000, that is about 600 students that are being trained here in American schools of public health in international health, to go back in health administration, epidemiology, tropical medicine, maternal and child health, family planning, the very disciplines which are so much in need in the developing world.

But in order to develop an ongoing education program and a sound research base, one has to have ongoing funding which you can rely upon, which you can plan upon. Much of our international health activities that we carry on now are carried on on the basis of contracts, many with AID, but in AID obviously their need and their end is a product and not necessarily concerned with institution building in order to be able to respond to the need; it's that they want the golden egg but they don't really have either the will or the authority or the budget to afford to feed the goose. And I think what we really need is more concern for the goose, so that we will be able in fact to provide the kind of support that they need on a continuing basis.

Senator JAVITS. One last question, the morale factor. Of the people who are training in international health, of which you have quite a substantial number, what do you think is their present state of mind with respect to working in this field, in the context of

the Health and Human Services Department and the AID, and what would be the effect in your judgment as both a doctor and an educator if we did have a service like the International Health Service? You've heard me describe it. Can you give us your opinion on that?

Dr. BANTA. Well, we have a number of really dedicated individuals who want to serve in international health. Many of these individuals come to us from the mission field, who have been missionaries and who come back for further training in public health because they wish to apply public health methods and not alone primary care or clinical medicine.

So they have a very high morale. Many of them go back to their mission organizations.

Other young people, and some very good young people, ex-Peace Corps volunteers, for example, are very much concerned about what will my career opportunities be once I am trained? How can I utilize the skills which I acquire? And they look at the Government and they don't really see a very clear pathway in this regard; they don't see a very clear pattern either within the Public Health Service or within AID—and they are concerned about this. And I spend many hours counseling students in this regard. And one of the things that I have to counsel is patience and at the same time don't give up—keep trying, keep pushing.

But a lot of wasted energy, a lot of wasted motion in this exercise. While if there were a clear career pathway, it could be more easily mobilized.

One of the things we lack are resources, for example, to send young people overseas in a training capacity either for biomedical research or for public health activities. And I think this is a very badly needed component.

Senator JAVITS. Well, Dr. Banta, you have been very helpful, and I am very grateful to you.

If there is any further information that you wish to supply us with, as you consider your testimony, we will receive it by July 21 and incorporate it in the record.

Without objection, the record will remain open for that purpose.

Thank you very much.

Dr. BANTA. Thank you, sir.

Senator JAVITS. Our next witness is Russell E. Morgan, executive director of the National Council on International Health.

Dr. Morgan, without objection, we will include your total statement in the record, and could you please try to testify to a summary of it in 10 minutes.

STATEMENT OF RUSSELL E. MORGAN, JR., PH. D., EXECUTIVE DIRECTOR, NATIONAL COUNCIL ON INTERNATIONAL HEALTH

Dr. MORGAN. Thank you very much, Senator Javits, and I will try to comply with your time.

I appreciate very much your inviting me here this morning to testify on both your bill, S. 1424, and Senator Kennedy's amendment to that bill. I am speaking this morning in my capacity as executive director of the National Council on International Health. The comments which I make are those of my own and do not

represent necessarily a consensus of all the different member organizations of the Council.

In my testimony I give a broader understanding of the Council and its functions, but I think it's important to point out that the Council's principal mission is to make more effective use of U.S. resources for international health activities, particularly as they relate to the developing countries.

I would like to begin by commending both you, Senator Javits, and Senator Kennedy, together with other members of your committee and your staff for recognizing the important role of the United States in international health activities in the developing world.

Senator JAVITS. Doctor, would you mind if we carried appendix A right at the top of your testimony? That is a list of your members.

Dr. MORGAN. That would be fine.

Senator JAVITS. We will include that at the very top of your testimony.

Dr. MORGAN. The preambles of both your bill and of Senator Kennedy's outlined some of the important issues that relate to the United States and its activities in international health, and, as we are all aware, the developing countries themselves are becoming more assertive and ever more determined to exert their own leverage in the international system, and therefore, whether in health or in other segments, the idea of cooperation and joint participation is an absolute element in the decisionmaking process.

And recent activities, both in the World Health Organization, in the UNICEF, and the World Bank, underscore the importance which health as an overall factor in development is being given.

We are here this morning because we recognize that resources for international health are somewhat limited. If we go back to 1958, we can find that Senator Hubert Humphrey returned from Europe and found that there were a large number of opportunities for the United States. In his report: "The U.S. Government in the Future of International Medical Research," he pointed out the real benefits that could be accrued from the United States joint Government and private agency interventions.

More recently, as was pointed out in other testimony today, the White House issued a report illustrating that there were 22 Federal agencies involved in international health. But recently there was a survey completed, in June of 1980, which identified an initial group of 325 U.S. private sector organizations, including voluntary agencies, professional groups, universities, religious organizations, foundations, consulting groups, corporations, and labor unions which presently have international health activities in developing countries. And of those, 176 of these organizations collectively provide $410 million a year in support of these international health activities in developing countries.

It seems obvious to us therefore that with the vast wealth of resources in the United States there should be joint U.S. Government and private sector collaborative efforts. And therefore we certainly favor any legislation which is aimed at increasing the coordination within the U.S. Government and the private sector, especially one which is aimed at increasing and targeting the U.S. resources in specific areas. We also favor legislation which encour-

ages increased direct collaboration efforts between the United States and the developing countries.

