# DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE APPROPRIATIONS FOR 1961

# HEARINGS

BEFORE THE

## SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS HOUSE OF REPRESENTATIVES

EIGHTY-SIXTH CONGRESS

SECOND SESSION

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

JOHN E. FOGARTY, Rhode Island, *Chairman*

WINFIELD K. DENTON, Indiana
FRED MARSHALL, Minnesota
MELVIN R. LAIRD, Wisconsin
ELFORD A. CEDERBERG, Michigan

ROBERT M. MOYER, *Staff Assistant to Subcommittee*

## STATEMENTS OF MEMBERS OF CONGRESS, INTERESTED ORGANIZATIONS, AND INDIVIDUALS

Printed for the use of the Committee on Appropriations

Library
National Institutes of Health
Bethesda, 14, Maryland

# DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE APPROPRIATIONS FOR 1961

# HEARINGS

BEFORE THE

## SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS HOUSE OF REPRESENTATIVES

EIGHTY-SIXTH CONGRESS

SECOND SESSION

U.S. Congress. House.

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

JOHN E. FOGARTY, Rhode Island, *Chairman*

WINFIELD K. DENTON, Indiana
FRED MARSHALL, Minnesota
MELVIN R. LAIRD, Wisconsin
ELFORD A. CEDERBERG, Michigan

ROBERT M. MOYER, *Staff Assistant to Subcommittee*

APR 29 '60

## STATEMENTS OF MEMBERS OF CONGRESS, INTERESTED ORGANIZATIONS, AND INDIVIDUALS

Printed for the use of the Committee on Appropriations

UNITED STATES
GOVERNMENT PRINTING OFFICE
52692 WASHINGTON : 1960

## COMMITTEE ON APPROPRIATIONS

CLARENCE CANNON, Missouri, *Chairman*

GEORGE H. MAHON, Texas
HARRY R. SHEPPARD, California
ALBERT THOMAS, Texas
MICHAEL J. KIRWAN, Ohio
W. F. NORRELL, Arkansas
JAMIE L. WHITTEN, Mississippi
GEORGE W. ANDREWS, Alabama
JOHN J. ROONEY, New York
J. VAUGHAN GARY, Virginia
JOHN E. FOGARTY, Rhode Island
ROBERT L. F. SIKES, Florida
PRINCE H. PRESTON, Georgia
OTTO E. PASSMAN, Louisiana
LOUIS C. RABAUT, Michigan
SIDNEY R. YATES, Illinois
FRED MARSHALL, Minnesota
JOHN J. RILEY, South Carolina
JOE L. EVINS, Tennessee
JOHN F. SHELLEY, California
EDWARD P. BOLAND, Massachusetts
DON MAGNUSON, Washington
WILLIAM H. NATCHER, Kentucky
DANIEL J. FLOOD, Pennsylvania
WINFIELD K. DENTON, Indiana
TOM STEED, Oklahoma
HUGH Q. ALEXANDER, North Carolina
ALFRED E. SANTANGELO, New York
JOSEPH M. MONTOYA, New Mexico
GEORGE E. SHIPLEY, Illinois

JOHN TABER, New York
BEN F. JENSEN, Iowa
H. CARL ANDERSEN, Minnesota
WALT HORAN, Washington
GORDON CANFIELD, New Jersey
IVOR D. FENTON, Pennsylvania
GERALD R. FORD, JR., Michigan
HAROLD C. OSTERTAG, New York
FRANK T. BOW, Ohio
CHARLES RAPER JONAS, North Carolina
MELVIN R. LAIRD, Wisconsin
ELFORD A. CEDERBERG, Michigan
GLENARD P. LIPSCOMB, California
JOHN J. RHODES, Arizona
JOHN R. PILLION, New York
PHIL WEAVER, Nebraska
WILLIAM E. MINSHALL, Ohio
KEITH THOMSON, Wyoming
ROBERT H. MICHEL, Illinois
SILVIO O. CONTE, Massachusetts

KENNETH SPRANKLE, *Clerk and Staff Director*

002635

# DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE APPROPRIATIONS FOR 1961

MONDAY, FEBRUARY 29, 1960.

FOOD AND DRUG ADMINISTRATION, AND PUBLIC HEALTH SERVICE

## WITNESS

**MRS. DOROTHY GOODMAN, WASHINGTON REPRESENTATIVE, CONSUMERS UNION OF UNITED STATES, INC.**

Mr. FOGARTY. The committee will convene to hear public witnesses. First, we shall hear Mrs. Dorothy Goodman representing the Consumers Union of the United States, Inc. Mrs. Goodman, you may proceed.

Mrs. GOODMAN. My name is Dorothy Goodman. I am the Washington representative of Consumers Union of United States, Inc., with headquarters at Mount Vernon, N.Y. We are a nonprofit organization established in 1936 and chartered under the membership corporations law of the State of New York. We derive our income solely from the sale of our publications, chief of which is the monthly Consumer Reports. You might be interested in copies of our February issue which has reports on radioactivity in milk and on chemicals in food, including comments on PHS and FDA programs.

As you probably already know, Mr. Chairman, Consumers Union has no connection of any kind with any commercial interest. This is our bias, a noncommercial bias. We accept no advertising and our ratings and reports are solely for the information of our 850,000 members, subscribers, and newsstand buyers—and a good many more readers whom we reach through libraries, schools, and so forth.

We are one of the few and by far the largest independent organization speaking for the consumer as such. It is our business, our only business, to define the consumer interest. The modern consumer problem has developed in two spheres—that of consumer choice, and that of consumer protection. Under the former comes, of course, the work for which we are probably best known—the independent, comparative testing of consumer goods, and the publishing of the test results. We make the consumer a more rational being—or rather, we put information at his disposal which can make him a more rational being if he uses it to arrive at his individual economic decisions. This, in Consumers Union's view, is one way to make competition work better. Moreover, it is a service to the individual consumer facing, in a modern industrial economy, a complicated set of choices among goods about which he cannot possibly have enough knowledge to buy wisely.

Secondly, there is consumer protection. There are many areas where individual action is simply not effective. Here Consumers Union urges governmental action once we have defined, to the best of our ability, where the consumer interest lies. Defining the genuine consumer interest—sorting out the public interest from the many pressing private ones—is, as you gentlemen of the Congress know only too well, often very difficult, sometimes more difficult than deciding which is the best buy in washing machines. And conscientious citizens frequently differ on the definition of public interest in a specific issue.

Happily it is difficult for conscientious citizens to disagree on the matters before us today. What special interest can possibly be served by the Food and Drug Administration, or by the Public Health Service? From the consumer's standpoint they are as "pure" as human institutions can be. Naturally over the years Consumers Union has followed with particularly close interest the work of these two agencies.

FOOD AND DRUG ADMINISTRATION

As we said in an issue some months ago:

> In terms of direct protection to the consumer, the Federal Food, Drug, and Cosmetic Act is the most important single piece of legislation in the United States.

Gratified as we were that the Congress raised the FDA appropriation for fiscal 1960 by $2 million, Consumers Union would be only too glad to see a doubling, even a tripling, of FDA's budget. Similarly, we could almost automatically recommend, in any fiscal year, substantial increases over any conceivable budgetary proposal for the Public Health Service. No amount of money is too much to safeguard that most precious of our national resources, the health of the people.

Rapidly developing technology in the chemical industry continues to spawn new drugs, pesticides, and food additives, which lay a growing burden on the resources of the Food and Drug Administration.

Four long inflational years ago Consumers Union proposed that FDA's appropriation be increased to $20 million annually. That figure falls far short of today's much larger needs. Therefore the $16,852,000 for fiscal 1961 is, in Consumers Union's opinion, a very inadequate sum to ensure public protection. Even if it were raised to $18 million it would be a mere 10 cents per annum per head of population.

Much more attention must be given to the detection of pesticide and drug residues as certain famous events in recent months have well demonstrated. The FDA must devote more study to the bacterial content of frozen foods, and to their handling in the course of distribution; it must also have more resources to examine the properties of wax containers for cancer-causing or other dangerous chemicals; it must look further into the problem of deceptive packaging; it needs more money for the inspection of imports; and for its radiological program. In our opinion, FDA, with its practical pragmatic approach, is peculiarly well qualified to work on the determination of permissible levels of radioactivity in foods, drugs, and cosmetics.

Since FDA itself covers only interstate commerce, another urgent problem is State food and drug protection. This is very uneven and

in some places totally inadequate. Perhaps funds could be given FDA to investigate how to help the States improve their food and drug laws, and improve the enforcement of those laws.

Then there is the recruiting problem. It is exceedingly difficult for organizations of limited means—both inside and outside the Government—to compete with industry in recruiting technicians. Would it not be possible to change some of the civil service regulations so that FDA could hire scientists at higher grades?

We realize that very large budgetary increases would probably strain FDA's administrative structure, but we wonder whether this is not the time to stoke the fire rather beyond the point of easy current absorption. After the inevitable period of growing pains, public protection would be greatly enhanced. This committee, Mr. Chairman, would do the country an enormous service by seizing the initiative to secure a more rapid development of this scientific institution, the Food and Drug Administration.

One single measure which would substantially shorten the awkward period would be the provision of the new building here in Washington. The five scattered centers must be brought under one roof. I know this is not directly under your consideration at this time, Mr. Chairman, but CU is concerned that ground be broken at the earliest possible moment. FDA has too long been a Cinderella among Federal agencies, having to accept with a smile the crumbs of laboratory facilities grudgingly proffered by others.

### PUBLIC HEALTH SERVICE

Turning to the Public Health Service, may I say first, Mr. Chairman, that Consumers Union will be sending a letter for your deliberations next week on the environmental health problem. Meanwhile, we should like to note that the PHS allocation for water pollution should be greatly increased, first, to make possible long-term planning for entire drainage basins, and secondly, to develop new techniques for the treatment of wastes.

Mr. DENTON. We were not two-thirds in the overriding of the veto. The members here felt the same way you did.

Mrs. GOODMAN. I am glad to hear that.

Another PHS program which CU would like to see strengthened is accident prevention, for we have constantly a larger and larger population to protect. CU, by the way, has itself done some tests on auto seat belts, and also some work on poison control.

As with FDA, CU would like to emphasize the importance of Federal leadership in these PHS programs as a stimulus, direct or indirect, to local efforts.

Finally, radiological health. This is a problem close to us because, as perhaps you know, we undertook some 2 years ago a study of fallout, particularly of strontium 90 in milk. The first report was published in our March 1959 issue, and we again reported on milk in our February 1960 issue. We are currently working on strontium 90 in total diet.

The Surgeon General's Advisory Committee, headed by Prof. Russell Morgan, of Johns Hopkins, recommended last year that the Public Health Service burget for radiological health be increased radically so that within 5 years it would be on an annual level of $50 million. I doubt the $6 million-odd in this budget for fiscal year 1961 is enough

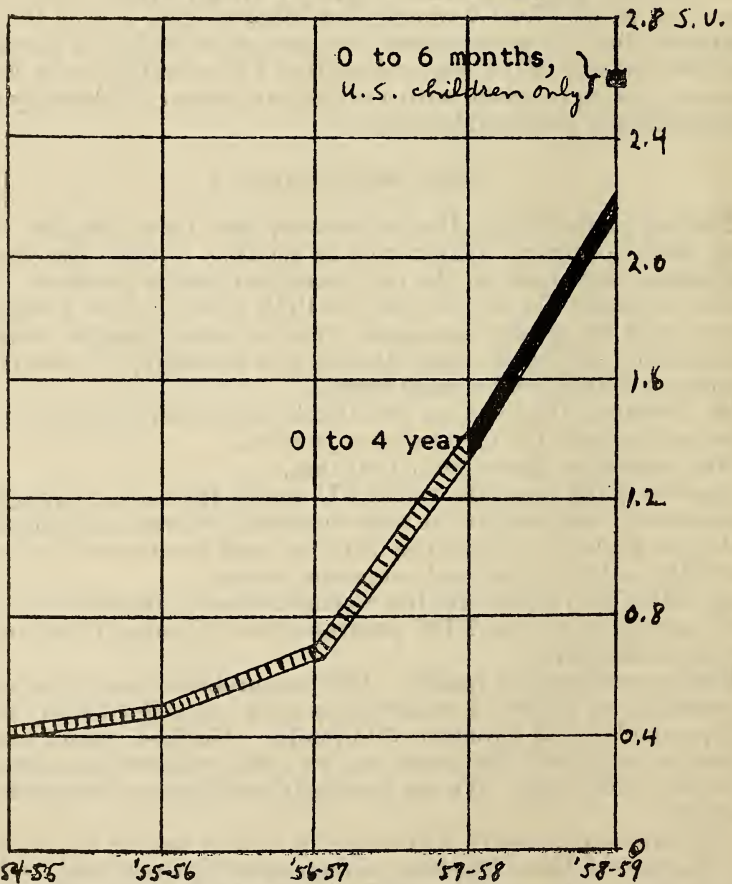
to keep pace with the Morgan recommendations. It may be sufficient for the work the Division of Radiological Health has actually planned, but it is unrealistically low in relation to public need. There is pitifully little testing of milk going on, much less than one sample per month per State, and none at all from some States. Moreover, this must be extended to regular studies of total diet, a job which the Public Health Service, with resources so infinitely greater than CU's, ought to do on a systematic basis.

I want to conclude with two bits of evidence which dramatize the need for more work on radiation hazards. Here is a graph of strontium units in children's bones published by the Atomic Energy Commission in its January 1960 quarterly report. It shows that the average of strontium 90 units in children's bones reached in all-time high between July 1958 and June 1959. I will submit that for the record, if I may, Mr. Chairman.

(The graph referred to follows:)

PRESENTED BY CONSUMERS UNION OF U.S., INC., FEBRUARY 29, 1960

AVERAGE STRONTIUM UNITS IN CHILDREN'S BONES




The latest data released by the AEC[1] shows that the level of strontium units in the bones of North American and European children is still climbing rapidly.

[1] In the January 1960 Quarterly Statement of the AEC.

Mrs. Goodman. Secondly, may I draw your attention to an article called "Leukemia and Geography" in the October 24 issue of the Lancet, the British medical journal. This article links strontium 90 more directly with leukemia than we have heretofore thought possible. A Welsh county medical officer has noted a marked increase during the 1950's in the incidence of leukemia in four rural counties in England and Wales, all mountainous, all with high rainfall, and all on or near the west coast. This British report is most suggestive for studies that should be made in this country. We need a much larger monitoring program and a much larger program in epidemiology.

Consumers Union urges your committee, Mr. Chairman, to increase the appropriations for FDA and PHS substantially above the proposed figures.

Mr. Fogarty. Thank you, Mrs. Goodman.

## National Rehabilitation Association

### WITNESS

### E. B. WHITTEN, EXECUTIVE DIRECTOR OF THE NATIONAL REHABILITATION ASSOCIATION

Mr. Fogarty. It is good to see you back again, Mr. Whitten.

Mr. Whitten. Thank you, Mr. Chairman. It is a privilege to be here again.

As I indicated in my first paragraph I have been up here so much I feel it is not necessary for me to go into detail in the identification of the National Rehabilitation Association which I represent.

I think I will stick to the brief statement I prepared, since I find frequently that when I summarize my statements I take longer summarizing them than I do reading them.

The budget recommends an allotment base of $63 million for grants to the States for vocational rehabilitation and an appropriation of $53 million to implement this allotment. We are asking that the allotment base be raised to $75 million for 1961, which will require an appropriation of $55.6 million.

As members of this committee know, there remains a tremendous job to be done in the vocational rehabilitation of the Nation's handicapped citizens. We shall not argue the values of vocational rehabilitation, for there seems to be no disagreement in either the executive or legislative branches of Government that rehabilitation is sound socially and economically, and that vocational rehabilitation programs should be expanded as rapidly as possible until the number of persons being rehabilitated is roughly equivalent to the annual increment of the number of individuals needing rehabilitation services.

So far as studies have revealed this appears to be $250,000 to $300,000 a year. It seems agreed by all that to do this is not only good for the individuals being served but is sound public policy in every way.

It is encouraging that many State legislatures show an increasing interest in vocational rehabilitation. With an allotment base of $63 million for 1961, 18 States would have a total of $4 million which would be unmatched by the Federal Government. A list of these States and the amounts of unmatched money they would have was

inserted in the record, we understand, by Miss Switzer when she appeared before this committee. If the allotment base is raised to $75 million, eight States will still have unmatched State funds. As indicated above, raising the allotment base to $75 million will require only $2.6 million additional appropriation. This additional appropriation will result in approximately 3,000 additional rehabilitations, considering these at the average cost in 1960.

### RESEARCH AND DEMONSTRATION

The budget calls for $7.8 million for research and demonstration for 1961. We are requesting that this amount be raised to $9.8 million. Our own investigations reveal that this research and demonstration program is having a tremendous effect in increasing interest in rehabilitation throughout the country, in bringing about the effective cooperation of public and voluntary agencies, and most important of all, of course, in revealing new methods and techniques for providing rehabilitation services to severely handicapped individuals. It will be difficult to completely evaluate the results of this research and demonstration for many years, yet already far-reaching results are clearly evident to those of us engaged in promoting rehabilitation.