I think overall I can say that I, and I believe the Council, are very supportive and enthusiastic about the legislation which is proposed by yourself and Senator Kennedy.

There are three things, though, in general that I would like to point out in terms of our concerns about the legislation.

First, is an issue that may not be immediately addressed by this legislation, but which certainly is a concern to all of us in the international health field; that is, the lack of a clear U.S. policy about the United States and its role in international health. We find that there are many Government agencies involved, and each agency more or less is deciding its own policy and its own direction for international health. Our feeling is that Congress needs to give some guidance and policy direction to Government if coordination in fact is to really be achieved.

The second concern is that we would like to see more emphasis on the participation of U.S. private sector organizations in the coordination effort. As I pointed out, there are hundreds of U.S. private agencies involved in this effort, and with these resources we believe that the United States can make a more valuable contribution than through Government efforts alone.

And, finally, the third concern is the fact that the term "health" needs a more refined definition. We would particularly like to see health be interpreted both in the context of preventive as well as medical and curative services. The fact is that health is linked to overall development, including agriculture, education, and industrialization. Health is also a linkage among the various sectoral programs, such as population, disease control, and sanitation.

I would like to now focus on what I consider to be the four main elements of the legislation, and provide you with some comments.

The first element is the concept of increasing Government coordination in international health. The legislation suggests the institutionalization of the International Health Subcommittee. We certainly believe that such legislation is necessary. Currently, as was pointed out, there is an informal subcommittee, but the success of that seems to us highly dependent on the personalities of the current chairmen. And, as Dr. Hamburg pointed out, looking down the road several years from now, we believe that the idea of institutionalizing it through formal legislation would be an important element. We would only like to encourage that the amendment in Senator Kennedy's bill is added on to yours in the sense of including the private sector as a partner in that coordination process.

Second, the concept of formalizing the Office of International Health in the Department of Health and Human Services. There are six operating agencies within the Department of Health and Human Services; each of those six agencies has an international health component. We think that one of the elements that may be unclear in the legislation at this point is the process by which decisions would be made among those agencies in that coordinated effort. Once this is decided, then certainly an office such as the Office of International Health, could be selected as the lead agency in that effort.

There is a second element of strengthening the private sector participation in international health through the establishment of the Hubert Humphrey Fund. We certainly applaud the concept of establishing a fund that would be outside the Government to promote the private sector agencies, and have special emphasis on the voluntary organizations. And we also applaud the concept of naming this after Senator Hubert Humphrey for his previous achievements in this area.

There are four aspects, though, within the establishment of the fund that we would like to make as recommendations.

The first is to increase the number of people on the fund to 22 representatives. The additional six representatives we believe should include individuals from the developing countries, because they bring an important perspective into our decisionmaking process.

Second, the idea that the fund should support voluntary agencies—we think very strongly that that is appropriate—but we also think that there are other private sector organizations in the United States which also should be able to receive support from such a fund, and therefore we would suggest that the definition of "private sector" be expanded.

And, third, we talk about the fund not limiting itself solely to receiving Government support, but that it might be established in somewhat the element of an endowment fund, being able to receive both private and Government support, and both from the United States as well as from the developing countries.

And, finally, we point out that the fund would promote research specifically designed to mobilize private sector support for international health. This could include such activities as the role of the pharmaceutical corporations in developing new drugs for developing countries.

There are two issues that we raise about the establishment of the fund. The first of which is that the fund may be in some competition to the role of the Private and Voluntary Cooperation Office of the Agency for International Development; and, second, we question whether it is necessary to establish an entirely new organization to manage the fund, or whether this might not be undertaken by some existing agency.

It is also pointed out in the proposed legislation that there be the establishment of a medical emergency mission. The experience which has been seen over the last 10 to 12 months with the Cambodian refugee effort in particular has pointed out the absolute importance of the coordinated effort in the refugee relief, and particularly in the health sector. We have seen that the voluntary agencies and the Government agencies have been able to come together and in a very short amount of time respond to the needs in Thailand and produce very substantive results. We certainly would endorse the idea of a medical emergency mission; we would just question, though, that the amount that is being requested is rather small, considering the expense for travel and other items involved.

The third element in the proposed legislation is the idea of the U.S. developing new health manpower in international health. Certainly one of the real problems today is that there are almost no

formalized graduate or postgraduate training programs in the United States specifically for international health. And, in addition, there are fewer opportunities for individual Government employees to use their skills and experiences to help counterparts in developing countries to produce more effective results.

Therefore, we would support the concepts, but we would say that within the training area that opportunities ought to be directed not only toward physicians but also with greater importance toward nurses, public health workers, laboratory technicians, allied health professionals, and, as was pointed out, research scientists.

We also believe that this training should have a heavy emphasis on field activities which can be tied into some of the U.S. voluntary agencies which are working in the country. The idea of the international health corps, if established, we believe might be specifically designed to facilitate the exchange of Government personnel from the United States to the governments of the developing countries. This would represent for some Government employees both a career opportunity, and for others it would be a midlevel opportunity for them to work with their counterparts in other countries.

What we would be very cautious about is that the corps not be set up in competition with the private sector organizations, the professional agencies, the consulting agencies, the universities, which are providing health manpower to these countries, and therefore the idea of a corps on a government-to-government basis would seem appropriate to us.

And, finally, the legislation focuses on the idea of U.S. involvement in international health research. There is no question that health research is a priority need in developing countries. We would just caution, though, that the research incorporate a number of values that we pointed out in our testimony I think the most important of these values is that the research focus on two things. One, building up the capacity within the developing countries; and, second, that it focus on applied research, particularly as it relates to primary health care.

There are many of my colleagues who are working in the primary health care area in developing countries who are concerned that unless specific guidelines are placed on research activities, that there is a tendency that they will tend to gravitate toward highly technical subjects that might have limited application for the developing countries.

Again, the research between the universities and the voluntary agencies is an area for possible collaboration and one which we would endorse.

I would like to say, Mr. Chairman, that we are enthusiastic, have a strong interest in this bill, and we are very happy to support it and to work with you and your committee, as you see fit, to helping it become a realistic piece of legislation. We would like to reemphasize the importance of the U.S. private sector in our Nation's international health efforts, and we would hope that any modifications that the bill will take will encourage the role of the private sector and increase the effective cooperation between the U.S. Government and the private sector agencies in the United States toward the goal of world health.

Thank you very much.

[The prepared statement of Dr. Morgan and additional statements supplied for the record follow:]

Testimony on Senator Javits' Bill (S-1424) to Amend the Foreign Assistance Act and the Public Health Service Act, and on Senator Kennedy's Ammendment to Senator Javits' Bill

Presented to

The Senate Subcommittee on Health and Scientific Research
Committee on Labor and Human Resources

July 2, 1980

Presented by

Dr. Russell E. Morgan, Jr., Executive Director
National Council for International Health
Washington, D.C.

Mr. Chairman, members of the subcommittee, I appreciate your inviting me here this morning to give testimony on Senator Javits' Bill (S-1424) and Senator Kennedy's amendment to that Bill, both of which are to amend the Foreign Assistance Act and the Public Health Act and to provide for the advancement of international cooperation and assistance in health.

The focus of my testimony will be two fold: first, in more general terms, to outline how the proposed legislation could be strengthened so that our country can move more closely toward development of a unified international health policy; and second, in specific terms, to identify strengths and weaknesses in the major components of the proposed legislation. I have also taken the liberty to propose several new ideas which I believe will help in overcoming some of the weaknesses which I identify.

I am speaking to you today in my capacity as Director of the National Council for International Health (NCIH). However, the comments which I make are my own and do not necessarily reflect a concensus of the member organizations of the Council. The Council was established in 1971 as a non-profit organization with membership including both individuals and organizations. Its Governing Board now consists of twenty-two private and government agencies involved in international health (refer to Appendix A). The Council has its permanent staff and headquarters office in Washington, D.C., and we receive our funding from both private and government sources. The Council serves as a link - an "umbrella" organization, gathering and disseminating information, offering technical assistance, and a forum where those involved in international health can meet and share ideas and experiences. Each year we hold an annual international health conference in the United States. This year our meeting focused on the theme of evaluation, and three hundred fifty representatives from the U.S. and foreign countries attended. The principle mission of the Council is to make more effective use of U.S. resources in international health activities, especially as they relate to the needs of the developing countries.

I would like to commend Senator Javits and Senator Kennedy, together with the other members of this subcommittee, for their recognition of the important role of the United States in helping to meet the international health needs of the developing world. Clearly, the United States, with its extensive human and organizational resources in the health sector, must take a leadership role and make a commitment now to work with the developing countries in seeking practical solutions. The health problems which face these countries inflict not only human suffering, but also directly affect the ability of the developing

countries to achieve satisfactory economic productivity and political stability.

Status of U.S. International Health Efforts

The preambles to the bills of both Senator Javits and Senator Kennedy identify the important linkages which exist between the United States and the developing world and the key role which health assistance plays in bringing the two more closely together. Increasingly, the United States' stake in developing nations is deepening, both for humanitarian as well as economic and political reasons. Similarly, the developing countries themselves have grown more assertive and evermore determined to exert their own leverage in the international system. As a result, decisions, whether in health or other sectors, must be designed cooperatively and implemented through common agreement.

Recent developments in the United Nations system echo these changes in international relationships. The New International Economic Order (NIEO) is the most candid of these movements in which developing countries are negotiating for their equal share. To achieve this goal, a New International Development Strategy is being designed, and one of its most crucial components is the concept of Technical Cooperation among Developing Countries (TCDC).

New relationships leading to international cooperation have clearly emerged in the development sector. For example, the International Year of the Child and the Decade for Women and Development have both resulted in a new emphasis on programs to enhance the human resource potential of the developing countries.

New health initiatives supported by World Health Organization and UNICEF leadership have been given the awesome reponsibility of underpinning the development of these human resource initiatives in developing countries. Using the slogan of "Health for All by the Year 2000", WHO is now working with member countires to make this goal a reality. Primary Health Care is seen as a key component in the health delivery system; major research and commuinity based field projects are being designed and tested to determine which primary health care approach is most successful. Similarly, the World Bank has just issued a major policy statement which will enable it to make direct loans for health programs in the developing countries.

Limited resources for health, both national and international, however, make the process of achieving "Health for All by the Year 2000" evermore difficult.

Over the past few decades a number of significant changes have begun to occur within the United States which have direct bearing on the ability of the United States to respond to the health needs of developing countries. In 1958, Senator Hubert Humphrey returned from Europe and in his report, "The U.S. Government and the Future of International Medical Research", he extolled the benefits to be derived from a strengthened global health policy. From that point on, the number of U.S. governmental and private agencies involved in international health increased.