This has been one of the amazing and unexpected results of this program, the fact that it has not exactly forced but provided avenues through which public and voluntary agencies work together in the rehabilitation process. Never before have we had anything which could compare with this cooperative effort which is going on in the development of special projects, particularly of the demonstration type throughout the country.

With the additional $2 million we are recommending, we are hopeful that the Office of Vocational Rehabilitation will be able to expand its research and demonstration activities particularly in these areas. There is no limit in the areas to which money could be spent. We are still in the stage of having to be highly selective in the use of the limited amounts of funds available in order to try to accomplish the most good with the limited means we have, so we think in the establishment of priorities for additional funds that are made available some of these should be had: the rehabilitation of the homebound; selected demonstrations in the rehabilitation of the mentally retarded and the mentally ill; rehabilitation programs for the chronically ill in hospitals, and demonstrations of how independent living programs can be developed. The inadequacy of this program at the present time is demonstrated by the fact that in 1960 there are only 14 demonstration projects dealing with mentally retarded, 5 for the mentally ill, 2 for rehabilitation in chronic illness hospitals, and 1 in independent living programs in State agencies.

I think everyone would agree there should be one to each State, although some States would not be in position to carry on such a project; there are only five for the mentally ill; only two projects dealing with the rehabilitation in chronic illness hospitals, where there is one of the greatest possibilities of finding individuals who can be removed from such hospitals by the effective use of known rehabilitation techniques, and there was only one program demonstrating how cases can be selected for independent living rehabilitation programs where vocational rehabilitation may not be the immediate objective.

I might say here that between——

Mr. FOGARTY. Where is that project?

Mr. WHITTEN. In Iowa. Between 15 and 20 States already have adopted State legislation for independent living for participation in Federal programs of this kind. This was one of the States.

They took advantage of State legislation to get funds locally.

The $2 million additional appropriation will enable Office of Vocational Rehabilitation to increase the number of new projects by 60 to 70 over the number that would have been begun with the amount recommended in the budget.

TRAINING

Seven million dollars is recommended for training in 1961. We are recommending that this amount be increased to $8 million. The involvement of the colleges and universities of the country in the rehabilitation movement has been most important. The individuals trained in the various university programs are already coming into the rehabilitation movement in considerable numbers, and this number will increase as years go on.

As will be noted in the figures given by the committee by the Office of Vocational Rehabilitation, the number of traineeships is still very small in comparison with the number of individuals who are needed to man the expanding programs which are contemplated. With $1 million additional funds which we recommend, we hope that the Office of Vocational Rehabilitation can expand substantially its efforts in these fields—preparing speech and hearing pathologists and audiologists, increase substantially the number of research fellowships, encourage additional training institutes for administrators of rehabilitation facilities, and to support more liberally inservice training programs in the State rehabilitation agencies.

I would like to say a word or two about one of these items I have mentioned.

The present training authority of the Office of Vocational Rehabilitation includes authority to train speech and hearing pathologists and audiologists, although it may be that the language in the act should be cleaned up a little bit to make it very specifically clear that this is not a limited authority. Office of Vocational Rehabilitation has begun a program in that field, in its second year, and a very limited number of fellowships and grants to colleges are available. The great need in this field is such that there has already been introduced special legislation dealing particularly with this problem which is now before the committees of Congress.

With respect to the research scholarships, it is through the research scholarships we will find the research people who will direct special projects of the future who will teach in the university training programs and such. That is one of the most tremendous lacks we have at the present time.

My own association, for instance, does a good deal of what we call survey research of various kinds. When you develop a project which you know is worthwhile, and can start looking around for someone to run it, an individual who has both rehabilitation knowledge and research knowledge, it is extremely difficult. We are almost in a position of stealing from each other.

We would like to say a word about the administrators of rehabilitation facilities.

With the funds recommended we hope to support one training institute for rehabilitation center administrators in 1961. It has no plans for offering training to administrators and supervisors of workshop programs. It is imperative that something be done along this line without delay. We are having numerous workshops developed in local communities throughout the country. Many of them are dealing with the specific categories of the mentally retarded and mentally ill and cerebral palsy.

Many of these workshops have to hire individuals who do not have previous experience in the workshop movement. They would be glad to hire better trained individuals and would do so if they were available. In many instances they would be willing to release their present administrators and supervisors to attend these training courses if they were available, but they are not.

We hope a substantial part of the additional money might be used by the Office of Vocational Rehabilitation in this field.

One other word about the training. I mentioned inservice training in State agencies. We already have in this country about 2,000 rehabilitation counselors, for instance, who are attached to the State rehabilitation agencies. Most of these individuals are people with families. They cannot stop their work for a year and go off to college to take a master's degree in rehabilitation counseling. Salaries do not justify that kind of thing.

We strongly feel that every possible emphasis should be put upon giving these people who are presently working opportunities to increase their skills by inservice training.

OVR has a small program where it is making a few thousand dollars available on some kind of matching basis through the State agencies to do that, but it is perhaps $5,000 to a State. It does not touch the need there.

In other words, the type of program releases a man for 6 weeks or 3 months or brings the faculty to the agency, so to speak, for inservice training programs. That would be of great value.

### NEED FOR EXPANDED OFFICE OF VOCATIONAL REHABILITATION

Without making specific recommendations, we would like also to call the attention of the committee to the fact that an expanded Office of Vocational Rehabilitation is necessary to meet its obligations for providing assistance to the States in this period of program expansion. We hope the committee will examine closely and sympathetically the request for additional funds for expansion of this Office. It is still badly understaffed in comparison with the work which is to be done.

I continually marveled how this Office can even presume to do the things that it attempts to do in providing technical aid to a State program of this magnitude and difficulty. These are among the most difficult programs technically that we have in Government.

REHABILITATION FACILITIES

A few words about rehabilitation facilities. We are switching to the Hill-Burton Hospital Survey and Construction Act. The budget includes $5 million for rehabilitation facilities under this act. This is $5 million less than the full appropriation authority and $5 million less than was actually appropriated in 1960. This program is proving to be very helpful in securing rehabilitation facilities, especially medically oriented facilities in connection with hospitals.

Even the allotment of $10 million, the maximum authority, results in individual State allotments so low that wise use of the money sometimes is difficult. We think this is the reason we are having small sums of that money left to revert. I understand this year there will be about $1 million to revert to the Treasury.

A lesser amount than $10 million allotted would result in such small allotments that this problem would be additionally complicated.

CRIPPLED CHILDREN'S SERVICES

Now, about the "crippled children's services." We are also asking that the appropriation for "Crippled children's services" be increased to $20 million, the full authority under the law. I could not say too emphatically that this is a very worthwhile but badly undernourished program. It is a matter of surprise and disappointment to us that this budget does not call for the full amount appropriated.

Certainly, strong programs for children are a necessary foundation for total rehabilitation programs. There is a tremendous backlog of applicants on the registers of the State agencies for crippled children who are receiving no service, or at best totally inadequate service.

For instance, it is not uncommon in a State crippled children's service to find an agency running out of money and having to order children out of hospitals, sending them home until they have additional funds available to continue treatment. This is not an isolated case at all. I do not know why it is. Perhaps we are guilty of this ourselves. Our emphasis over the years was principally in adult programs, but I do not know why it is that this committee has not had emphasized as much as it should have been emphasized the tremendous values that this program could have if it were really adequately financed and staffed to do a total job with crippled children in this country.

It is indeed encouraging to be able to report that rehabilitation programs throughout the country are rapidly improving in the quality of the work they do as well as in the number of people being served. More and more of the severely disabled people are on the rolls of the State agencies. Never have the efforts of the personnel been more dedicated and never have they worked more effectively. It is encouraging to note that voluntary efforts are at an alltime high. A study undertaken by the National Rehabilitation Association for the Department of Health, Education, and Welfare indicated that voluntary expenditures on rehabilitation during the 1958 fiscal year was between $50 and $60 million. This was an increase of 54 percent over the amount intended by these same agencies in 1954.

It will be seen, therefore, the expanded Federal effort is resulting in an expanded voluntary effort to rehabilitate the Nation's handicapped people.

I always feel a sense of inadequacy in coming before an appropriation committee recognizing your time limitations and trying to express to you the deep feelings we have with respect to these programs.

We have to just give you a sketch and depend upon your own tremendous knowledge and concern for these programs to see that they are adequately provided for.

Mr. FOGARTY. I do not think you have to apologize for your presentation. You always do a good job before this committee.

I am surprised you are not asking for more money.

Mr. WHITTEN. You are always very kind.

Mr. FOGARTY. You are making a modest request here. I am surprised you are not asking for more in the training program.

I received a letter a few days ago telling me about a study made 2 or 3 years ago in the area of training. I understand the needs are greater now than when they were reported by him 2 or 3 years ago.

You ask for only $1 million increase in training. I thought it was not very much so far as needs are concerned.

Mr. WHITTEN. I suppose we are guilty in our organization of being more conservative than others.

As I said a moment ago, there is no reasonable limit to the amount of money that could be used effectively.

Take existing programs, for example. Instead of providing scholarships for 50 positions a year I am sure money could be well spent for 100 a year.

Instead of providing scholarships for 400 counselors I am sure 600 or 700 could be used.

I have tried to point out principally the areas where I think there is almost total neglect at the present time and where there should be beginnings made.

Mr. FOGARTY. We had the Secretary of Health, Education, and Welfare before us and he kept telling us he knows their needs but they have to balance the budget.

I always thought this kind of work was more important than balancing the budget.

Mr. WHITTEN. I think so, too.

Mr. FOGARTY. As far as your program is concerned I have always been led to believe if you spent a little more money in this area it would help balance the budget in the long run.

Mr. WHITTEN. That is true.

Mr. FOGARTY. Is that not still true?

Mr. WHITTEN. It is not felt immediately in 1 year's budget. When you consider the accumulated good effects of rehabilitation over the years it will certainly result in lesser expenditures in other things. This is as true now as it ever was, the fact is that this is an economically sound and profitable program.

Mr. FOGARTY. This is false economy, in other words, to hold down these appropriations.

Mr. WHITTEN. I think so.

Mr. DENTON. I have no questions.

Mr. MARSHALL. Off the record.

(Discussion held off the record.)

Mr. FOGARTY. Thank you very much, Mr. Whitten.

LETTER FROM DR. HOWARD A. RUSK

I have a very good letter from Dr. Howard A. Rusk, who is known and admired by all who have an interest in this work. We will place his letter in the record at this point.

(The letter referred to follows:)

THE NEW YORK TIMES,
*New York, N.Y., February 19, 1960.*

Representative JOHN E. FOGARTY,
*House Office Buildings, Washington, D.C.*

DEAR JOHN: As you know, because of my deep interest in rehabilitation, I always look forward each year to seeing the proposed budget for the following year for the Office of Vocational Rehabilitation. It is extremely gratifying to all of us so deeply concerned with rehabilitation to see the steady growth which has been achieved in our public program of vocational rehabilitation. It is also most gratifying that the Congress recognizes the basic principles embodied in the Vocational Rehabilitation Act of 1954 and has supported the administration's budget for the Office of Vocational Rehabilitation.

When the first proposed budget was presented to the Congress after the enactment of the Vocational Rehabilitation Act of 1954, you may recall you sought my opinion on the suggested appropriation for training and traineeships. You recognized that if the goals of rehabilitation of more of our disabled citizens to employability were to be realized, there would need to be a substantial increase in the number of trained professional personnel available to provide rehabilitation services.

At that time a special Subcommittee on Paramedical Personnel in Rehabilitation and Care of the Chronically Ill of the Health Resources Advisory Committee of the Office of Defense Mobilization of which I was chairman was engaged in a study of this subject. The study, which was issued in January 1956, was the most complete, authoritative study which had been done on this subject. This group called attention to what many of us had long recognized—that the greatest single bottleneck to the more rapid extension of rehabilitation services to all categories of our Nation's disabled is the lack of sufficient trained personnel to administer such services.

In summary, this group found:

1. Against a national supply of 7,200 physical therapists, there was a national need for 12,449.

2. In occupational therapy, our national supply was 3,700 but our national need was 9,520.

3. From 800 to 1,000 new graduate medical social workers and 1,000 new graduate psychiatric social workers were needed each year.

4. Our national need for clinical psychologists and counseling psychologists was far greater than our supply and that this need would increase in the future.

5. Our national supply of speech and hearing personnel was but 3,350, but our national need was 16,500.

6. Our national supply of rehabilitation counselors was only 1,350 as compared to a need for 1,700, but that our national need would grow to over 5,000 by 1959.

Since the inception of training and traineeship program of the Office of Vocational Rehabilitation, our national supply of rehabilitation personnel has increased markedly. Otherwise we could not have had an increase of from 60,000 in 1954 to over 80,000 in 1959 rehabilitated into employment under our public program of rehabilitation.

As the number of disabled persons rehabilitated into employment has grown, the number of disabled persons needing rehabilitation services has grown even greater. This has resulted from various factors. Among them are:

1. An actual increase each year in the number of persons with physical disabilities as a result of increased longevity.

2. An increased recognition of the value of early rehabilitation.

3. A growth in the number of resources providing such services.

4. Technological advances resulting from research which make rehabilitation feasible for persons with severe disabilities formerly considered helpless.

Recently, I resurveyed our national personnel needs in rehabilitation and I found that the gap between our national supply and national needs in many of these professions was even greater than 5 years ago. Right now, for example, there are 5,800 position vacancies for physical therapists. Over half of the positions for physical therapists in the New York City Department of Hospitals are unfilled.

The American Occupational Therapy Association reports a national need for 8,000 more occupational therapists now and need for an additional 7,000 by 1961. I can believe this. Of 338 positions in occupational therapy in New York State government agencies last October, only 152 were permanently filled, another 100 were temporarily filled, and 86 were vacant.

I have cited figures from New York City and the State of New York because I am familiar with these figures, but I am sure the need is even greater in many parts of the United States. In the December 1959 issue of the Physical Therapy Review, I counted listings by 66 hospitals and rehabilitation centers in 22 different States seeking one to a dozen physical therapists.

The same situation exists in speech and hearing, rehabilitation counseling, prosthetics, orthotics, psychology, social work, and other areas of rehabilitation.

I can personally attest also to the need for physicians trained in rehabilitation. Our training program for physicians in physical medicine and rehabilitation, here at New York University-Bellevue Medical Center is the largest in the world, but for every qualified young physician who completes his postgraduate training in our Department, 15 to 20 medical schools, hospitals or rehabilitation centers seek his services. One young physician who recently completed his training under a fellowship from the OVR was offered teaching positions in seven different medical schools.

During the first few years of the training and traineeship program of the Office of Vocational Rehabilitation, the amount of funds which could be used profitably was limited, for complex training programs involving universities must be developed slowly. We have reached the stage now, however, in which I am firmly convinced that a greater increase in funds for training and traineeships in the Office of Vocational Rehabilitation fiscal year 1961 budget is desirable. Our universities and other training resources have developed to the point that they can increase their output of trained personnel substantially if funds are available. To fail to utilize these potential training resources to their maximum will mean a continuation of national shortages in these fields and fewer opportunities for rehabilitation by our disabled.

On the last Sunday of each year in my weekly column in the New York Times, I always review the accomplishments in rehabilitation of that year. I do the same sort of review article on rehabilitation for a number of encyclopedia yearbooks. Though there is always substantial progress to report, year after year I must point out that once again the greatest single deterrent to the more rapid expansion of rehabilitation services is the lack of trained personnel. I look forward to the year when this statement is not true.

With best personal wishes.

Sincerely,

HOWARD A. RUSK, M.D.

LETTER FROM HON. ELIZABETH KEE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WEST VIRGINIA

Mr. FOGARTY. Congresswoman Kee has written to me concerning West Virginia's problem under the budget for this program. We shall place her letter in the record.

(The letter referred to follows:)

HOUSE OF REPRESENTATIVES,
*Washington, D.C., February 19, 1960.*

Hon. JOHN E. FOGARTY,
*Chairman, Subcommittee on Departments of Labor, Health, Education, and Welfare and Related Agencies, House Appropriations Committee, 1133 New House Office Building, Washington, D.C.*

DEAR MR. FOGARTY: At this time I should like to highly commend you for the outstanding work that you have been doing during your service in the Congress, and for the splendid manner in which you have been discharging your important responsibilities on the Appropriations Committee.

In this connection, my home State of West Virginia has a problem and I will personally be most grateful to you for anything that you may be able to do to help us.

It is my understanding that the administration has requested the Congress to appropriate $53 million for Federal grants to States under section II of the Rehabilitation Act of 1954 (Public Law 565) with a limit on the base for allocation for Federal funds to the States of $63 million for fiscal year 1961.

West Virginia, especially in our coal-producing areas, has the highest rate of unemployment—lack of job opportunities—to be found in the United States. Our people on the local level are doing everything within their power to provide job opportunities.

West Virginia, with an extremely efficient rehabilitation program, has approximately 5,000 disabled citizens awaiting rehabilitation services. In the recent session of the West Virginia Legislature, the appropriation of State funds for rehabilitation was increased, in an effort to directly help unemployed handicapped persons who are in need of earning a living, and we now have in excess of $100,000 which will be unmatched if the administration request is accepted by the Congress.

Therefore, it will be of considerable benefit direct to the people in our depression area if this more than $100,000 State funds is matched by Federal funds. In order to accomplish this urgently needed objective, I am advised that it will be essential to increase this $53 million appropriation to $55,600,000 and to increase the $63 million base for allocation of Federal funds to $77 million.

In addition to West Virginia, I am advised that the citizens of approximately 15 States, which have appropriated funds in excess of Federal matching funds, will benefit if the Congress will increase the appropriation and base for allocation as outlined above.

With all good wishes, I am,

Sincerely yours,

ELIZABETH KEE
Mrs. John Kee,
*Member of Congress, Fifth West Virginia District.*

LETTER FROM HON. JOHN M. SLACK, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WEST VIRGINIA

Mr. FOGARTY. The letter, on the same subject from Congressman Slack, will be placed in the record.

(The letter referred to follows:)

HOUSE OF REPRESENTATIVES,
*Washington, D.C., February 29, 1960.*

Hon. JOHN E. FOGARTY,
*House of Representatives,*
*Washington, D.C.*

DEAR REPRESENTATIVE FOGARTY: Among the items in the budget proposal for the Department of Health, Education, and Welfare, which is being considered by your subcommittee, there is a particular item concerning which I feel it necessary to report to you the feeling of my constituents and of the informed officials of my State of West Virginia. I refer to the proposed program for the Office of Vocational Rehabilitation.

There is proposed for the next fiscal year the appropriation of $53 million for grants to the States to provide vocational rehabilitation services. I am advised that this sum would be insufficient to match the moneys available for vocational rehabilitation services in the States.

We have a serious problem to deal with in West Virginia. As I am sure you know, the bituminous mining areas of the State are chronically depressed, and will remain so until the thousands of miners whose jobs vanished with mechanization are rehabilitated. Several promising new programs are now underway at the State and local level to encourage economic redevelopment of these areas, but there are important obstacles. For one thing, mining is a very hazardous means of earning a livelihood, and thousands of these unemployed have suffered injuries of various kinds. They cannot be returned to work similar to what they have previously done, but must be rehabilitated and retrained. There are some 5,000 disabled persons awaiting rehabilitation in West Virginia, and their prospects are delayed for lack of funds.

The State has a strong rehabilitation program, and has appropriated substantially more money for the purpose than could be matched under the provisions of the bill as it stands. The West Virginia Legislature, at a session just completed, increased the State appropriation for rehabilitation by $52,000, and this brings to more than $100,000 the State funds which could not be matched and made operative in behalf of the disabled if the appropriation bill before you remains at its present total.

The situation in West Virginia is not unique. There are several other States, notably those with the same chronic unemployment problem, who have adopted the same course and increased their appropriations for rehabilitation. I am sure you have followed the debates on various area redevelopment measures, and have noted the assertions to the effect that the stimulation of economic resurgence should be a State and local matter. This line of thinking appears to have successfully sidetracked the Douglas-Spence area redevelopment bill which passed the Senate at the first session.

Here, however, we have an instance in which the affected States are willing to make the first move, and have appropriated funds as a sign of their determination to improve the employment potential of their unemployed. It would seem that the appropriation of adequate Federal matching funds would be both economically and socially justified, and would be a tangible sign of the intention of this Congress to take action in behalf of those with the greatest need of support.

I understand from the statements of those who are directly involved in vocational rehabilitation that, to create a matching fund sufficient to equal the available State funds ready for use, it will be necessary to increase the appropriation for the Office of Vocational Rehabilitation from the proposed $53 million to a total of from $63 million to $77 million. I am writing to recommend strongly that you consider such increases, inasmuch as it would appear from the evidence that these funds will be repaid many times over in the removal of persons from the unemployment rolls and their transfer to employed taxpaying status.

Yours sincerely,

JOHN M. SLACK, JR., *Member of Congress.*

ADDITIONAL CORRESPONDENCE

Mr. FOGARTY. We will also place in the record material sent to us by Senator Fulbright, the letter from Senator Randolph, and from the Kentucky chapter of the National Rehabilitation Service.

(The additional correspondence referred to follows:)

U. S. SENATE,
COMMITTEE ON FOREIGN RELATIONS,
*Little Rock, February 23, 1960.*

Hon. JOHN E. FOGARTY,
*Chairman, Subcommittee on Health, Education, and Welfare,*
*House Appropriations Committee,*
*House of Representatives, Washington, D.C.*

DEAR MR. CHAIRMAN: I enclose a letter which I have received from Mr. Don W. Russell, director of the Arkansas Rehabilitation Service, concerning the budget request for the vocational rehabilitation program.

I hope that your subcommittee will give serious consideration to Mr. Russell's comments on the need for a change in the allocation base and additional funds for the program. This has been a most successful program in Arkansas, and additional funds are vitally needed to continue the progress which is being made.

With best wishes, I am,
Sincerely yours,

J. W. FULBRIGHT.

STATE OF ARKANSAS REHABILITATION SERVICE,
STATE BOARD FOR VOCATIONAL EDUCATION,
*Little Rock, February 23, 1960.*

Hon. J. W. FULBRIGHT,
*Senate Office Building,*
*Washington, D.C.*

DEAR SENATOR FULBRIGHT: Enclosed is a brief statement and a chart giving some information relative to the budget request of the Office of Vocational Rehabilitation which is now being considered by Mr. Fogarty, chairman of the Appropriations Subcommittee for Labor-HEW. I understand that the House committee will probably report it out within 2 or 3 weeks.

You will note from the information on the chart that many States are progressing much faster in the field of rehabilitation than Congress is supporting with Federal grant-in-aid funds. These progressive States are being hampered in their efforts because of the lack of Federal funds to match all available State funds. Arkansas is an excellent example. As the chart shows, we have $284,785 in State funds in excess of the amount required to match the available Federal funds. If Federal funds were available on the same matching basis we would receive an additional $664,486 of Federal funds.

I am particularly interested in seeing the allotment base and the appropriation increased to the maximum extent possible. I doubt that we can hope for more than the $70 million allotment base and $54.7 million appropriation. This is favored by the Office of Vocational Rehabilitation and all of those States listed on the chart.

If this can be done it will eventually mean that Arkansas can secure sufficient Federal funds through the regular OVR budget to operate its present program and the Hot Springs Rehabilitation Center. This will mean that we will not have to request special funds from Congress or the Office of Vocational Rehabilitation in the operation of the center. It seems to me that this is the most logical approach we can take.

The National Rehabilitation Association and the directors in the rehabilitation programs in each State listed on the chart are requesting their Members of Congress to look with favor on this request and discuss it with the members of the House and Senate Appropriations Committees.

I hope you will feel that this is a sound request, will support it, and talk to the members of the Appropriations Committee.

Very sincerely yours,

DON W. RUSSELL, *Director.*

STATEMENT OF DON W. RUSSELL, DIRECTOR, ARKANSAS REHABILITATION SERVICE, RELATIVE TO BUDGET REQUEST FOR OFFICE OF VOCATIONAL REHABILITATION, FEBRUARY 23, 1960

The President's recommendation for vocational rehabilitation in the States for the 1961 fiscal year is an allotment base of $63 million and an appropriation base of $53 million for the budget request. This will be insufficient to match State funds available in many of the States. Below is given a brief background of the situation with a recommendation for your consideration.

The Vocational Rehabilitation Amendments of 1954 (Public Law 565) authorized the appropriation of $30 million for the fiscal year ending June 30, 1945, $45 million for the fiscal year ending June 30, 1956, $55 million for the fiscal year ending June 30, 1957, $65 million for the fiscal year ending June 30, 1958, and for each fiscal year thereafter such sums as Congress may determine.

In the allocation of Federal funds to the States the act established—

(*a*) A base allotment for each State. This allotment was the same amount of Federal funds the State received during the fiscal year with the same amount of matching funds required and involved in a total of $23 million in Federal funds. The matching ratio for Arkansas was approximately 60 percent Federal to 40 percent State.

(*b*) A supplemental allotment to each State. This represented the Federal funds appropriated in excess of the $23 million required in the base allotment. These additional Federal funds were to be allocated to the States on a matching formula based on population and per capita income with a maximum Federal participation of 70 percent and a minimum of 50 percent. Arkansas qualifies for the 70 percent.

(c) A procedure whereby the base allotment formula would change to the supplemental allotment formula beginning July 1, 1960. The transition was to be made in a 3-year period.

The actual effect of this legislation, from a financial standpoint, is to retard the development of an adequate rehabilitation program in many of the States. This is done through the limitation of Federal funds available to any one State. The act removed the open-end appropriation principle which had existed since Public Law 113 of 1943, and did not provide for the redistribution of Federal funds allocated to States but unused because of insufficient matching funds in those States. At the present time there are more than 15 States which have more State funds available than are required to match the available Federal funds. These States would like to move forward in the development of an adequate program but cannot do so due to the lack of Federal funds.

To partially compensate for this situation the Congress has resorted to the policy of establishing one amount for allocation purposes and another for the actual appropriation. For example, the OVR budget now being considered provides for an allocation base of $63 million, with an appropriation of $53 million. While this is of some help to the more progressive States, it is not sufficient to meet the existing need.

The attached chart shows the situation existing at the present time. Under the present budget request the States listed on the chart have State funds in excess of the amount required to match available Federal funds. This information is shown in columns (1), (2), and (3). You will note that almost $4 million of State funds is being spent without Federal grant-in-air assistance.

Under present Federal legislation the only way these States can receive additional Federal funds to match the State funds being spent is for Congress to increase the allotment base and the appropriation.

An allocation base of approximately $100 million, with an appropriation of approximately $58 million, would be required to match all existing State funds. I feel that it would not be possible to secure this action from Congress this year. An allocation base of $70 million, however, would only require an appropriation of $54.7 million, an increase of $1.7 million over the budget request. This would provide some additional funds to all of the States involved, although it would still leave almost $3 million of State funds unmatched. This is shown in columns (4), (5), and(6).

The Office of Vocational Rehabilitation inserted this chart in the hearings before the House Subcommittee on Appropriations for Labor-HEW as a result of questioning by Mr. Fogarty, chairman of the subcommittee. The Office of Vocational Rehabilitation favors the increase in the allocation base and the appropriation.

*Effect of different allotment bases on Federal grants to States under sec. 2 of the Vocational Rehabilitation Act*

| States | $63,000,000 allotment base | | | $70,000,000 allotment base | | |
|---|---|---|---|---|---|---|
| | Federal funds (1) | State funds matched (2) | Excess State funds (3) | Federal funds (4) | State funds matched (5) | Excess State funds (6) |
| Arizona | $450,225 | $241,620 | $19,611 | $457,789 | $261,231 | 0 |
| Arkansas | 1,348,163 | 619,280 | 284,785 | 1,493,739 | 681,670 | $222,395 |
| Delaware [1] | 174,606 | 134,918 | 3,738 | 173,043 | 133,355 | 5,301 |
| Georgia | 2,381,043 | 1,150,735 | 261,727 | 2,621,929 | 1,253,972 | 158,490 |
| Kentucky | 524,041 | 288,489 | 26,924 | 586,864 | 265,393 | 0 |
| Louisiana | 1,796,249 | 803,792 | 10,979 | 1,821,867 | 814,771 | 0 |
| Massachusetts | 942,802 | 766,982 | 105,065 | 1,062,066 | 866,511 | 5,586 |
| Minnesota | 1,178,111 | 691,256 | 3,134 | 1,183,585 | 694,390 | 0 |
| Nevada | 61,077 | 49,854 | 12,656 | 67,258 | 55,769 | 6,741 |
| New York | 3,417,858 | 3,114,513 | 1,180,085 | 3,763,639 | 3,460,294 | 834,304 |
| Oklahoma | 1,232,449 | 621,812 | 48,453 | 1,334,331 | 670,265 | 0 |
| Pennsylvania | 3,933,438 | 2,713,380 | 1,535,508 | 4,331,377 | 2,993,247 | 1,255,641 |
| South Dakota | 263,445 | 181,419 | 2,199 | 298,576 | 133,618 | 0 |
| Vermont | 193,666 | 103,060 | 4,707 | 263,192 | 107,767 | 0 |
| Washington | 938,414 | 683,713 | 47,260 | 1,003,321 | 730,973 | 0 |
| West Virginia | 1,183,850 | 555,389 | 223,443 | 1,303,618 | 606,718 | 172,114 |
| District of Columbia [1] | 231,217 | 159,497 | 144,503 | 229,149 | 157,450 | 146,550 |
| Guam | 51,062 | 21,884 | 9,055 | 56,228 | 24,098 | 6,841 |
| Total | 20,331,716 | 12,801,573 | 3,923,832 | 22,021,581 | 13,911,492 | 2,813,913 |
| Other States | 32,683,856 | 19,975,640 | ---------- | 32,683,856 | 19,975,640 | ---------- |
| Total | 53,015,572 | 32,777,213 | 3,923,832 | 54,705,437 | 33,887,132 | 2,813,913 |
| Adjustment | −15,572 | ---------- | ---------- | −5,437 | ---------- | ---------- |
| Total | 53,000,000 | 32,777,213 | 3,923,832 | 54,700,000 | 33,887,132 | 2,813,913 |

[1] Delaware and the District of Columbia are "floor" States. The portion of their allotments above the base allotment is attributable entirely to the amount of funds available for redistribution under a given allotment base (sec. 2(a)(5)(B) of the Vocational Rehabilitation Act).

U.S. SENATE,
COMMITTEE ON LABOR AND PUBLIC WELFARE,
*February 17, 1960.*

HON. JOHN E. FOGARTY.
*1133 New House Office Building,*
*Washington, D.C.*

DEAR JOHN: Vocational Rehabilitation, through its budget, provides for Federal grants to States under section II of the Vocational Rehabilitation Act an amount of $53 million. This fund does not match all the moneys which States have appropriated or made available for vocational rehabilitation services.

West Virginia is one of the States that has appropriated considerably more money than would be matched under the provisions of the budget bill. Our State has had an active rehabilitation program and has a substantial handicapped population in need of rehabilitation services. There is a backlog of approximately 5,000 disabled persons awaiting service because of lack of funds. Because vocational rehabilitation is a service that directly helps unemployed handicapped persons who are having a difficult time earning a living, action in the recent West Virginia legislature increased the appropriation of funds for rehabilitation in West Virginia by $52,000. The State has money in excess of $100,000 which is unmatched by Federal funds. I am advised that in order for West Virginia to have all of its funds for rehabilitation purposes matched by Federal funds, that it will be necessary to increase the Federal appropriation for rehabilitation from $53 million to approximately $55,600,000 and to increase the base for allocation for Federal funds to the State from $63 million to $77 million.

There are a number of other States that have made appropriations in excess of Federal matching, and I believe that there is good reason to give favorable consideration to an increase in the appropriation and in the allotment base for rehabilitation this year. A number of the States involved in this matter are depression-pocket areas in which unemployment is high. Those States are attempting to meet this situation by appropriating more money for rehabilitation.

It would seem practical and economical for the Congress to match this money and thereby help them to improve the economic situation.

If a State is willing to appropriate for the rehabilitation of its handicapped unemployed people, we believe it to be sound for the Congress to appropriate to match the State funds on the established basis.

Your attention to this problem will be personally and officially appreciated.

Best regards,

JENNINGS RANDOLPH.
J.R.

P.S.—My personal wishes are sent to you.

---

KENTUCKY REHABILITATION ASSOCIATION,
WAVERLY HILLS SANATORIUM,
*Waverly Hills, Ky., February 26, 1960.*

Hon. JOHN E. FOGARTY,
*Chairman, Subcommittee of House Appropriations Committee, House of Representatives, Washington, D.C.*

DEAR SIR: As president of the Kentucky Chapter of the National Rehabilitation Association I am vitally interested in the 1961 appropriations for vocational rehabilitation in the States. We feel so strongly the need of more services to the handicapped. Increasing the allotment base to $70 million will make possible an adequate matching of State funds in Kentucky and many of our neighboring States.

We urge you to consider the importance of the higher base and to exert your valuable influence on fellow members of the committee for favorable consideration.

As always the organization I represent is concerned with securing the best possible services for the handicapped segment of our population all over the country. Kentucky's needs are deeply felt. We are striving to strengthen the program of rehabilitation of our disabled.

Most sincerely,

CATHERINE B. RICHARDSON,
*President, Kentucky Chapter, National Rehabilitation Services.*

## APPRENTICESHIP, VETERANS' REEMPLOYMENT RIGHTS, AND VETERANS' EMPLOYMENT SERVICE

### WITNESSES

**MILES D. KENNEDY, NATIONAL LEGISLATIVE DIRECTOR OF THE AMERICAN LEGION**
**CLARENCE W. BIRD, DIRECTOR OF THE AMERICAN LEGION NATIONAL ECONOMIC COMMISSION**

We shall be glad to hear from you Mr. Kennedy.

Mr. KENNEDY. My name is Miles D. Kennedy. I am the national legislative director of the American Legion.

I have with me Mr. Clarence W. Bird who is a director of our national economic commission, under whose aegis this matter comes.

Mr. Bird has a statement, Mr. Chairman, copies of which I have given Mr. Moyer.

With your permission I respectfully request that Mr. Bird's statement be incorporated in full in the record.