In 1979, for the first time, a White House report was issued which provided an overview of all aspects of the U.S. Government's activities in international health. The report noted that although the Government's efforts were substantial - twenty-two Federal Agenices with a total budget of $528 million a year contributing to international health - these efforts "have been heretofore piecemeal and uncoordinated". The report further states that "there has been in the past no effective overall U.S. international health policy".

In 1980, a survey of the U.S. private sector organizations involved in international health was completed. This survey identified an initial group of 325 U.S. private sector organizations, including voluntary agencies, professional groups, universities, foundations, consulting groups, corporations and labor unions, which are presently active in international health activities in developing countries. Of this group, 176 organizations collectively provide $410 million a year in support of these international health activities.

Given this vast wealth of resources in the United States, it is clear that steps should be taken to help the U.S. government and private sector to cooperate more actively with one another so they can better meet the needs of the developing countries.

New legislation is therefore timely and necessary. This legislation should result in:

1) more coordination and effective use of U.S Government and private sector resources;

2) more targeted and practical approaches to U.S. international health efforts;

3) increased direct collaboration efforts between U.S. and developing country organizations.

Comments on Provisions in the Javits and Kennedy Bills

General Comments

Overall, I am very supportive and enthusiastically endorse the provisions outlined in each of the bills. They are timely, and emphasize important priority roles for the U.S. in international health. The bills focus on increasing the effectiveness of the U.S. response, and on increasing the efficiency of our operations. The total annual amount being requested is more than relaistic during this period of budgetary constraints, and represents less funds then required to produce one new F-14 fighter plane.

There are several areas in the proposed legislation, however, which I believe require additional thought. First, the bills do not address a key issue and a fundamental problem that still exists - the lack of a clear U.S. policy regarding international health assistance. At present, each government agency determines its own policy. Congress needs to give guidance and policy direction if government agency coordination is to be achieved. Second, the bills do not adequately emphasize or give enough support and participation to U.S. private sector organizations in developing U.S. coordination activities. To be most effective, coordination should involve both government and private sector efforts. In this respect, the private sector includes both profit and non-profit voluntary organizations. Third, there is a need to emphasize, and to check carefully the wording in the legislation, to assure that the term "health" is consistently used. "Health" should be clearly defined to incorporate both the preventive as well as medical/curative aspects of care. Health in this context should also incorporate the concepts of integration at various levels. Health is linked to overall development, including agriculture, education, and industrialization. Health is also a linkage among population, nutrition, disease control, sanitation, and other sectoral activities. The present draft of the bill leaves this issue ambiguous, and thus allows possible confusion in future implementation.

Finally, I would like to point out that the legislation presented by Senator Javits and Senator Kennedy omits direct proposals for coordination within government agencies, other than the Department of Health and Human Services. Since such agencies as the International Development Cooperation Agency, the Department of State and the Peace Corps also have major roles in U.S. Government international health policy and programs, a review of their internal coordination system would seem useful at an appropriate time.

Specific Comments

The activities outlined in both Senator Javits' and Senator Kennedy's bills can be divided into four major categories as related to their objectives:

1. Increase Governmental Coordination in International Health
2. Strengthen U.S. Private Sector Participation in International Health
3. Promote U.S. Manpower Development for International Health
4. Expand U.S. Involvement in International Health Research

1. Increase Governmental Coordination in International Health

A. Institutionalize the International Health Subcommittee

It is clear that a problem exists, given the multiplicity of government agencies involved in international health. Already an informal health coordinating subcommittee has been established, but its success is highly dependent on the personalities of its chairmen. The need exists now to formalize this effort and to include private sector partnership in this activity.

To do this effectively, it is recommended that the committee be formally established, and that, as stated in Senator Kennedy's bill, a representative of the private sector be included in its composition.

B. Formalize the Office of International Health in the Department of Health and Human Services

There exists the need to bring U.S. Government health resources more actively into relationship with their counterparts in developing countries. Currently, there are six operating agencies within the Department of Health and Human Services. It would seem appropriate that coordination should exist among the different international components of each of these agencies. The Office of International Health may be the best agency to carry out this mandate. The bill, however, is unclear about the process by which decisions for agency coordination would take place. This process should be clarified before any final decision on a lead agency is finalized.

If the Office of International Health is selected, it would seem appropriate to bring the Fogarty Center and the proposed International Health Service Corps under the direction of this

Office. With regard to the Fogarty Center, some of the functions proposed may be more appropriately assigned to other agencies, as described later in this testimony.

2. Strengthen U.S. Private Sector Participation in International Health

A. Establishment of the Hubert H. Humphrey Fund for International Health

The idea of establishing a Fund outside government to promote U.S. private agencies, with special emphasis on voluntary organizations, is excellent and one whose time has arrived. Similarly, naming the Fund in honor of Senator Humphrey is a most appropriate and fitting testimony to his achievements in the area of international health.

In reviewing the proposed legislation, I noticed several areas where I believe some modification could help strengthen the concept of the Fund. First, I would recommend that the Fund's Board be increased to twenty-one members. The six new representatives should come from developing countries, thus bringing this important perspective to the decision-making process. Second, I would recommend that, although the private voluntary organizations would be the principle recipients of the Fund's support, other private sector organizations should also be eligible to receive support. A clear definition of which private organizations which can receive support is thus needed in the legislation. Third, I would recommend strongly that the Fund not limit itself solely to receiving government funds, but rather that the Fund be established as an endowment: receiving government and private funds both from the U.S. and the developing country. A creative matching grant and incentive program could also be incorporated into the Fund. Fourth, I would recommend that the Fund support research specifically designed to mobilize increased private sector support for international health. This research could include such topics as the role of private industry in international health. I do not believe the Fogarty Center in its proposed revised role as a government agency could carry out such activities effectively.

There are two issues raised by the creation of a Fund , which I would like to bring to your attention. The first relates to the role of the Fund in relation to the role of the Private and Voluntary Cooperation Office in AID which has a similar function. How will these two agencies differ and cooperate? The second issue is whether it is necessary to establish a separate new organization to manage the Fund, or whether this activity can be added to an existing non-governmental agency.

B. Establishment of a Medical Emergency Mission

The United States has long needed to establish a mechanism to respond rapidly and effectively to medical disasters and emergencies in developing countries. Recent experience in the Cambodian refugee situation has shown that coordinated health efforts offered by foreign countries can have a significant impact. This experience has shown the need for the rapid deployment of health professionals, initially for epidemiological surveillance and later for information and resource coordination among the private and government relief agencies .

Given the increasing rate of disasters and refugee problems which have been occurring throughout the world, it would seem that the amount of $1.0 million per year is rather conservative and that additional funds should be authorized in the final legislation.

3. Promote U.S. Health Manpower Development for International Health

Today no formalized graduate or post-graduate training programs exist for U.S. health professionals who want to work in developing countries. In addition, there are fewer opportunities for individual government employees to use their skills and experience to help their counterparts in developing countries.

The proposal in the legislation to (1) support graduate and post-graduate training via grant and contractual support administered through the Fogarty Center, and (2) establish an International Health Service Corps, are seen as most important.

It is recommended that the training opportunities not only be directed toward physicians, but also with greater importance to nurses, public health workers, laboratory technicians, and research scientists. Including field experience as part of the program is essential, and it is strongly recommended that the placement of many of these students should be with private voluntary agencies which are operating community-based primary health care programs in developing countries.

The International Health Service Corps, if established, should be specifically designed to facilitate the exchange of government personnel from the United States to the governments of developing countries. This would represent for some U.S. government employees a career development opportunity in international health, and for others it would represent a mid-level career opportunity to share their experiences and knowledge with counterparts in developing countries. I would recommend that the Corps first be tried on a two-year experimental basis, and thereafter reviewed. I would hope

that the positions filled by the Corps would not compete with those manpower resources provided by the U.S. private sector through voluntary agencies, professional associations, universities, and consulting firms which are also actively working in the developing countries.

4. Expand U.S. Involvement in International Health Research

The need to intensify research on health problems affecting developing countries is clearly evident; the approach by which this can be accomplished effectively is still unclear.

The concept of establishing centers for international health research and training in the United States will, I believe, only be successful if (i) the consortium of institutions with expertise in the U.S. are linked together to form the centers, (ii) the U.S. center is linked to counterpart research/training institutions in several developing countries, (iii) the U.S. and developing countries jointly decide on priorities of research, (iv) a critical part of the program involves building up the capacity of the research/training institutes in the developing countries, and (v) the emphasis of the activities is focused on applied research activities related to primary health care and strengthening of the national health care delivery system.

Many of my colleagues who are working in primary health care programs in developing countries are concerned that unless specific guidelines are placed on the research activities, they will gravitate toward highly technical subjects with limited practical application.

This is an especially good area for joint cooperation betweeen the university research community and the private and voluntary organizations which stress an applied approach toward problem solving. I would hope that the Fogarty Center would encourage this form of collaboration in supporting such research activities.

I would also suggest that the Fogarty Center is not the appropriate institution to document international health experiences. Rather, I believe this responsibility should be delegated to the National Library of Medicine (NLM). The NLM has the expertise and the systems capability to document and index international health experiences in primary health care. They also have the computer system to quickly share this information with research and training institutions in the developing world. To try to duplicate this system would seem to me to be unnecessary. The need to document and share the information is, however, essential for both training and research and on-going evaluation.

Mr. Chairman, I would like to stress the enthusiasm and interest which the members of the National Council for International Health have in Senator Javits' and Senator Kennedy's legislation. I hope you find these comments constructive. Within our resources, the Council would be pleased to be of any further assistance, as your committee sees appropriate in helping to further this legislation.

Finally, I would like to re-emphasize the importance of the U.S. private sector in our nation's international health efforts. I hope any modifications in the bill will help encourage their role, and will increase the effective cooperation between the U.S. Government and private agencies in helping the world to reach a better state of health.

Thank you for allowing me to present my views to your Committee today.