(The statement referred to follows:)

STATEMENT OF CLARENCE W. BIRD, DIRECTOR, NATIONAL ECONOMIC COMMISSION, THE AMERICAN LEGION

Mr. Chairman and members of the subcommittee, I wish to thank you for this opportunity to appear before you and present the views of the American Legion on certain items contained in the fiscal 1961 budget request of the Department of Labor.

In the past we have consistently supported adequate funds for the Veterans' Employment Service, the mature worker program, the Bureau of Veterans' Reemployment Rights, and the President's Committee on Employ the Physically Handicapped. At our 1959 annual national convention we again adopted resolutions urging adequate funds for these programs and services.

VETERANS' EMPLOYMENT SERVICE (RESOLUTION NO. 332)

Through the Veterans' Employment Service, the Department of Labor carries out its legislative mandate to provide for veterans of any war, "The maximum of job opportunities in the field of gainful employment."

In cooperation with the public employment services in each State, the State veterans' employment representative is directed to:

(1) Be functionally responsible for the supervision of the registration of veterans of any war in local employment offices for suitable types of employment and for placement of veterans of any war in employment;

(2) Assist in securing and maintaining current information as to the various types of available employment in public works and private industry or business;

(3) Promote the interest of employers in employing veterans of any war;

(4) Maintain regular contact with employers and veterans' organizations with a view of keeping employers advised of veterans of any war available for employment; and veterans of any war advised of opportunities for employment; and

(5) Assist in every way possible in improving working conditions and the advancement of employment of veterans of any war.

Naturally, the American Legion is pleased that most economic indicators point to a continued expanding economy. Reports received in the Labor Department's Bureau of Employment Security show that veterans as a group recovered quite well from the effects of the recent economic recession. A major factor in this accomplishment unquestionably was the work done by the Veterans' Employment Service, for the records of the State employment security offices show that more than 1,300,000 veterans were placed in jobs during the past year, and among these, 320,000 were 45 years of age or more. Nevertheless, the Labor Department reports that as of November 30, 1959, there were still 606,512 veterans unemployed. These figures, coupled with the fact that veterans comprise almost one-third of the civilian labor force and about 45 percent of the male segment of the labor force, with the attendant relocation and reemployment problems, indicate that there remains a tremendous task to be performed by the Veterans' Employment Service.

Our resolution urges Congress to appropriate sufficient funds to insure adequate service to veterans of the Nation through the Bureau of Employment Security, its U.S. Employment Service, the Veterans' Employment Service, and through grants to the State employment services to the end that the provisions of the law may be carried out as contemplated in its original enactment.

The American Legion is of the opinion that all employment services to veterans are unquestionably justified. Further, we believe that the operation of the Veterans' Employment Service and the State employment security agencies in their respective programs of special service to veterans during the past years has been successful. Therefore, it is, we believe, sound business judgment to make available to the personnel of these services the most efficient tool with which to work.

Examination of the budget submitted by the U.S. Department of Labor for fiscal year 1961 shows that the sum of $1,252,000, has been requested for the Veterans' Employment Service. We note that the requested sum is identical to that as appropriated by the Congress for fiscal year 1960.

The American Legion supports the appropriation of the above sum as being fair, reasonable and adequate for the purpose of carrying out the intent of this program as experienced during the past year. We respectfully request that the sum above referred to be approved.

EMPLOYMENT OF OLDER WORKERS (RESOLUTION NO. 248)

The American Legion has, for a number of years, devoted considerable time and effort in developing and publicizing a program to educate employers and the public about the advantages of employing older workers and to combat arbitrary employment policies which squeeze and eliminate older workers out of the em-

ployment market. You are undoubtedly familiar with our efforts along these lines, such as the national observance of "Employ the Older Worker Week", during the first week in May which we conceived and sponsor every year.

But we realize that something more concrete must be done also if any real achievements are to be accomplished. That is why we sought the establishment of specialized services for older workers in all of the local offices of the U.S. Employment Service. We have been pleased by the progress made along these lines by the Labor Department's Bureau of Employment Security.

Still, there is much to be done. Our position this year is stated in the resolving clause of the above resolution as follows:

"* * * that legislation be sought * * * to provide funds for, and require the extension of, specialized services for older workers in all of the local offices of the (U.S. Employment Service) * * *."

The resolution also calls for the allocation of staff time realistically related to the needs of the older worker. We respectfully request that you give this matter your serious consideration.

VETERANS' REEMPLOYMENT RIGHTS (RESOLUTION NO. 206)

The American Legion advocated the reemployment rights benefits which Congress first granted veterans of World War II and appreciates the legislative support and continuation of this program which provides a direct service to veterans, ex-servicemen, reservists and members of the National Guard who leave their jobs to perform military training or service.

Because the American Legion supports a strong national defense and an adequate military reserve program, we realize an obligation to these young men upon their return to civilian life. Therefore, at our 1959 national convention we adopted Resolution No. 206, the resolve clause reading in part as follows:

"* * * that we request the Congress to insure that, adequate personnel is employed in the Bureau of Veterans' Reemployment Rights to enable it to provide prompt and effective service to all persons having rights and oblgiations under the reemployment rights statutes."

The American Legion is appreciative of the cooperative arrangements between the Department of Defense and the Department of Labor, to alert persons who are eligible for protection under the reemployment rights statutes. Further, we are pleased with the Bureau of Reemployment Rights' ability to provide vigorous and effective service on behalf of those affected by these statutes. It is imperative that this Bureau continue this same efficient service.

We would like to point out for emphasis that the work of the Bureau of Reemployment Rights is most important for two reasons:

(1) Results of their efforts with respect to any individual case may well affect his employment situation in future years;

(2) The Bureau's method of settling cases by negotiation establishes a precedent which results in the extension of benefits to many additional veterans who never file a claim.

Hence, efficient and proper handling of each and every claim is absolutely necessary.

The American Legion believes it is apparent that the work performance by this Bureau is relatively inexpensive in terms of its importance and the broad scope it covers. For these reasons we sincerely urge this subcommittee to give favorable consideration to the Bureau's current budget requests.

We note that the Department of Labor has requested the sum of $592,000 for fiscal year 1961 for allocation to the Bureau of Veterans' Reemployment Rights. The American Legion respectfully requests the approval of said amount by the subcommittee.

PRESIDENT'S COMMITTEE ON EMPLOYMENT OF THE PHYSICALLY HANDICAPPED (RESOLUTION NO. 239)

As in the past, the American Legion would like to take this opportunity to endorse the work and programs of this committee and renew our pledge of continued support.

Mr. KENNEDY. Further, in order to save time, I would like permission to have Mr. Bird to hit a few of the high spots of the statement.

Mr. BIRD. Mr. Chairman and gentlemen, I work in all these programs and I appreciate the consideration you have given the veterans

in general. I have been a member of the President's Committee on Employment of the Physically Handicapped and in all our rehabilitation work I feel a full-time job is necessary.

I was talking to your friend, John Ryder, last night, who is very much interested in the problem of the aged and hospitalization.

We feel very strongly that our big problem now regards the more mature and older worker. I am getting up there myself and I can appreciate it.

The Veterans' Employment Service, which I work with very closely, I feel is doing an outstanding job. I have worked with the men in the various States and find them very cooperative.

With regard to reemployment rights of veterans, Mr. Bradley and his staff, being the smallest unit of the Department of Labor, do an outstanding job. I have had two cases come into my office this morning.

We are now starting our National Rehabilitation Conference and all the boys are in from the field, so we are washing our hands trying to save your time and my own time.

I feel that helping the physically handicapped is an important job and it has gone a long way. The main thing is the problem of the older worker, discrimination by management against the older worker which I know you gentlemen have heard so much about.

I feel something must be done about it because we are throwing too many able-bodied workers who are loyal to this country into the ashcan and they are being discriminated against.

With our race against Russia to see which of our systems works out I think we can ill afford to discard these older workers who have proven their worth and can, if permitted, still do a good job. We find that once the older worker is given an opportunity in employment, he frequently proves to be a better employee than his younger coworker. Once on the job, the older worker shows greater stability as to quits, separations, absenteeism, accidents, and so forth.

Mr. Fogarty. This committee has given the Department of Labor additional funds for research projects in the employment of people over age 45, but the Department of Labor never has come up with anything really worthwhile so far as I can remember in the last 3 or 4 years. We have urged them to pay more attention to this problem but they seem to lack interest.

Mr. Bird. I have Mr. Klein, a specialist down in the Department of Labor, appearing before my committee in the next couple days, and we will put him through the wringer if you already have not.

Mr. Fogarty. I have already asked the Secretary of Labor about this in the past year and I am not satisfied with what the Department of Labor has done.

Mr. Bird. I am glad to know that because we will back you up in the same way we do all the time.

At least we have made a beginning. I have been down here in Washington only 6 years, and I recall 2 years ago in sitting on the Secretary of Labor's Advisory Committee that I brought up this matter.

Mr. Kennedy. We hold no brief for the Labor Department in the event they are not doing the job they should. We would be the first ones to criticize them and we are happy you brought up this point. I can assure you we will be glad to take it up with them.

If you wish us to we will ask them to get in touch with you or anyone on the committee you designate to see if they cannot expedite the matter and carry out the intent of the appropriation. We hold no brief for things like that.

Mr. DENTON. I wish the Legion would give some consideration to this new legislation on this matter. We appropriated large sums of money to investigate this problem and correct it by education. We have books at least 2 feet high on that subject prepared by Labor and HEW.

We found out child labor laws are very effective and we cannot understand why they would not work that same way for older groups.

Mr. BIRD. I have the full report from Senator McNamara's committee on the problems of the aging and I have also been in close touch with the State of New York, Senator Desmond who has made a thorough study of this.

Mr. DENTON. They passed this legislation.

Mr. BIRD. We are putting on a special program with regard to this problem. It starts Thursday at the Statler. We are having a special speaker from HEW to speak on this problem. We will also have Mr. Klein.

Rest assured my Commission will ask many questions and I will get a copy of the legislation and I will bring it up for discussion when our committee meets.

Mr. DENTON. They are against it.

Mr. BIRD. They are against it?

Mr. DENTON. Yes.

Mr. BIRD. The Legion?

Mr. DENTON. No, the Labor Department.

Mr. BIRD. I will take it up with our Commission and discuss it. Mr. Ryder will be down with regard to his interest in the problem of the aged.

Rest assured I will try to keep in close touch with you and go all-out.

Unfortunately I am no longer a member of the Advisory Committee of the Secretary of Labor. I wish now that I were because of this special interest.

That covers my statement.

Mr. FOGARTY. Questions, gentlemen?

Mr. MARSHALL. I would like to commend you for the able way you represent the Legion on the Hill, gentlemen, and I also would like to mention the fact that during my visits around the District last fall I was appalled at the number of World War I veterans who are beginning to run into problems on this age proposition. It is really pretty tragic when a person loses his job and has to find a new line of work. People came before me who were able in every way but they couldn't find employment because of their age. Many of those are World War I veterans.

These people have gotten to be the forgotten men.

Mr. KENNEDY. I thank you for those remarks, Mr. Marshall. You and I know it is an important problem.

Any time any of you want to call on our office, the Economic Commission, or any of our people and you feel we can help you, feel perfectly free to do so. That is what we are there for.

Mr. Bird. This is a sad situation, Congressman.

I have seen sick veterans but there is no man sicker than one who does not have a full-time job to provide for his wife, children, and dependents.

Mr. Denton. A few have social security.

Mr. Kennedy. The problem with social security is that most of our World War I fellows, at retirement age, have not accumulated many years of service under social security, especially those engaged in lines where physical stamina was required. They will not do too well under social security.

Mr. Marshall. We are unfortunate in my area because in many instances people have not been covered long enough.

Mr. Kennedy. That is what I mean, sir.

That went into effect in around 1935 and they were pretty well along already.

Mr. Denton. I am a strong advocate of giving them a pension. The Legion has not gone along with that. Eventually they may.

Mr. Fogarty. We have expressed an interest in this problem of employment of people over 45 years of age and tried to keep the Department of Labor interested in it. We have asked them to come up with suggestions as to what we can do about it, but they have not suggested anything new.

Mr. Kennedy. Speaking in behalf of the entire Legion, Mr. Chairman, I want you to know that our organization is grateful to you personally, and to your associates on the subcommittee, and the full committee of the entire Congress, for the very fine appropriations we feel you have given the respective divisions of Government.

Mr. Fogarty. You remember the day when the Veterans Employment Service did not fare so well.

Mr. Kennedy. I sure do.

Mr. Fogarty. We had problems for a couple of years.

Mr. Kennedy. That is right.

Mr. Fogarty. Thank you, gentlemen.

## Budget for the Department of Health, Education, and Welfare

### WITNESS

### BRADSHAW MINTENER

Mr. Fogarty. We shall now hear from Mr. Mintener.

Mr. Mintener. It is always a pleasure to come up here because I feel this subcommittee is dealing with the most important programs of the whole Government, and they are in the area of health, education, and welfare. I want to thank you for the opportunity again to come here and express a few views as a private citizen.

I want to express my appreciation to you for your leadership, Mr. Fogarty, in connection with the budgets of HEW and also to the members of the subcommittee. It is a pleasure to see Mr. Denton and Mr. Marshall from my home State again.

There are three areas with respect to the new HEW budget I would like to comment on briefly this morning. The first is the Food and Drug Administration budget.

The second one is that portion of the Public Health Service, the NIH budget, which relates to the National Advisory Council for Health Research facilities.

Lastly we have Gallaudet College.

I was very pleased to see that the budget as it was finally passed last year provided for the restoration or the increase of the $2 million which this committee put back in the budget and with respect to which I testified last year. It shows again that you gentlemen realize the deficiencies that were in that budget.

Mr. FOGARTY. Did it ever occur to you that you might have been a very persuasive witness when you appeared before this committee last year?

Mr. MINTENER. No, but I was glad to see my views were followed.

FOOD AND DRUG ADMINISTRATION

As you know, I have a very deep and strong conviction about this whole matter. I am convinced that the Food and Drug Administration is not and cannot ever do the job that it is required to do under the law unless it has the necessary funds, facilities, and personnel.

Mr. FOGARTY. I agree with you 100 percent.

Mr. MINTENER. I know you do, and that is why I am always amazed when I realize what the Food and Drug Administration around the country does in the way of a workload and in the way of accomplishment with the totally inadequate facilities and personnel they have had throughout the years.

I find now that instead of the 96,000 we used to talk about when I was Assistant Secretary of HEW, FDA now has something over 100,000 establishments that it is responsible for policing.

In addition, we have 56,000 retail druggists. Some of them are making over-the-counter sales of prescription drugs and have to be policed by the FDA.

We have 319,000 public eating places under the margarine law, and there are about $4 billion worth of foreign imports falling under the jurisdiction of the laws which the FDA administers.

To cover this workload as of today, as I understand it, FDA has a staff of 1,660 people, of which fewer than 500 are inspectors.

When I came here in 1954 we had something like 197 or 201 inspectors. This staff obviously permits FDA to inspect these establishments irregularly and in most cases less than once every 5 years which to me is an impossible situation.

I checked again regarding the Department of Agriculture. They have nearly eight times as many inspectors as the Food and Drug Administration, 3,900 according to the figures I received, to keep watch on 1,357 meat-processing plants. They need those inspectors for those plants. I do not want to downgrade the Meat Inspection Service in the Agriculture Department, but it shows in contrast how understaffed the Food and Drug Administration is.

Mr. FOGARTY. What about the new poultry inspection law??

Mr. MINTENER. The same thing applies. Last time I checked they were asking for 1,100 or 1,200 inspectors for 1,100 or 1,200 plants, and it is probably up now over that amount.

This budget you are considering for 1961 asks for a substantial increase. I think it is about $3,052,000, from $13,800,000 to $16,852,000 for the 1961 budget.

I am told this amount would provide increases of staff nearly equal to those projected for 1961 in accordance with the recommendations of the now famous Citizens Advisory Committee which I had the honor and pleasure of setting up at Mrs. Hobby's request.

Mr. FOGARTY. Some of us feel the recommendations of that Committee are perhaps out of date now because of the new food additives law that was passed, and other legislation which has been passed, and imposed new responsibilities on the Food and Drug Administration.

Mr. MINTENER. I am sure of that. I would like to see a new committee appointed.

Mr. FOGARTY. I think your Committee did an excellent job and gave us some good guidelines to work on and it served a good purpose.

Mr. MINTENER. I am sure they did.

Mr. FOGARTY. It should be reconstituted.

You should speak to some of your friends there in the Department.

Mr. MINTENER. I would like to see that done, and with that suggestion I will go to work.

I have already made several hints there that I thought that Committee or a similar one should be appointed to look into the situation as it is now, some 5 years later.

This new budget, as I read it, also permits the renovation of several FDA district offices. I don't know how many of you gentlemen have been in FDA district offices, but recently I have been in the New York, Boston, and Buffalo offices and they are absolutely unbelievable from the standpoint of a Federal law enforcement office.

The walls are dirty, blinds are dirty and torn, and the conditions under which they work are almost as bad as they are in South Agriculture in the second subbasement. I hope some funds will be provided for the renovation or cleaning up and refurbishing of the various offices around the country which need it.