APPENDIX A

NATIONAL COUNCIL FOR INTERNATIONAL HEALTH- 1980
COUNCIL MEMBERS

Sponsoring Organizations

American Dental Association
Dr. Charles T. Henry
Ms. Jan Walquist

American Hospital Association
Dr. Matthew F. McNulty, Jr.
Dr. Jose Gonzalez

American Medical Association
Dr. C. H. William Ruhe
Dr. Ira Singer

American Nurses Association
Dr. Doris E. Roberts
Dr. Mary S. Harper

American Public Health Association
Dr. Susi Kessler

American Society of Tropical Medicine and Hygiene
Dr. G. Thomas Strickland

Association of Schools of Public Health
Dr. Carl E. Taylor
Dr. Derrick Jeliffe

National Council of Churches
Dr. John Dr. Frame
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Mr. C. R. Cronk
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Dr. Henry L. Feffer
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Dr. Lilian K. Gibbons
Pan American Health Organization

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University of Michigan

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World Vision Relief Organization

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American Council of Voluntary Agencies for Foreign Service

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Peace Corps
Mr. David Levine

Official Canadian Observers

Canadian International Development Agency
Dr. C. W. L. Jeanes

Canadian Medical Association
Dr. John S. Bennet

U.S. COMMITTEE FOR W.H.O.

AMERICAN ASSOCIATION FOR WORLD HEALTH, INC.

777 United Nations Plaza
New York, N.Y. 10017
Area 212 — 986-8451

Office of the President: New York, NY • 212/369-7300

June 27, 1980

Mr. Robert Graham
c/o Senator Theodore Kennedy
United States Senate
431 Russell Senate Office Building
Washington, D.C. 20510

Dear Bob Graham:

In lieu of a personal appearance at the July 2nd hearings, the AAWH submits the attached material for inclusion in the record.

Sincerely,

Ruth Watson Lubic

Ruth Watson Lubic
President

Enc.

*Formerly **National Citizens Committee For The World Health Organization, Inc.**; since its founding on October 31, 1951 in San Francisco, membership and interest in all international health work so broadened that the new corporate name was adopted on June 21, 1966; directors and patrons are the **United States Committee For The World Health Organization.** Our purpose continues the same: to inform Americans about world health problems, to interest them in and to assist the programs of the W.H.O. and other agencies toward solving these problems, and so to work for world peace through better world health.

U.S. COMMITTEE FOR W.H.O.

AMERICAN ASSOCIATION FOR WORLD HEALTH, INC.

777 United Nations Plaza
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Office of the President: New York, NY • 212/369-7300

International Health Cooperation Act of 1980

Testimony of American Association for World Health/United States Committee
For The
World Health Organization

Submitted by,

Ruth W. Lubic

Dr. Ruth W. Lubic
President

Our Association, in my letter to you of June 6, has already placed itself on record as favoring the enactment by the Congress of the "International Health Cooperation Act of 1980." I shall not repeat, here, the points made in my letter, but ask that, this testimony be included in the hearings record.

The American Association for World Health (AAWH) was, I believe, the first national voluntary association dedicated to providing information to the U.S. public about the World Health Organization (WHO), and, in turn, to helping mobilize support from the American people for the objectives and programs of WHO. Established in 1951, it was originally called the "National Citizens Committee for the World Health Organization." The Citizens Committee developed essentially, though not exclusively, as an organization of professional health workers and its name was changed to the present one in 1966. We are currently embarking on an effort to expand the non-professional membership greatly, to establish local units in various parts of the country, and to improve our services to WHO and to the Pan American Health Organization (PAHO). Among other services, we plan to distribute selected publications of these two international health organizations. We will also be able to provide direct services to them under contract and will assist in creating a public awareness of the fine work these two organizations are doing. The AAWH is the only one of the several national voluntary organizations in the U.S. and working in international health, whose objectives are clearly related by its charter to public education and to mobilization of public support for international health.

Our interests are not limited to WHO and PAHO; we are also deeply interested in all international health programs including those sponsored by the U.S. government such as U.S./AID and the Peace Corps and in private initiatives of all kinds devoted to the health of human beings in all parts of the world. We are delighted to collaborate with other U.S. voluntary agencies whose interests and objectives are similar to or compatible with ours. These include the National Council for International Health, the International Health Society and the Pan American Health & Education Foundation, among others.

Our Association is supported by dues paid by its professional and public members, by contributions from public and private foundations, and from corporations interested in the international health field. We would like now to provide the Committee with some suggested amendments to the Bill which it is considering:

*Formerly **National Citizens Committee For The World Health Organization, Inc.**; since its founding on October 31, 1951 in San Francisco, membership and interest in all international health work so broadened that the new corporate name was adopted on June 21, 1966; directors and patrons are the **United States Committee For The World Health Organization.** Our purpose continues the same: to inform Americans about world health problems, to interest them in and to assist the programs of the W.H.O. and other agencies toward solving these problems, and so to work for world peace through better world health.

1. In Sec. 4(4): The Pan American Health Organization (PAHO) should be added to the list of international organizations with which the proposed office for International Health would maintain contacts.