This problem of radioactivity is important. This program was started when I was there. It is an important program. I hope that funds for this program requested in this budget will be provided.

I think one of the outstanding needs of the Federal Food and Drug Administration today, Mr. Chairman and members of this committee, is this long planned for and delayed headquarters building for the Food and Drug Administration. We thought that was settled once, and then it was not. I was up in Canada some time ago and saw their new building. I was told by Dr. Morrell and Mr. Curran, their counsel, that this new building has resulted in greater efficiency there, more work, and better law enforcement by the Canadian Food and Drug Administration. In my judgment we desperately need that new FDA building now.

For example, over in South Agriculture, I happened to be there the other day, the whole wing on the 12th Street side was originally built for laboratories, gas service, water service, and so on.

So far as I can see, just from walking on two or three of the floors, half of that whole wing now is used for ordinary office space. In

other words, expensive laboratory space is being used for ordinary offices.

I know we are desperately in need of space all over Washington, but it seems to me that ordinary office space is a lot easier and cheaper to find than this laboratory space.

Last year when I was here the Food and Drug Administration was in five different buildnigs. Now, they are in six and about to go into a seventh, I think.

The expense of building new labs, the expense of moving them seem to me is all out of proportion and represents poor planning.

Mr. DENTON. What can we do on it until there is legislation?

Mr. MINTENER. The first thing is to get that new building out of hock, if I may use the expression.

Mr. DENTON. We make the appropriation but there is no legislation authorizing it.

Mr. FOGARTY. It is before the Public Works Committee now.

Mr. MINTENER. I saw two conflicting reports in the papers. One was from a Senate subcommittee.

Mr. FOGARTY. They discussed it a couple weeks ago and passed it over for some reason.

Mr. MINTENER. Anyway, whatever force I can add to the support of this new building, I just say it is desperately needed. I hope some way can be found to provide it.

I do not know whether you and Mr. Marshall have been over to see those laboratories in south Agriculture, but if you have an hour's spare time you should go there and you will be convinced, as I know Mr. Fogarty was, with the absolutely disgraceful conditions under which these people are operating. They are testing our foods, drugs, and cosmetics, and working to protect the public so far as these responsibilities they have are concerned, so I repeat that I am convinced that unless these facilities and personnel provided in this new budget and this new building is provided the Food and Drug Administration never will do the job it is required to do under the law.

Anything you can do to help remedy that situation certainly will be appreciated. I think Dr. Flemming, who of course has had experience in the Government throughout the years, has supported the Food and Drug Administration tremendously. George Larrick is one of the outstanding Commissioners. I have known them all. I know you have, also. George has been through some of the most difficult days of his whole lifetime the last year or so in connection with these programs. I know Jack Harvey, Billy Goodrich, and the whole staff over there are doing outstanding work.

It is a tremendously difficult job for these people to communicate with each other. Some are in one building, some are in another, some are in another. Even physically to get together and consider some of these problems is a difficult thing. Therefore, the whole operation of the Food and Drug Administration is stymied. So if there is anything any of us can do to help this situation, I certainly hope it can be done.

In that connection, I guess you gentlemen are familiar with the association which is known as the Association of Food and Drug Officials of the United States. That association comprises all of the State food and drug commissioners in the country. Mr. Sullivan

of Indiana is a member of the executive board. Henry Hoffman of Minnesota is on it. It also includes a number of other persons in industry who are interested in these problems.

We have associate members, numbering about 200 or 300 from industry and other related State officials in this Association of Food and Drug Officials, and I happen to be the chairman this year of the liaison committee of the associate members. At a meeting a couple of weeks ago attended by Dr. Harold Clark, the food and drug commissioner of Connecticut, who is this year's president of the association, we passed a resolution in which I was authorized to state on behalf of the associate members of the Association of Food and Drug Officials of the United States that we support this request for this new building, and urge the Congress to provide the funds and the necessary legislation to put it under construction.

HEALTH RESEARCH FACILITIES

The second thing I would like to talk about is another subject which is very close to me because I worked on it when I was in Government. That is this National Advisory Council on Health Research Facilities. Again, I want to thank you gentlemen for the leadership you gave—you especially, Mr. Fogarty—in this area. I hope the $30 million requested will be provided again this year. You remember last year they tried to cut it to $20 million and you restored it to $30 million.

Mr. FOGARTY. I did not restore it. The majority of the committee restored it.

Mr. MINTENER. All right; you helped restore it, anyway, and the rest of you supported it.

Mr. FOGARTY. You are talking to a friendly group here this morning.

Mr. MINTENER. Exactly; and I appreciate that. I was glad when that went through, because this Council is not only one of the best councils out at NIH because of its membership, but it is doing one of the outstanding jobs. We visit every single place where there is an application for one of these grants to build health research facilities.

Mr. FOGARTY. Why do you think the Bureau of the Budget would cut something like that?

Mr. MINTENER. I have not the slightest idea. All they have to do is send a few people around to look at the program and what has been done, because every single dollar the Federal Government has contributed to this program has been matched 4 to 1. So we have $450 million worth of health research laboratory construction accomplished thus far on the basis of $90 million of federally appropriated funds.

I read this speech the other day in the Record, Mr. Fogarty, the one you gave last November up at Boston before the Beth Israel Hospital, in which you pointed out that the research done in the hospitals, not alone in the medical schools and other places, is producing tremendous results in the areas of health, and is also producing the technicians who have to do this work. All the money in the world is no good, as I understand it, unless you have the people to do the work.

Mr. FOGARTY. I agree with you. I cannot understand why the Bureau of the Budget would cut such an important program as this, one which is producing such outstanding results.

Mr. MINTENER. I was asked last year where this extra money was coming from. I gave the opinion that we have to distinguish between what is really important and what is unimportant. This is one of the most important areas of Federal expenditures I know of, and one of the best programs the Federal Government has ever gotten into, because research is being improved, research is being expanded, research is being helped in these health areas, not only in medical schools, which have been obsolete throughout the country generally, but in hospitals, clinics, and other places which have been the beneficiaries of these grants.

I just want to say that this Council, not because I am a member of it, is composed of "savvy" men who know their business. They have dealt with this program and have spent a lot of their own time going around to visit these places. The splendid staff out at NIH under Mr. Francis Schmehl has done a tremendous job. We have our next meeting on March 7 and 8. I think there are 150 applications to be considered for grants under this program. I hope someday we will be able to expand this program to include teaching facilities. I am not worried about Federal aid to education in this area at all, because this will provide medical schools and hospitals which have wonderful teaching courses, and even clinics, with additional funds which will enable them to produce more researchers and expand and improve the health research of the country.

## GALLAUDET COLLEGE

Lastly, Gallaudet College which, as you know, is another institution which has been aided tremendously by the building program which this committee supported, which was also started when I was in the Federal Government, and now we are in our last stage of construction. This year we have asked for something like $2,432,000 to finish this program and also to provide for some renovation of existing buildings. I know Mr. Fogarty has been out there, but if you other gentlemen have not been out to see Gallaudet, there again you will see the only college for the deaf in the world. It is doing a tremendous job in education.

I happened to be out at Purdue, Mr. Denton, on one of these health research facility grant visits. I visited their new hearing and speech clinic there. Dr. Steer, who runs it, had not then been to Gallaudet. I suggested he come and look at this place. He did. This new hearing and speech clinic which is being built——

Mr. DENTON. Is that at Purdue?

Mr. MINTENER. He is building one at Purdue, but they also have just completed one at Gallaudet.

Mr. DENTON. I am very much in sympathy with this program.

Mr. MINTENER. I have made three visits to Purdue. One was to the veterinary school.

Mr. DENTON. Of course that is new.

Mr. MINTENER. That is right. Then this new hearing and speech clinic where they are doing some of the outstanding work in this area of research on hearing and speech in the country.

Mr. DENTON. At Purdue?

Mr. MINTENER. Yes, sir. Anyway, they were away down in the basement. They used a vault. It was a baling wire operation down there. But now they have this new section of one of the new buildings. Anyway, Dr. Steer came here and, as a result of his communication back and forth, they have now set up a cooperative program in this area of health research related to speech and hearing which will benefit many people in this country.

I hope Gallaudet will receive the requested appropriation which has been requested in this budget.

Again I want to thank the committee for the great help to all these programs I am interested in. I am appreciative of the opportunity to appear.

Mr. FOGARTY. The committee agrees with you on all these projects. Sometimes we think you do not go far enough. As you know, we included $2 million more than the President asked for last year for the Food and Drug Administration. We restored the $10 million cut that was made in the President's budget last year for these health research facilities. We also restored some of the cuts in the building program at Gallaudet. We endorse that program.

We were very happy when we were told that it had received its accreditation. I think you deserve a lot of thanks for being so helpful in all of these programs.

Any questions?

Mr. DENTON. No questions.

Mr. MARSHALL. We in Minnesota recognize you, Mr. Mintener, as very well informed in your field. You recall this committee and the Congress increased the funds over the President's budget. In your observations during the past year, do you feel that has brought about an improvement?

Mr. MINTENER. Absolutely, Mr. Marshall. There is no question about that.

Mr. MARSHALL. There is no question about that at all.

Mr. MINTENER. I agree with Mr. Fogarty there are not enough funds yet. In fact, I have been criticized for coming up and testifying that these programs need more funds. As long as I have these convictions, I am going to come up and do what I can do to get them, because I believe in these programs when the health and welfare of the Nation are at stake.

Mr. MARSHALL. That is the reputation you enjoy in Minnesota, and you are living up to it.

Mr. MINTENER. It is not too popular with some of the people, you know, but still it does not make any difference to me.

Mr. FOGARTY. I hope the committee will do the same thing it did last year—correct some of these inadequacies which exist in the present budget and try to do a job for the people.

Mr. MINTENER. I hope so, too. As a citizen, I want to thank you again.

Mr. FOGARTY. We are glad you appeared here, because the Food and Drug Administration is one group in Government which needs support. They do not have any organized groups which come in here speaking for them. You are one of the few who will come in and

testify for their needs. That has been one of their drawbacks over the years, as you know.

Thank you very much.

Mr. MINTENER. Thank you, gentlemen.

---

MONDAY, FEBRUARY 29, 1960.

## WATER POLLUTION CONTROL

### WITNESS

### J. W. PENFOLD, CONSERVATION DIRECTOR, IZAAK WALTON LEAGUE OF AMERICA

Mr. FOGARTY. We shall hear now from Mr. J. W. Penfold, conservation director, Izaak Walton League of America.

Mr. PENFOLD. Mr. Chairman, my name is J. W. Penfold, conservation director of the Izaak Walton League of America. The league is a nationwide membership organization dedicated to the conservation and wise use of America's natural resources.

It is with regret that we cannot come before you today to request funds to implement the larger Federal water pollution control program we believe essential. We were hopeful that Public Law 660 of the 84th Congress would be amended to expand its program of assistance to communities and so hasten the day when our streams and lakes might again be clean and fully useful.

Mr. FOGARTY. You know how these three members voted the other day, I would hope.

Mr. PENFOLD. Yes, sir, we do know, and we are appreciative.

Public Law 660 has been working most successfully. It is an example of Federal-State-local cooperation of the highest order. It is helping get a basic resource job done. It is encouraging local communities to shoulder their responsibilities. It has stimulated pollution abatement activities at all levels. It has strengthened the hand of State pollution enforcement authorities. Over 2,000 communities have already been assisted. Another 1,000 are in various stages of engineering and financing their plans.

Although the budget requests but $20 million for assistance to municipalities in the construction of sewage treatment facilities, we believe it imperative that funds be appropriated up to the full $50 millions authorized by Public Law 660. After years of apathy and very spotty efforts to clean up our waters, momentum has been built up. It would be tragic should any of that momentum be lost. The population is increasing at too great a rate to permit any kind of slowdown for any reason.

We concur in funds requested for State water pollution control programs, $2,700,000, and interstate programs, $300,000, and hope such funds are sufficient for these essential activities.

Again we are disappointed that operation funds for the Federal pollution program are buried in the general category of environmental health. Public interest in the pollution program is such that the budget should set forth the funds requested and appropriated in a clear manner, so people can see what they are.

After a lot of digging, and a lot of questions, it appears that requests have been made for:

| | |
|---|---|
| Research | $1,640,900 |
| Basic data collection and analysis | 842,000 |
| Technical assistance | 933,700 |
| Comprehensive water pollution control programs | 998,500 |
| Enforcement, regular | 937,200 |
| Enforcement, radioactive wastes | 401,700 |
| Administration construction grants | 644,800 |

We urge these funds be appropriated and earmarked so none can be syphoned off for nonwater pollution control activities in the general budget category in which they have been lumped.

We are pleased to see a modest increase requested ($4,312,100 to $4,900,000) for air pollution to expand research in automotive exhaust problems and other research including the national air sampling network.

The Izaak Walton League of America appreciates the opportunity to appear before this committee.

Mr. Fogarty. Thank you, Mr. Penfold.

Would you care to comment on the President's veto message on the bill which we voted on last week? This is a national program, is it not?

Mr. Penfold. We certainly think it is, Mr. Chairman. The Izaak Walton League pretty much concurs with the President's veto message, except for the veto itself. We agree that the Federal Government can help focus public attention on the blight of pollution in our rivers and streams. We agree that the Federal Government should help with State programs and technical assistance. The President suggested modest amounts. We feel that the amounts which have been made available so far are quite modest. We certainly agree in expanding Federal research in the field of pollution abatement and inforcement.

Mr. Chairman, when it is all said and done, when the public has been alerted, when the research has been completed, and so on, facilities still have to be built; and that is where pollution control takes place. After all the research has been done, the communities still have to build facilities to take care of their pollution. That is where the communities need the help the most. So, in our opinion, the President's proposal so far is 100 percent minus in the area where the job must be done, in the last analysis.

Mr. Fogarty. I agree with you. I thought he was all wrong, too. That is why I voted that way the other day.

Mr. Denton. Of course, I live on the Ohio River, and I am very much in sympathy with your program. I know that small communities have greater financial difficulties in building sewage disposal plants. Maybe the larger communities can take care of it, but smaller communities pollute streams just as much as the larger ones do. Of course, I am very much against this cut, because there are places that Indiana will not take Federal funds, and here is one where it does. We were given the greatest cut of any State in the Union. So, for a selfish reason, and also for national reasons, I am very strong for this program.

Mr. Penfold. The history of the program, Mr. Denton, certainly indicates that the smaller communities, the ones which traditionally

have the most difficult task in funding public works, have been helped the most. I think something like 80 percent of them so far are of 25,000 population or less.

Mr. MARSHALL. No questions.

Mr. FOGARTY. Thank you very much, Mr. Penfold.

(The following was subsequently submitted for the hearings record:)

THE IZAAK WALTON LEAGUE OF AMERICA, INC.,
*Washington, D.C., March 1, 1960.*

Hon. JOHN E. FOGARTY,
*Member of Congress, House of Representatives,*
*Washington, D.C.*

DEAR MR. FOGARTY: You asked yesterday, while I appeared before your Appropriations Subcommittee on Labor, Health, Education, and Welfare, about the league's reaction to the President's veto of H.R. 3610. I hope my off-the-cuff reply indicated our keen disappointment.

For your further information I am attaching a copy of our letter written House Minority Leader Halleck following the unsuccessful effort to override the veto.

Needless to say, we are most appreciative of your continuing strong support for this vital program.

Sincerely yours,

J. W. PENFOLD,
*Conservation Director.*

THE IZAAK WALTON LEAGUE OF AMERICA, INC.,
*Washington, D.C., February 26, 1960.*

Hon. CHARLES A. HALLECK,
*House of Representatives, Washington, D.C.*

DEAR MR. HALLECK: The unsuccessful effort in the House of Representatives to override the veto of H.R. 3610 is disappointing to conservationists nationwide. There is no resource problem that looms larger than that of assuring an adequate, usable water supply to meet the municipal, industrial, agricultural, and recreational needs of a burgeoning population.

The grants-in-aid to assist municipalities in the construction of sewage treatment facilities under Public Law 660 has proved to be a most effective cooperative Federal-State-local program. It has been getting a basic job done. It has encouraged local communities to shoulder their responsibilities. It has stimulated pollution activities at all levels. It has strengthened the States in the enforcement of State pollution laws.

It has not been adequate, however, to keep pace with new sources of pollution and at the same time catch up with backlogs accumulated over the years. It will be recalled that the sponsors of Public Law 660 pointed out originally that a Federal program of $100 million per year for 10 years would be needed. H.R. 3610, which had the broadest kind of nonpartisan public support, was an effort to expand the program to the size originally proposed and factually required. Additionally, it would have assisted communities to undertake joint projects in the interest of efficiency and economy.

Secretary Flemming has repeatedly and in strong language correctly stated that cleaning up the Nation's water resource is a priority matter. The President correctly has spoken of our rivers and streams as "a priceless national asset" and of polluted water as "a threat to the health and well-being of all our citizens." Yet, the budget request for Federal assistance to municipalities in abating the threat to health and well-being and to our priceless water resource, both for fiscal year 1960 and fiscal year 1961, has been but two-fifths of what Public Law 660 authorizes. Moreover, the administration has urged that the program be discontinued in its entirety.

The administration has found unacceptable the program and H.R. 3610 to expand it, which would appear to place on it the responsibility to develop and propose the dynamic kind of program which will achieve the fully agreed upon pollution abatement objective.

We concur heartily with the President's request for a stepped up enforcement program, financial assistance to States and interstate programs and expan-

sion of Federal activities in research and technical assistance. We concur that the Federal Government can perform an important function in focusing national attention on the blight of water pollution—the present program has already proved this.

But when all the education has been accomplished, the research completed and the enforcement procedures followed, treatment facilities will still have to be constructed. This is where municipalities need help the most. Public Law 660 has been providing that kind of help. H.R. 3610 would have expedited that kind of help to more communities needing it.

We respectfully inquire as to an alternative plan whereby construction of sewage treatment facilities can catch up and keep up with the ever-increasing need.

In the final analysis, the American people will pay for pollution—in dollars for treatment works; or in disease, lack of well-being, and in lost opportunity of every kind that relates to water use, and what does not.

Sincerely,

J. W. Penfold,
*Conservation Director.*

---

Monday, February 29, 1960.

## Water Pollution Control

### WITNESS

### DANIEL A. POOLE, EDITOR, OUTDOOR NEWS BULLETIN, WILDLIFE MANAGEMENT INSTITUTE

Mr. Fogarty. Next we shall hear Mr. Daniel A. Poole, editor of the Outdoor News Bulletin, Wildlife Management Institute.

Mr. Poole. Mr. Chairman, my name is Daniel A. Poole, representing the Wildlife Management Institute. Mr. Gutermuth, vice president of the institute, was scheduled to be here today, but he is not feeling very well and he asked me if I would come down.

With the committee's agreement, I would appreciate having this statement appear in the record as though it were given by Mr. Gutermuth.

Mr. Fogarty. Surely.

Mr. Poole (reading): Mr. Chairman, I am C. R. Gutermuth, vice president of the Wildlife Management Institute. The institute is one of the older national conservation organizations and its program has been devoted to the wise use of natural resources in the public interest since 1911.

Conservationists are amazed that the 1961 budget again fails to request the full authorized amount—$50 million—for grants to communities for construction of State-approved sewage treatment facilities. This highly successful program which was authorized in section 6 of Public Law 660 of the 84th Congress, simply cannot be slashed $25 million as proposed in the budget.

Mr. Chairman, this committee, in its wisdom, has overridden previous attempts of the President to stifle the grants program. The committee's action has been supported firmly by the Congress, and by the public in all parts of the country, and it is for that reason that I say we are amazed at this renewed effort to jettison one of the Nation's most outstanding natural resources programs.

To delve into history for a moment, the President asked for $45 million for this program for fiscal year 1959, the same amount that was requested and granted in 1958. He stated, however, that funds

would not be included in the 1960 budget if the recommendation of the Joint Federal-State Action Committee that the responsibility for all pollution control he handed to the States "be accepted as practicable by the Congress."

The President asked only $20 million for construction grants in 1960 and reiterated that funds would not be sought in 1961 if Congress accepted the Joint Action Committee's recommendation. Congress rejected the President's request and provided $45 million for the successful grants activity.

The President now is saying in his current budget message that $20 million, instead of the customary $45 million—

represents the maximum amount which I believe is warranted for a construction program which is and should remain primarily a State and local responsibility.

Mr. Chairman, the Joint Action Committee's recommendation never has been accepted as legitimate. Few persons can ascribe logic to the fact that telephone users should be asked to pay for controlling pollution that is created by all the people. The House Government Operations Committee (30th Report, 85th Cong., 2d sess.) flatly contradicted the Joint Committee's recommendation by stating, in part:

The transfer of Federal grant programs is no panacea for the weaknesses of State and local government. If the intent of such a proposal is to increase State responsibility, this approach alone would neither foster responsibility nor alter the conditions which earlier inhibited State action * * *. Responsibility cannot be created by a transfer of programs and tax sources.

Congress did act to terminate the telephone tax as requested effective June 30 this year, but that action was in no way linked with the pollution control program. It also is interesting to note that the Budget Bureau now is asking that the telephone tax be extended beyond the termination date.

The need for continuing the grants program is obvious to all those who will take the time to look at the record. There is a present backlog of about 1,250 projects applications for Federal aid to support projects estimated to cost more than $784 million. This program is not another Federal giveaway and it is stimulating construction of needed sewage treatment facilities.

The municipalities have pledged $553.6 million on their part for $131.6 million received in Federal aid. More than $4 in local funds are being spent for each $1 of Federal aid received. I know of no other Federal grant program that can compare even remotely with this enviable record of stimulating direct local financial participation.

Conservationists are hopeful that once again this committee will help rescue the American people from the blight of water pollution by approving at least $45 million for the construction grants program. The record is clear, Mr. Chairman. Statements before both the House and Senate committees and during the floor debates, show that the construction grants program is the only activity that is making measurable progress in halting the flow of obnoxious municipal wastes into America's waters. It also is equally clear that the American people are demanding that the Federal Government assume its responsibility and assist the States and municipalities in halting water pollution.

We wish to commend this committee for its recommendation in 1960 that the HEW Department, in preparing the 1961 budget, give serious consideration to—

* * * setting forth separately in the budget all water pollution control activities, and all air pollution control activities. This will give everyone concerned a much clearer picture of what is being spent on these activities, than is shown when they are partially amalgamated under the general title "Sanitary Engineering Activities" and partially set out separately.

The President's Water Pollution Control Advisory Board supported your recommendation, Mr. Chairman, when it resoluted on January 19, 1960 that—

* * * the budget should contain a separate and distinct item for water pollution control activities so as to be readily identifiable at all stages of the budget and appropriation process.

Conservationists heartily endorse this proposal. I personally suggested it to Secretary Flemming and he assured me that it would be considered. Once again we find that it is virtually impossible to locate the water pollution control appropriation request in the 1,000-page budget document. And once again, the index contains no listing for "water pollution control." The items are scattered and there is no way of knowing how much is being requested for various aspects of the program, and whether the allotments are going for the intended purposes.

Both the air and water pollution control now are under a new heading—"Environmental Health Activities." These important programs are now mingled with fly-spraying operations, occupational health, and accident prevention. We do not believe that the committee had that kind of a breakdown in mind. It certainly is not what we have been urging. Who can say that item 2(b), "Direct operations," on page 587 of the budget includes funds for administration of construction grants, public awareness, enforcement, basic data, and comprehensive planning? How much is being requested for each, and why are construction grants listed as a separate appropriations heading?

Conservationists are convinced that administratively and budgetwise, the water pollution control program should be set forth separately in the budget and the various program details presented the same as they are spelled out in the Water Pollution Control Act of 1956. We are talking about and referring to a big program, Mr. Chairman, one that involves many millions of dollars, and not some small incidental activity that should be relegated into the seventh subbasement.

In conclusion, Mr. Chairman, conservationists urge this committee to provide not less than $45 million for continuation of the construction grants program. The present situation is no less acute than it was last year when the committee increased the budget request to $45 million and stated:

The budget was completely unrealistic in view of the needs. It was brought out during the hearings that it would take 3½ years at the rate of appropriations recommended for 1960 just to finance the applications for grants that are currently on hand.

Lastly, we wish to express complete agreement with this committee of the urgent need for setting out the water pollution control program as a distinct, easily identifiable budget item. The public wants to know how much money is being asked for in all aspects of the program. They want to be able to identify those items and to have the

added assurance that the money that is appropriated is being used as Congress intended. Here is the suggested budget itemization or breakdown that was proposed last year. It follows the customary pattern and is consistent with the procedure used by the Bureau of the Budget.

(The document referred to follows:)

WATER SUPPLY AND WATER POLLUTION CONTROL

For expenses necessary to carry out the provisions of sections 301 and 311 of the Public Health Service Act, as they relate to water purification and supply, and to carry out the purposes of the Water Pollution Control Act (33 U.S.C. 466–466d, 466f–466k) including $2,700,000 for grants to States and $300,000 for grants to interstate agencies; $_____ to remain available only until June 30, 1961 (Department of Health, Education, and Welfare Appropriation Act, 1961).

Appropriated 1960, _____ Estimated 1961, _____

*Program and financing*

| | 1959 actual | 1960 estimate | 1961 estimate |
|---|---|---|---|
| Program by activities: | | | |
| 1. Grants for water pollution control: | | | |
| (*a*) State control programs | | | |
| (*b*) Interstate water pollution control agencies | | | |
| 2. Direct operations: | | | |
| (*a*) Research | | | |
| (*b*) Basic data collection and analysis | | | |
| (*c*) Technical assistance | | | |
| (*d*) Comprehensive water pollution control programs | | | |
| (*e*) Enforcement of interstate water pollution control | | | |
| (*f*) Administration of grants for waste treatment works construction | | | |
| 3. 1959 program obligated in 1959 | | | |
| Total obligations | | | |
| Financing: | | | |
| Comparative transfers to other accounts | | | |
| 1959 appropriation available in 1958 | | | |
| Unobligated balance no longer available | | | |
| New obligational authority | | | |

1. *Grants.*—Expansion and improvement of State and interstate agency water pollution control programs are supported throughout the country. Funds are allotted according to specifications provided in the Water Pollution Control Act (33 U.S.C. 466c).

2. *Direct operations.*—(*a*) Research: Basic laboratory and field research is conducted in the biochemistry and physical biology of aquatic organisms; and the chemistry and physics of substances dissolved or suspended in water. Applied laboratory and field research investigates the detection, identification, evaluation, and treatment of matter found in water; the stabilization of aqueous wastes; and the purification of water. Through publication, seminars, and other scientific gatherings, and through continuous liaison with official and private agencies, a continuing effort is made to stimulate growth of research in the fields mentioned above.

(*b*) Basic data collection and analysis: Information is collected with the aid of State and local agencies, analyzed and pblished on needs and facilities for waste stabilization and municipal and industrial water supply; and on trends in water pollution reflected by the quality of the water itself at selected locations in the major drainage basins of the country.

(*c*) Technical assistance: The program offers (1) scientific, engineering, and administrative consultation, demonstrations and field assistance to State, local, and Federal agencies on unusual problems in pollution control and water supply practice; (2) legislative reference service to State agencies; and (3) cooperative public information and training services to help State agencies obtain public cooperation and improve waste treatment and water supply operations.

(d) Comprehensive water pollution control programs: Objectives of water pollution control are stated in broad terms for the drainage basins of the country and their major subdivisions, with consideration for all anticipated uses of the water in each basin. More detailed studies, resulting in specific engineering recommendations for water pollution control and municipal and industrial water supply are undertaken in cooperation with State agencies and with Federal agencies that are concerned with water resource development.

(e) Enforcement of interstate water pollution control: The Water Pollution Control Act provides for abatement of pollution that endangers the health or welfare of persons in a State other than that in which the pollution originates. The Public Health Service maintains reconnaissance in areas where such pollution may occur, and works with States to help them solve interstate pollution before formal proceedings become necessary. In most formal proceedings, the first stage conferences of those concerned agree upon satisfactory schedules of abatement.

(f) Administration of grants for waste treatment works construction: Grants for waste treatment works construction, from funds appropriated under that title, and authorized by the Water Pollution Control Act are administered by the Public Health Service. Most of the administrative work is performed by regional office staffs in close cooperation with the State water pollution control agencies and the applicant municipalities.

Mr. FOGARTY. Thank you. That is a very fine statement, Mr. Poole. I think the committee will take some action on this appropriation structure this year.

We should like to try to correct this budget as we did last year. We said last year it would take 3½ years at the rate of appropriations recommended for 1960 just to finance the grants currently on hand. What is the situation this year?

Mr. POOLE. I used generally the same figures that were used last year. When the statement was prepared, I did not have the benefit of the debate which appears in the Congressional Record in the last 2 days or so. There are more project applications now. I notice the figure was approximately 200 more, I believe, than we have stated here.

Mr. FOGARTY. So it is going up.

Mr. POOLE. So it is around 1,400 or so. It is going up, yes.

The other thing we feel should really be stressed, a point which did not appear to have gotten across in all areas of Congress at least, is the fact that these Federal grants are stimulating the expenditure of $4 on the part of States and local communities for constructions programs, for each $1 of grants.

Mr. FOGARTY. What do the conservationists think of the President's veto message of last year?

Mr. POOLE. They feel it ill-advised and most unfortunate.

Mr. FOGARTY. You are being pretty kind, are you not? Is that all?

Mr. POOLE. We are speaking English here.

Mr. FOGARTY. Ill-advised. You are very kind.

Mr. Denton.

Mr. DENTON. No questions.

Mr. FOGARTY. Mr. Marshall.

Mr. MARSHALL. No questions.

Mr. FOGARTY. Thank you very much. Mr. Poole.

STATEMENT OF MAYOR RUSSELL P. SMITH, CAMBRIDGE, MD.

Mr. FOGARTY. Mayor Smith from Cambridge, Md., was to appear this morning. We understand he is not feeling well. His statement will be filed.

(The statement referred to follows:)

STATEMENT OF RUSSELL P. SMITH, MAYOR OF CAMBRIDGE, MD., ON BEHALF OF THE AMERICAN MUNICIPAL ASSOCIATION

Subject: Federal water pollution control program and hospital survey and construction program.

Mr. Chairman, my name is Russell P. Smith. I am mayor of the city of Cambridge, Md. I am appearing before you today in my capacity as chairman of the American Municipal Association's Committee on Water Resources and on behalf of the Maryland Municipal League.

The American Municipal Association through its affiliated leagues of municipalities and the direct membership of cities in 49 States, the District of Columbia, and Puerto Rico represents nearly 13,000 cities, towns, and villages of all sizes. The association formulates and executes the national municipal policy which suggests broad areas of responsibility for municipal, State, and Federal authorities on matters affecting municipal government.

At the American Municipal Association Congress in Denver, Colo., on December 2, 1959, the following national municipal policy statement was adopted:

"Passage of the Federal Water Pollution Control Act in 1948 and its extension in 1956 indicates that the Federal Government, too, has an interest in the pollution problem because of its jurisdiction over the Nation's waterways and because of the benefits of pollution abatement to the public health. The act establishes and continues the policy of Federal responsibility for research and technical services, financial assistance to States and municipalities, and enforcement of interstate pollution controls."

The Congress is urged to continue and expand the 1956 Water Pollution Control Act by:

1. Providing for an expanded program of research in waste treatment methods necessary for the reuse of our water resources as they pass from city to city;

2. Liberalizing the financial provisions of the act by increasing the total loan and grant authorization and by raising the percentage of Federal contribution available for each project to cover at least 33⅓ percent of the cost of the project, with no ceiling limitation as to the maximum amount;

3. Increasing the annual authorization from $50 million to $100 million;

4. Authorizing the reallotment of unused State grant allotments to States having projects for which grants cannot be made because of lack of funds;

5. Permitting communities to join together to build a common sewage treatment works to receive individual grants based upon their pro rata share of the eligible cost of such projects;

6. Appropriating adequate funds to provide for expanded research programs which will more diligently pursue the development of improved methods for the treatment and disposal of municipal, industrial, and radioactive wastes.

7. Authorizing studies of water pollution caused by the discharge of sewage and garbage from ships operating in navigable waters of the United States, and the development of methods for controlling this pollution so as to protect municipalities taking their water supplies from these sources.

THE EXTENT OF POLLUTION

Relatively few sewage treatment plants were in operation in 1920 and the municipal wastes treated and untreated reaching our streams had a pollution effect equivalent to the raw, untreated sewage from 40 million persons. Since then municipalities have built nearly 6,500 sewage treatment plants at a cost of approximately $8 billion. The population served by sewers has continued to grow, however, and at the end of 1957 municipal pollution reaching our streams was equal in effect to the raw, untreated sewage from 75 million persons. Thus, despite considerable progress, we have lost ground to sewage pollution in the amount equal to the sewage from 35 million persons.

The amount of industrial pollution from organic wastes (of animal or vegetable origin) being discharged into streams in 1920 had a polluting effect equivalent to the raw, untreated sewage from 17 million persons. Recent studies have indicated that the amount of industrial wastes now going into the Nation's streams is somewhat more than double the amount of municipal wastes. Thus, the amount of organic industrial wastes being discharged today is probably in excess of a population equivalent of 150 million persons, or an increase of more than 130 million since 1920.

In addition, there have been large increases in the discharge of inorganic industrial wastes (principally of mineral and chemical origin) which cannot be compared with sewage as to their polluting effects. Such wastes are acid mine drainage, metal finishing wastes, pickling liquors, and a wide variety of chemicals. Such wastes are corrosive; cause tastes, odors, and hardness; interfere with most water uses; and many are toxic. Although industry has spent considerable of its capital for pollution control through the years, it has also fallen steadily behing in meeting treatment needs.

### CONSTRUCTION—WASTE TREATMENT FACILITIES NEEDS

The Public Health Services recently completed 1957 Inventory of Municipal and Industrial Wastes Facilities reveals that a sewage treatment construction backlog amounts to more than 6,000 projects which would cost $1.9 billion if constructed today.

Nearly 2,900 new plants are needed to serve 19.5 million persons in communities now discharging raw sewage and 1,100 new plants are needed for 3.4 million persons in communities where existing plants are obsolete. Two-thirds of our sewage treatment construction needs are for entirely new plants and that one out of every seven plants in operation needs to be replaced.