2. Sec. 5(b)(1) would provide authority to make grants to or contracts with educational institutions to assist them to provide training to U.S. and other health workers in fields related to international health problems. As currently written this paragraph would limit such training to the United States. We feel this wording should be broadened not only to permit training to take place in the U.S. and other countries, but to permit reimbursement for costs and supervision of field trainees and/or establishment of field residence and/or clinical clerkships. The reasons for these suggested changes are as follows:

a. The WHO and PAHO sponsor many excellent training programs and centers in various parts of the world. In fact the U.S. is a participant in each one through its membership in those organizations and through its budgetary and technical contributions. These centers should be eligible for support and collaboration under the terms of the bill.

b. In some fields of public health international health practice such as tropical medicine, the problems are largely (though not exclusively) located in other countries. There are, of course, good academic programs in international health and tropical medicine in the United States, and they should participate. But we believe it would be unfortunate to exclude facilities in other countries which may be located closer to the field problems and would therefore be much more likely to be able to provide practical experience in program development and implementation in international rural health than would similar facilities in this country.

c. There are some fields in which the U.S. does not now provide training of the type needed in the world's less well developed areas. A good example is "primary care medicine," or "primary health care" as it is often called. These terms are used widely both in the U.S. and in developing countries, but they mean different things in the differing contexts and they are likely to be less widely applied both at present and in the future in the U.S. than in the developing nations. With the exception of the Frontier Nursing Service model, some programs of the Indian Health Service and a few urban and rural health centers in the U.S., we doubt that it would be efficient or efficacious to develop training programs for primary health care in the U.S. in the sense that it applies to the world's developing countries. Training should be carried out close to the contexts in which it will be used if at all possible.

d. Most field experience for health workers in community medicine and/or primary health care should be provided in the context and socio-cultural milieu, language and other characteristics typical of the people who are to be served and the situations under which these services are to be provided. This would be difficult within the United States and much more efficiently accomplished closer to the areas where U.S. health personnel might be asked to assist.

e. In addition it has become abundantly clear in the past few years that host countries, in requesting U.S. assistance in the international health area, insist more and more (as they should) that we send only people with considerable prior experience in planning and delivering such services. But, at the present time, there is no satisfactory or widely available mechanism by which interested young professionals, lacking this experience, can obtain it. They can rarely afford to "pay their own way" to a distant location in a developing country, much less provide for their own maintenance once they arrive; and the host countries seldom have the resources to provide these emoluments, much less the desired practical on-the-job supervision for the "student." The end result is a "Catch 22" type situation for those young, motivated professionals, who, faced with the requirement for considerable field experience, have no way to acquire it. This situation has resulted in a small to non-existent "pool" of academically and experientially qualified Americans who can staff U.S.-assisted programs in the area of international health.

All of these related issues support the view we have taken concerning the need for changing wording of Sec. 5(b)(1) to include overseas training and supervised experience.

3. Sec. 5(c): We see this provision for the establishment and support of health research (both theoretical and operational) and research training centers as of potentially very great and fundamental importance in expanding the "critical mass" of medical and health research capability throughout the world. Seen in this context, and since new medical and health promotion discoveries are available worldwide, the results of the program proposed to be created by this subsection may be fully as valuable to the people of the U.S.A. as they may be to the people of the less well developed countries themselves. In addition, there are many potentially capable investigators in the less well developed countries of the world who are excluded from making their contributions in their own countries by lack of resources and opportunities.

Our suggested amendment to this subsection is somewhat similar to the suggestion we have made with respect to subsection (b) of Section 5. We believe that the centers should be based, by and large, not in the United States, but in the developing countries themselves.

We believe, further, that the initiative to seek out and identify the U.S. institutions most appropriate to assist their counterparts in developing countries should be in the hands of the indigenous, rather than the U.S. institutions. We believe this change would not reduce or hurt the utilization of the best U.S. medical and health science centers. On the contrary, it would serve to direct their contributions toward the problems identified by the recipient institutions--a philosophy entirely consistent with the widely accepted principle that assistance must be in the context of the needs identified by the recipient institution, even if this identification does not fully correspond to that of the donor, providing institution. There is no better way to insure this absolutely vital condition than to put the initiative in the hands of the recipient. We also believe that AID missions, WHO, PAHO and appropriate other donors might be of significant service in this proposed program in assisting institutions in the developing world and in the United States to match their needs and their offerings efficiently for the benefit of both. The mechanism

of institution to institution linkages is not new in international technical assistance. The U.S./AID and bilateral programs of other countries have made wide use of them. WHO and PAHO have been less inclined to use this mechanism. It has been our observation that the success of such linkages, measured in terms of the improvement of the receiving institution, generally has depended on the extent to which the donor institution has been prepared to recognize those problems and programs identified by the recipient.

4. Sec. 6: We fully concur in the value of an International Health Service Corps. As has been shown by the Peace Corps, one of the great benefits to the United States of such a program would be the substantial number of young American health workers who, through direct grass roots service in a developing country, will understand and appreciate the very real health problems there, and in so doing develop greater appreciation for our own health problems and potential solutions. However, as we have already indicated in paragraph 2d, adequate professional supervision will be required if participation in Corps activities is to result in the kind of training experience we have recommended.

Our only suggestion with regard to Sec. 6 is that the 25% limitation, expressed in sub. par. (b)(2), on Corps members in areas such as planning, organization, management, etc. seems to us unfortunate. In fact, it is these very areas, more than in clinical fields, in which developing countries need help. We would much prefer to see the balance between the different services provided determined by the needs as they are seen by the requesting countries and agreed to by the Secretary and staff of the Department of Health & Human Services. Developing countries are emphasizing increasingly, the significance of good management and planning throughout the entire development process.