In addition to new plant needs, 779 plants serving 17 million persons and 851 plants serving 8.4 million persons need enlargement or addition of new treatment units or processes. Adding these needs to those for replacement indicates that one out of every three plants in operation is inadequate to meet pollution control needs of today, not to mention those of a rapidly growing population. In all, projects are needed to serve 48 million people, nearly half of all who are served by sewerage systems in the United States.

In addition to the backlog, rapid population growth and increasing urbanization are creating new needs continuously; also, these factors, plus time, are causing existing plants to become obsolete, requiring replacement.

If we are to catch up by 1965, municipalities will need to spend $1.9 billion for the backlog, $1.8 billion for new needs from population growth, and $900 million to replace plants that become obsolete in the interim—a total of $4.6 billion. This will require spending an average of $575 million per year.

### THE CONSTRUCTION RECORD

During the 5 years from 1952 to 1956, the period immediately preceding the Federal grants program, construction contract awards for sewage treatment facilities averaged $222 million annually.

In 1957, the first full year of the grant program, construction activity increased 58 percent over the previous annual average and amounted to $351 million. The program's second year was even more impressive for construction contract awards jumped to $389 million, an increase of 75 percent over the 1952–56 average.

For 1959 the construction total is estimated to equal $350 million, down about 10 percent from 1958. The drop is probably in large part due to the steel strike. Public works construction generally dropped 15 percent during the same period.

### THE GRANT PROGRAM RECORD

As we have already noted, nonassisted construction contracts during the 5 year period 1952–56 averaged $222 million annually.

During 1957 nonassisted construction activity equalled $232 million, $10 million more than the previous 5-year average, but an additional $119 million was poured into projects as a result of Federal aid. In 1958 nonassisted construction activity amounted to $234 while Federal aid stimulated the additional construction of $155 million worth of treatment facilities. For 1959 it is estimated con-

struction for nonassisted projects will amount to $210 million with Federal aid stimulating an additional $140 million.

On the basis of the facts it seems quite clear that the Federal grant program had the positive effect of stimulating construction activity to a significant extent.

The program should be continued. Although Congress has been prevented from taking postive action to help bring construction up to the $575 million annual level needed to adequately meet the acknowledged backlog and the needs developing out of population growth and obsolescence of existing facilities, we hope it will nevertheless act to keep the existing program at its present level.

We urge your approval of the full amount of $50 million authorized in Public Law 660 to continue to carry out this important program.

HOSPITAL AND MEDICAL FACILITIES SURVEY AND CONSTRUCTION PROGRAM

There is an urgent need for the full annual appropriation of funds authorized by the Hospital Survey and Construction Act (Hill-Burton). Obsolescence of existing hospital buildings and the need for new hospital construction to meet the requirements of the annual increase in our population are so great that in spite of the funds Congress has authorized under the present law, ground will be lost this year, as in past years, in terms of meeting the total hospital facilities need of the American people.

Not only has obsolescence outrun new construction and modernization in relation to the continuous population increase, but also no substantial inroads have been made on the backlog of construction needs resulting from the restricted hospital construction program during World War II and the preceding depression.

According to the most recent figures relating to facility needs, over 175,000 additional general hospital beds are needed to adequately serve the Nation. On the basis of current construction costs of $20,000 per bed, the provision of these badly needed additional facilities will cost over $3.5 billion. These figures do not take into account the additional requirements resulting from population growth, the increasing age of our population or the needs of patients suffering from long-term illnesses.

RENOVATION, MODERNIZATION AND REPLACEMENT

A study by the American Hospital Association made in 1956 indicated, as of that time, an accumulated backlog of over $1 billion worth of needed renovation and modernization of our older hospitals. The association now believes from later studies that this figure is too conservative and the need is now almost $2 billion.

For example, the hospitals of the city of New York have renovation and modernization needs along of about $200 million.

The larger and often older institutions in the Nation's urban areas are the centers of medical teaching. These institutions provide the facilities for modern medical research and the development of techniques and procedures. Their contributions are basic to health progress. To see that these institutions particularly are modern and efficient and developed so that they may be fully effective is unquestionably in the public interest.

Further, according to Public Health Service studies, approximately 9,500 hospital beds become obsolete each year and should be modernized. In some instances the complete replacement of facilities is preferable to modernization. There are obsolete facilities in every section of the country. Obsolescence, moreover, is not entirely a matter of age since rapid advances in medical techniques make many institutions inefficient despite their relatively recent construction.

The Hill-Burton program has accomplished a great deal to improve the Nation's hospital plant, but it has done this primarily in terms of new construction in rural areas and has virtually ignored a serious and rapidly growing need for renovation and modernization of our older urban hospital facilities.

The 1960 American municipal policy statement urges that the present hospital construction program be extended to include a category of assistance for the modernization and renovation of existing hospital plants, a category not covered by the present act. In the meantime, the full appropriation for the present hospital construction program is vital.

MONDAY, FEBRUARY 29, 1960.

WATER POLLUTION CONTROL

WITNESS

ROBERT M. PAUL, EXECUTIVE SECRETARY, SPORT FISHING INSTITUTE

Mr. FOGARTY. Next we have Mr. Robert M. Paul, executive secretary of the Sport Fishing Institute. Mr. Paul.

Mr. PAUL. Thank you, Mr. Chairman. I have a very brief statement.

My name is Robert M. Paul, executive secretary of the Sport Fishing Institute here in Washington, D.C.

We appreciate the opportunity of appearing before your committee again. I see no reason to duplicate the testimony you have heard from the previous witnesses representing conservation organizations which are similar to ours. We just want to go on record again as urging your committee to maintain the present program of water pollution control at least at the present level. We have no doubt in our minds that the program is working extremely well. I think it is the most important tool we have now to maintain future fishing recreation, and certainly we do not want to see any slowdown at this stage of the game.

I would like to speak briefly again in support of the items which are in this budget which are increased over last year for program operations within the Service.

As you recall, in the past we have recommended that the research phase, particularly the enforcement phase, needs to be stepped up. I think the Service has done an outstanding job in enforcement activities within the last year, considering what they had available—the number of conferences which have been held, the active work on the Columbia Basin and on the Missouri Basin, here on the Potomac River, and, last but not least, their outstanding job on the Animas River Basin, as far as radioactive wastes are concerned. You are more familiar than I am with the the difficulties they have had within the Federal structure in working out some of these programs.

We certainly want to make strong recommendations that the increases which are included in the budget be allowed to make the record clear that this is only a first step, as we see it, and there is some additional work badly needed in these areas.

Mr. FOGARTY. We were told this morning that we ought to be spending at the rate of $50 million a year on this problem of radiological health.

Mr. PAUL. I could not dispute that figure—I am rather familiar with radiological problems—as I think of the magnitude of the problem, when you project it 20 years in the future, which is the way we should be thinking now.

Mr. FOGARTY. Some of us are very much concerned about the problems of environmental health. We think the administration is away behind the times and this problem is catching up with us; that there are real dangers in the water and the air which we are not meeting or taking care of or planning for.

This committee will hold a special hearing next week on the problems of environmental health. We have other people coming in. If you would like to file a statement on the overall problems of environmental health, we should be glad to accept your statement.

Mr. PAUL. I should like to accept your offer, Mr. Chairman. We are extremely interested in this. As you know, or may recall from last year, this is the first year I have been in Washington. Previous to that I was in California in the environmental health field, both air and water pollution, and radiological waste disposal. I can say that, without exception, the State and local health agencies and the public at large are more concerned over this whole area of environmental health than anything else. I think the recent testimony and statements on the air pollution problems, for example, and bills such as the one introduced yesterday in the Senate dealing with this problem, indicate the magnitude of it.

One item that is proposed for increase in this budget, by the way, is the control of radioactive pollution from ore processing in the Colorado Basin. We have heard a lot in the past about States rights and the problems of the States with some phases of this program. Here is one that the States are urging the Federal Government to get into—the whole area of environmental health. It has been borne out by the activities of the past. There is no conflict here at all. The problem is so big that nobody can touch it.

That concludes my statement.

Mr. FOGARTY. Thank you very much, Mr. Paul.

I think I should ask you, as I have asked others who are interested in conservation and water and air pollution, what did you think of the President's veto message last week?

Mr. PAUL. I read the statement with considerable interest and some dismay, as you might imagine. At the same time, I think there are some positive points in the veto message which might be worth the committee's attention. For instance, I think this is about the strongest statement we have ever had from the administration on needs. I am thinking of some of the later paragraphs where he pointed out that industry has a role and that business should recognize its responsibility in this field. He makes specific recommendations, again, coming under the whole general area of environmental health. Ignoring the first part of the message, I feel all of us who are concerned with this can take the last 75 percent of the message and use it as a base upon which to build a very good program, and we should get very strong support from the administration in this area.

Mr. FOGARTY. Excuse me, but I just cannot agree with you. The President vetoed this last bill and he is even cutting the present program back $25 million. It just does not add up, to me.

Mr. PAUL. Mr. Chairman, I think I am known as an eternal optimist, but we took a beating on this.

Mr. FOGARTY. You really did take a beating, but this administration is known for saying a lot of encouraging things in these areas and doing nothing about it. After Congress does something about it, then sometimes, reluctantly, they will come along the next year and endorse what Congress supports.

Mr. PAUL. I have been told there is a building time lag in some of these considerations.

Mr. FOGARTY. Is that what you call this $25 million cut?

Mr. PAUL. No. In the broadest sense, I think this is a phase lag from some rather ill-advised considerations of about 3 or 4 years ago on the part of the administration, which we have not quite gotten away from yet.

Mr. FOGARTY. We are going the other way again, are we?

Mr. PAUL. We hope your committee will follow its past pattern and resist this trend.

Mr. FOGARTY. I hope so, too. I hope we have support in the committee to correct this. Thank you very much.

Mr. PAUL. Thank you, Mr. Chairman.

---

MONDAY, FEBRUARY 29, 1960.

## WATER POLLUTION CONTROL

### WITNESS

### CHARLES H. CALLISON, CONSERVATION DIRECTOR, NATIONAL WILDLIFE FEDERATION

Mr. FOGARTY. We are glad to have you back with us again, Mr. Callison. Go right ahead.

Mr. CALLISON. Mr. Chairman, the National Wildlife Federation, whom I am representing today, composed of State and local conservation associations and groups in all the States, has always supported the Federal water pollution control program under Public Law 660. We have appeared before this subcommittee every year since 1956 urging appropriations up to the authorized limit, and we wish to thank you and your colleagues for your own keen understanding of the water problem and for providing the funds to make the program work.

While the present program is making real progress, it is not going fast enough to catch up with and finally overcome the load of sewage pollution being dumped into our streams by growing cities.

Everyone admits the program needs to be speeded up. The National Wildlife Federation was one of the organizations that vigorously supported H.R. 3610, the bill recently vetoed by the President, which would have doubled, approximately, the present authorization for sewage treatment grants. We were grievously disappointed when the President vetoed the bill, as were all conservationists. We were disappointed that Congress failed to override the veto, but it is significant, we think, that more than 60 percent of the Members of the House present and voting last Thursday did vote for the bill.

The President's opposition to this program has been utterly incomprehensible to us. Even more incomprehensible has been his attempts to eliminate the modest grants program authorized by the 1956 act, as indicated in this years' proposed cut in the budget to $20 million.

In his own words from the veto message, the President said, and I quote, reading from the Congressional Record:

> The rivers and streams of our country are a priceless national asset. I accordingly favor wholeheartedly appropriate Federal cooperation with States and localities in cleaning up the Nation's waters and in keeping them clean.

This administration from the beginning has strongly supported a sound Federal water pollution control program. It has always insisted, however, that the principal responsibility for protecting the quality of our waters must be exercised where it naturally reposes, at the local level.

Polluted water is a threat to the health and well-being of all our citizens. Yet pollution and its correction are so closely involved with local industrial processes and with public water supply and sewage treatment that the problem can be successfully met only if State and local governments and industry assume the major responsibility for cleaning up the Nation's rivers and streams.

Mr. Chairman, that is exactly the way the Federal grants program under Public Law 660 works and would have worked if it had been increased by the enactment of H.R. 3610. Federal assistance stimulates, but local governments continue to assume "the major responsibility for cleaning up the Nation's rivers and streams."

To pinch pennies on this program makes the same kind of situation as refusing to fix a leaky roof for alleged economy reasons when the leak is causing rot which will cause the house to fall down.

Mr. Chairman, we respectfully urge that the funds for sewage treatment construction grants be approved at $45 million for fiscal year 1961, which is the same amount this subcommittee has approved and has been appropriated in each of the last 3 years.

Mr. FOGARTY. What would be the effect if this $25 million cut were allowed to stand?

Mr. CALLISON. The effect would be almost a complete halt to the present program which is almost letting us keep abreast of the sewage problem. The result would be a falling behind again in our efforts to clean up the polluted waters of this country and to prevent further spread of water pollution. It would be a very grievous setback.

Mr. Chairman, I voluntarily comment on the President's veto of H.R. 3610. I think it is a bad mistake. I think the Administration has been dead wrong on this program all the way through.

Mr. FOGARTY. I agree with you. When they say in one breath that they think this is a priceless resource, and then we have a budget before us which has been cut in half, it does not make sense to me.

Mr. CALLISON. The veto does not make sense in view of the rationalizations in the veto message, and it does not make sense in view of the facts, the needs, and the situation with respect to water supply.

Mr. Chairman, with your permission and that of the committee, I will file the rest of my statement, in which we support the other proposed budget items for water pollution control activities and also comment on the importance of having this program set forth clearly in the Federal budget, a matter which was commented on by previous witnesses.

Mr. FOGARTY. We expect we can take care of that this year.

(The statement referred to follows:)

Mr. Chairman, we are encouraged that the budget apparently allows $3 million for the State program grants and $6,372,600, a sizable increase, for direct operations of the Division of Water Supply and Water Pollution Control as listed as items 2(a) and 2(b) under "Program and financing" on page 587. We regret to say "apparently" because it is evident that attempts may be made to bury this program.

When H.R. 3610, amending the Federal Water Pollution Control Act of 1956, first was introduced, it contained a clause which would have elevated the water pollution control program to the status of an Office. This upgrading clause was stricken in committee when the Secretary, by administrative order, elevated the function to division status.

This committee's report, Report No. 309 of the first session of this Congress, on page 10 said: "The committee also recommends that in the preparation of the budget for 1961 serious consideration be given to setting forth separately in the budget all water pollution control activities, and all air pollution control activities. This will give everyone concerned a much clearer picture of what is being spent on these activities than is shown when they are partially amalgamated under the general title "Sanitary Engineering Activities," and partially set out separately.

The Water Pollution Control Advisory Board, all members of which have been appointed by the President, on January 19, 1960, adopted a resolution reading: "In view of increased public and congressional awareness and interest in the Federal water pollution control program, and their consequent interest in appropriations for such program, the Board believes that the budget should contain a separate and distinct item for water pollution control activities so as to be readily identifiable at all stages of the budget and appropriation process."

Now, Mr. Chairman, the well-informed members of this committee may consider that its recommendation of last year has been followed, but we do not. To have this vital function grouped with radiological health, sanitation, occupational health, and accident prevention under something new called environmental health activities in somewhat confusing to us. We do not underestimate or doubt the value of these other functions but see no purpose or point in grouping them with water pollution control. Speaking quite frankly, we do not think water pollution control will receive proper consideration until it is pulled out of the bureaucratic morass and allocated a separate and distinct budget—one which cannot be questioned or altered administratively. We urge that the committee demand such a budget.

We would recommend also that the water pollution control program be made an Office directly under the Secretary.

In conclusion, we would say that we think the $3 million program grants program has been quite beneficial in helping States develop their own programs. We also believe that the "operations" budget allocation would be wisely spent.

Thank you for the opportunity of appearing here today.

Mr. CALLISON. I am authorized to speak for the Committee of 100 for the Federal city, of which Rear Adm. Neill Phillips, U.S. Navy, retired, is chairman. The office of this civic body is in the Union Trust Building in Washington, D.C. I wish to place them on record in support of restoring the $45 million appropriation for sewage treatment and in support of the other pollution control appropriations.

Mr. Chairman, one of the real honors and pleasures which has come to me since I have been working for the National Wildlife Federation in Washington has been the privilege of appearing before this subcommittee. This is the last statement I will be presenting for the National Wildlife Federation, at least as a staff member. Beginning tomorrow, I join the staff of the National Audubon Society. I look forward to that new association with many pleasures, and one is that in this capacity I shall again have the opportunity of appearing before this distinguished committee and working with you gentlemen on conservation matters.

I now submit for the record a statement by Mr. Carl H. Buchheister, president of the National Audubon Society, supporting restoration of the sewage treatment construction grant funds to $45 million and in support of the other budgeted items for water pollution control.

Mr. FOGARTY. We shall put that in the record at this point.

(The statement referred to follows:)

STATEMENT BY CARL W. BUCHHEISTER, PRESIDENT, NATIONAL AUDUBON SOCIETY, NEW YORK, N.Y.