5. Sec. 6: Emergency Medical Mission (in our copy, both this and the previous section are labelled Sec. 6). With respect to this Section, we have two comments.

a. We would prefer for the Bill to authorize the Secretary to contract with a private organization for services or to provide the services directly with HHS resources, depending on the judgment of the relative efficiency of each approach. It might be appropriate for the Secretary to use a combination of both approaches.

b. We feel that the limitation of 3 months service to an affected country is unwise. Some epidemics last much longer than 3 months (the outbreak of meningococcic meningitis in Brazil in 1971-75, for example). Even in cases such as floods or earthquakes, the effect lasts much longer than 3 months. Careful planning and preparation for the next emergency should be an integral part of the assistance, but it seldom can be done in a 3-month period.

Thank you very much for this opportunity to comment and present our views.

TESTIMONY OF THE AMERICAN MEDICAL STUDENT ASSOCIATION
SUBMITTED TO THE
U.S. SENATE SUBCOMMITTEE ON HEALTH & SCIENTIFIC RESEARCH
HEARINGS ON THE
INTERNATIONAL HEALTH COOPERATION ACT OF 1980

Rocio Huet
National President

Joseph Adams
Dan Perlman
International Health Task Force

June 25, 1980

TESTIMONY OF THE AMERICAN MEDICAL STUDENT ASSOCIATION
SUBMITTED TO THE
U.S. SENATE SUBCOMMITTEE ON HEALTH & SCIENTIFIC RESEARCH
HEARINGS ON THE
INTERNATIONAL HEALTH COOPERATION ACT OF 1980

The American Medical Student Association (AMSA) is grateful for the opportunity to present the viewpoint of our membership. AMSA has over 20,000 members at 139 medical schools in this country. AMSA is a totally independent organization and we are proud of our record in improving medical education and health care. As future physicians we have a concern not only about problems affecting us directly, but in issues affecting the health of Americans and all peoples.

AMSA recognizes the need for and benefits derived from exposing American medical students and other health professionals to the particular problems and circumstances related to health in developing countries. The opportunity to compare and analyze other countries' varied situations allows us to more effectively appraise our own situation and hopefully apply these lessons to our own health care system through innovative means. As health professionals exposed to other countries, we also recognize the enormous potential for cooperation in the technical arena, especially training and research which could improve the health status of all populations. The United States has resources and personnel which could facilitate international health work throughout the world. AMSA has seen first-hand the new perspectives and insight gained by our own medical students after participation in the AMSA-sponsored trips to Cuba and China. We are sure many persons entering the health professions have particular interests in the issues of International Health; our own International Health Task Force within AMSA is the oldest and one of the largest task forces.

But we believe that many of these interested people can only be effective through familiarity with the special health problems of developing nations provided through field experiences. We not only see the value in cross-cultural experiences, but we also recognize that a greater emphasis on health in U.S. foreign assistance can foster better international relations and further international cooperation. The International Health Cooperation Act of 1980 addresses many of these issues in its provisions, and for this reason AMSA endorses this bill.

In order to improve and streamline international health activities, establish more coherent policy, and better distribute services, one department with a clear legislative authority for the oversight and coordination of all international health activities seems necessary. The department's efforts will be better coordinated and administered through an authorized position of Deputy Assistant Secretary for International Health.

New manpower training and research programs would provide valuable and needed support for U.S. institutions in a number of important fields related to international health. Resulting international field experiences will greatly further the competence of international health personnel. Collaborative research and training programs between institutions and professionals in more developed and less developed countries will have a positive impact on the most pressing health care problems of all the countries involved.

AMSA supports the creation of an International Health Service Corps. We have a great deal of experience with the National Health Service Corps through the Public Health Service Advocacy and NHSC Preceptorship programs. Medical care for millions of Americans would not be provided without the Corps, and there are many health professionals interested in providing care to these underserved areas. An IHSC would assist developing countries in strengthening and organizing their own health care

systems while providing very necessary care.

The U.S. Medical Emergency Mission could accelerate and improve the response of American health workers in disasters around the world. We strongly support the goals of this mission, and would stress that it should be mobilized solely upon request by other countries and for the purpose of providing health services.

In order to facilitate the improvement of U.S. involvement in international health and insure accountability of the various programs, the establishment of an intergovernmental coordinating committee for international health is desirable. It can serve the needed purposes of promoting coordination between U.S. agencies and reviewing and reporting the full range of U.S. international health activities.

In conclusion, in view of the unique resources of the United States, the potential for more coordinated and coherent policy, the opportunities to utilize American talent more fully, the potential insights with applicability to our own health care system, and the potential benefit to improved international health and cooperation, AMSA strongly endorses the International Health Cooperation Act of 1980.

Senator JAVITS. Thank you, Dr. Morgan. Now, I would like to do the same thing with you that I suggested to Dr. Hamburg. I would like to submit to you the outline of the departments of why they feel they have all the legislative authority they need, and have you advise us whether you agree or disagree, or what affirmative recommendations you have.

Would that be satisfactory to you?

Dr. MORGAN. I would be very pleased to do that, yes, sir.

Senator JAVITS. We will give you 1 week after July 21 to get it in, is that OK?

Dr. MORGAN. That would be fine.

Senator JAVITS. All right. Thank you very much, Dr. Morgan, we really appreciate your testimony.

Our colleague on the committee and a member of the subcommittee, Senator Hatch of Utah, had a statement with respect to these hearings and to the measures before us, which is to be included in the record immediately following my statement so they appear at the opening of this morning's hearing.

That completes our witness list for today. The subcommittee will stand adjourned at the call of the Chair.

[The subcommittee adjourned at 11:25 a.m.]

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