The National Audubon Society, one of the oldest and largest conservation organizations in the world with members and affiliated groups throughout the Nation, recognizes water pollution as one of the greatest threats to the welfare and security of the United States. The widespread and progressive contamination of our streams, lakes, and beaches with human sewage and industrial wastes not only destroys wildlife resources and recreational opportunities for all the people; it inhibits economic growth by rendering water unusable for industrial, municipal, and agricultural purposes. Untreated and untreatable (with present knowledge) chemicals are pouring into our public waters to constitute a health hazard which may in the long run be more serious than disease-carrying sewage.

Unless brought under control, water pollution can spell disaster to America.

The National Audubon Society has been pleased with the progress made under Public Law 660, the Water Pollution Control Act of 1956. Far more vigorous programs, greater in volume and more aggressive, are needed at all levels of government, however, if we are to catch up with the vast backlog of untreated wastes and solve the problem. The Federal Government, the States, and municipalities all must redouble their efforts.

We are greatly disappointed that the Federal budget proposes again to reduce the appropriations for the sewage-treatment construction grants program under Public Law 660, a program which since 1956 has resulted in doubling the national rate of sewage-treatment plant construction and cleaned up more than 15,000 miles of polluted streams.

We trust this subcommittee will again recognize the effectiveness and vital importance of this program and vote to appropriate at least $45 million for construction grants, instead of $20 million as has been recommended in the budget. We respectfully urge you to do so.

The National Audubon Society supports the other appropriations needed by the U.S. Public Health Service to carry out its responsibilities in water pollution control. We recommend this subcommittee provide the full amounts as proposed in the budget for the following activities and services:

| | |
|---|---|
| Construction grants administration | $644,800 |
| Program grants to States and interstate agencies | 3,000,000 |
| Research | 1,640,000 |
| Basic data collection and analysis | 842,000 |
| Technical assistance (to industry, local governments) | 933,700 |
| Comprehensive water pollution control program development | 998,500 |
| Enforcement of interstate pollution control | 937,200 |
| Control of radioactive waste pollution | 401,700 |

We thank you for the privilege of presenting our views.

Mr. FOGARTY. I am sorry you are leaving the wildlife federation, but we think the Audubon Society is important in this overall program, too, and we are happy to know you will continue your work in that field.

Mr. CALLISON. Thank you, Mr. Chairman.

Mr. FOGARTY. Thank you very much.

As subcommittee chairman, I have received an enormous amount of correspondence on this subject—too much to burden this record with all of it. However, I think some of these letters and resolutions from all sections of the country should be placed in the record.

(The material referred to follows:)

NEW ENGLAND INTERSTATE
WATER POLLUTION CONTROL COMMISSION,
*Boston, Mass., February 29, 1960.*

Congressman JOHN E. FOGARTY,
*Chairman, House Appropriations Subcommittee on Departments of Labor and Health, Education, and Welfare, Washington, D.C.*

DEAR CONGRESSMAN FOGARTY: I have been advised that your subcommittee is now holding budget hearings on fiscal year 1961 appropriations for program and construction grants under Public Law 660. It is my understanding that the budget provides for the continuation of $3 million for program grants but a decrease in the appropriation for construction grants from the authorized $50 to $20 million.

The commission has, on several occasions, informed your subcommittee on the effectiveness of the construction grants in substantially accelerating the water pollution abatement efforts in the New England-New York area. It had been hoped that through the Blatnik bill, increased funds needed for the expanding construction program might be authorized by this Congress, certainly not reduced.

In the opinion of the commission, the proposed decrease in construction grant funds would materially retard the progress being made to conserve the water resources of the region and the Nation. The commission, accordingly, wishes to be recorded with your subcommittee as urging the continuation of the construction grant program at the $50 million level authorized under Public Law 660.

Very truly yours,

JOSEPH C. KNOX,
*Executive Secretary.*

---

NEW MEXICO DEPARTMENT OF PUBLIC HEALTH,
*Santa Fe, March 1, 1960.*

Hon. JOHN E. FOGARTY,
*Chairman of the House Appropriations Subcommittee on Labor and Health, Education, and Welfare, House of Representatives, Washington, D.C.*

DEAR CONGRESSMAN FOGARTY: It was with considerable regret that we heard the news that House bill 3610 had failed to pass on an attempted override of the President's veto. The Federal Water Pollution Control Act, Public Law 660, has given considerable impetus to water pollution control here in New Mexico. We have at the present time 38 projects either completed, under construction, or planned. These projects are doing a great deal to bring clean water to the State. In fact, we are rapidly reaching a goal where we will have a modern sewage treatment plant for every sewered community. This has been made possible, of course, because of the help we get in the way of Federal financial assistance.

We sincerely hope that every attempt will be made to restore the $20 million figure in the President's budget, back to $45 million which has been the allocation in past years. This program means a great deal to us, so we sincerely hope that you will do everything in your power to restore the allocation as mentioned above.

Sincerely,

STANLEY J. LELAND, M.D., *Director.*

---

STATE OF MAINE WATER IMPROVEMENT COMMISSION,
*Augusta, February 29, 1960.*

Congressman JOHN E. FOGARTY,
*Chairman, House Appropriations Subcommittee, Departments of Labor and Health, Education and Welfare, Washington, D.C.*

DEAR SIR: The following is in reference to fiscal 1961 appropriations for construction grants under Public Law 660.

At the meeting of Maine's Water Improvement Commission, which is the agency charged under provisions of chapter 79, Revised Statutes of Maine of 1954, with administration of the State pollution control program, a resolution was discussed and then passed to support the restoration of the $50 million construction grant item to the budget.

Reduction of available funds would be a blow to the pollution abatement program at this time, and particularly in this State where at first the program did

not enjoy the success that it did elsewhere. At present it appears, that during this year, use of Federal grants will for the first time approximately keep pace with their availability and the water improvement commission hopes to maintain that rate of construction as such improvements are badly needed in many areas.

Attention is also called to State support for a construction grants program. In 1957 the Maine Legislature saw fit to provide matching grants of its own to aid, and to make even more desirable, municipal participation in the Public Law 660 program by providing State assistance equivalent to two-thirds of the Federal contribution to the construction of municipal treatment works.

Again in the interests of continued progress in the pollution control program, National and State, the Maine Water Improvement Commission wishes to urge the restoration of $50 million to the fiscal 1961 budget for use in sewage treatment works construction grants.

Sincerely yours,

R. W. MacDonald,
*Chief Engineer, Water Improvement Commission.*

---

California State Water Pollution Control Board

Resolution No. 60-4—Recommending That the U.S. Public Health Service Initiate a Comprehensive Water Pollution Control Study of the Colorado River and Its Tributaries as Expeditiously as Possible

Whereas at the request of the water pollution control agencies of the States in the Colorado River Basin, the U.S. Public Health Service (under provisions of the Federal Water Pollution Control Act) held a conference on pollution of interstate waters of said basin, at Phoenix, Ariz., on January 13, 1960; and

Whereas the water pollution control authorities of all of the States in said basin attended and participated in said conference; and

Whereas it was the opinion of the conferees at said conference that there is immediate need for an investigation of interstate pollution problems which may exist in the waters of the Colorado River; and

Whereas said conferees unanimously agreed that the Public Health Service, in cooperation with other Federal agencies and the State water pollution control agencies of Arizona, California, Colorado, Nevada, New Mexico, Utah and Wyoming, should undertake a comprehensive water pollution and water quality study of the Colorado River and its tributaries; and

Whereas in the first supplemental appropriation bill for fiscal year 1960 there is a $350,000 item for radiological health studies for the sanitary engineering activities of the U.S. Department of Health, Education, and Welfare, $88,000 of which is intended for use in studying wastes from uranium ore processing; and

Whereas the Federal appropriation bill for fiscal year 1961 for said Department (under line item: Enforcement—Water Supply and Pollution Control—Environmental Health Activities) includes $400,000 for the conduct of the proposed pollution control study of the Colorado River: Now, therefore, be it

*Resolved*, That the California State Water Pollution Control Board earnestly recommends that the Surgeon General of the U.S. Public Health Service initiate, at the earliest possible date, the comprehensive water pollution control study of the Colorado River and its tributaries, as proposed at said January 13, 1960, conference; and be it further

*Resolved*, That said board respectfully urges that the $88,000 in the 1960 first supplemental appropriation bill earmarked for study of wastes from uranium ore processing be used to initiate said comprehensive study of the Colorado River during the current fiscal year; and be it further

*Resolved*, That said board hereby expresses its support and approval of the $400,000 budget item in the Federal appropriation bill for the conduct of said comprehensive study during fiscal year 1961; and be it further

*Resolved*, That the executive officer of the State water pollution control board be directed to forward a copy of this resolution to the Representatives of the State of California in the Congress of the United States, to the chairmen of the Senate and House committees on appropriations, and to the Surgeon General of the U.S. Public Health Service.

THE WATER RESOURCES COUNCIL, INC.,
*New York, March 1, 1960.*

Hon. JOHN E. FOGARTY,
*Chairman, House Appropriations Committee*
*Washington, D.C.*

DEAR SIR: I am writing to protest against the President's cut in the budget for the pollution control program. The $30 million eliminated should be restored because any attempt to emasculate this program strikes a body blow to the Nation.

If the President is really sincere in his hold-the-line-on-spending operation, he would be far better advised to tackle the programs which are obviously a waste of the taxpayers' money, such as the farm program. But this program is putting nearly equal amounts of local, State and Federal money into projects which are self-sustaining and self-liquidating from earnings for services rendered on a quid pro quo basis. It is the sort of program which should receive encouragement for this reason alone.

The President's contention that this is a purely local problem is an ancient dogma which has been growing whiskers since he was a boy in Abilene. Some one should tell him that times are different and that the new set of conditions are crowding out the old concepts. The rapid growth in population and industry, the fact that we are no longer predominantly agricultural but urban, the increased uses for water created by scientific research and technique, all are factors which have almost obliterated the so-called local lines in many parts of the Nation. As an example, consider the eastern seaboard which is one vast Megalopolis from Maine to Washington, D.C. Who dumps on who is no longer a matter of easy definition. Consequently, all experts agree unanimously that this is a problem for joint participation by local, State and Federal Governments.

This is a $12 billion program, the main burden of which will fall on some 5,000 little villages. Has the President been told that out of the 6,686 towns needing sewage plants, 75 percent have populations of 2,500 or less, and 50 percent have populations of 1,000, or less. These towns are not only small but crowded by debt. They will never voluntarily accept the President's thesis. They never have and never will lift a finger without both a sense of compulsion and some financial aid. If successful the President's action will bring the program to a halt.

If you would care to explore my views further I refer you to the Federal water pollution control hearings (No. 86–4) before the House Committee on Public Works, on H.R. 3610.

I am also enclosing my comments on the Broomfield bill H.R. 2733, which I think would have great bearing on the subject under discussion.

As for my qualifications to speak on this subject—chairman of Clean Streams Committee, Water Resources Council, Inc.; commissioner, New England Interstate Water Pollution Control Commission; member, advisory panel, Vermont State Water Conservation Board.

Thanking you for your consideration of the above, I am,

Sincerely yours,

ROBERT ALDRICH RODGER.

---

STATE OF OREGON, FISH COMMISSION OF OREGON,
*Portland, February 18, 1960.*

Congressman JOHN E. FOGARTY,
*Chairman, Subcommittee on Labor, Health, Education, and Welfare, House Appropriations Committee, House of Representatives, Washington, D.C.*

DEAR CONGRESSMAN FOGARTY: The State of Oregon Fish Commission is vitally concerned with the effect of pollution on the fishery resources of Oregon and the Pacific Northwest. We urge support of the budget requested by the President for water pollution control activities in the Public Health Service except for the amount requested for construction grants to municipalities. In lieu of the $20 million requested by the President for this item, we recommend appropriation of the authorized $50 million. The programs of water pollution research and basinwide pollution control planning by the Public Health Service are of particular importance to us. Affirmative action by your subcommittee will do much to aid our efforts in fish conservation.

Sincerely yours,

ALBERT M. DAY,
*State Fisheries Director.*

NEW HAMPSHIRE WATER POLLUTION COMMISSION,
*Concord, February 17, 1960.*

Hon. JOHN E. FOGARTY,
*Chairman, House Appropriations Subcommittee on Department of Labor and Health, House of Representatives, Washington, D.C.*

DEAR MR. FOGARTY: Enclosed is a copy of a self-explanatory letter regarding the commission's views on Federal assistance for pollution control projects.

Since you have been intimately associated with the valuable efforts made possible by the Federal aid system under Public Law 660, and also for the reason that the matter will require further action by your committee, the commission felt that you should be advised of its position in this important program.

Very truly yours,

WILLIAM A. HEALY, *Technical Secretary.*

STATE OF NEW HAMPSHIRE,
WATER POLLUTION COMMISSION,
*February 16, 1960.*

Hon. STYLES BRIDGES,
*U.S. Senate, Washington, D.C.*

DEAR SENATOR BRIDGES: At a recent meeting of the commission, the status of Federal financial assistance under provisions of Public Law 660, 84th Congress, was discussed. The review at this time was prompted by the estimated allocations to the States and territories for fiscal year 1961, as contained in the President's budget. Reference to this document will indicate that New Hampshire's allocation would amount to $213,110 for construction assistance and the sum of $23,700 for expansion of the pollution control program at the State level.

Since August 1956 when the financial assistance program was initiated, communities in New Hampshire have made considerable progress in the construction of needed pollution control projects. Outstanding evidence of this accelerated program is demonstrated by the installation or renovation of sewage and waste treatment plants at Derry, Dover, Jaffrey, Keene, Newbury, and the county institutions at Brentwood, Grasmere, and Unity. Currently the cities of Portsmouth and Nashua are about to undertake major control projects as a result of Federal grant offers.

During the last session of the legislature, State aid became a reality and the appropriations authorized are at a level which would afford communities a 50 percent grant when coupled with the Federal 30 percent assistance. Due to the incentive of the assistance money, a large number of other towns are actively planning pollution control programs. Included among these would be: Boscawen, Concord, Conway, Epping, Exeter, Goffstown, Hampton, Hanover, Hudson, Laconia, Lincoln, Newport, Peterborough and Salem.

It is apparent to us from the foregoing that we have reached the time where there is competition as between communities for the funds at the $50 million a year rate, as authorized originally under Public Law 660. Accordingly, the commission unanimously voted to instruct the technical secretary to notify the New Hampshire delegation of its opposition to the reduction in allocations, as proposed in the President's budget, and to indicate the commission's support of increased appropriations to municipalities for the construction of sewage treatment works under Public Law 660 (see Blatnik bill H.R. 3610). Further, that the commission considers the continuance of program grants under section 5 of Public Law 660 essential to successful operation of the State control program and strongly urges the adoption of necessary legislation to maintain the program beyond the fiscal year ending June 30, 1961.

It was further voted that the commission's position with reference to Federal construction grants be made known to Congressman John A. Blatnik, sponsor of H.R. 3610, and Representative John E. Fogarty, chairman, House Approriations Subcommittee on Departments of Labor and Health, Education, and Welfare.

Very truly yours,

WILLIAM A. HEALY, *Technical Secretary.*

NEW MEXICO DEPARTMENT OF PUBLIC HEALTH,
*Santa Fe, March 1, 1960.*

HON. JOHN E. FOGARTY,
*Chairman of the House Appropriations Subcommittee on Labor, and Health, Education, and Welfare, House of Representatives, Washington, D.C.*

DEAR CONGRESSMAN FOGARTY: We have heard with considerable dismay that House bill 3610, which was vetoed, failed to pass on an attempted override of the veto. Public Law 660, the Federal Water Pollution Control Act, means a great deal to us here in New Mexico, as it does in other parts of the country. Because of the funds which we receive, approximately $631,000 per year, from the Federal Government, we have been able to carry on a very extensive program of water pollution control. It has made it possible for us to resolve many old and vexing problems which would still exist today if it had not been for this Federal assistance.

It is our understanding that there was only $20 million provided in the President's budget for this purpose. This would reduce our allocation to about $245,000 per year. This would not be sufficient for us to continue to stimulate the interest of our communities in building modern and adequate sewage treatment plants. We respectfully request, therefore, that every consideration be given to raising the amount to at least the $45 million as has been the case for several years.

We are enclosing for your information a copy of our summary report of the Federal water pollution control program in New Mexico. If we can supply you with further information we will be happy to do so.

Sincerely,

CHARLES G. CALDWELL,
*Director, Environmental Sanitation Services.*

---

MONDAY, FEBRUARY 29, 1960.

## LIBRARY SERVICES

### WITNESS

### MISS GERMAINE KRETTEK, DIRECTOR, WASHINGTON OFFICE, AMERICAN LIBRARY ASSOCIATION

Mr. FOGARTY. We shall hear now from Miss Krettek, director of the Washington office of the American Library Association. Miss Krettek.

Miss KRETTEK. My name is Germaine Krettek. I am director of the Washington office of the American Library Association, a nonprofit, professional association of more than 23,000 members, consisting of librarians, trustees, and friends of libraries interested in the development, extension, and improvement of libraries as essential factors in the educational, social, and cultural needs of our Nation.

The American Library Association has directed me to appear before this subcommittee and recommend that the full amount of $7,500,000 authorized under the Library Services Act of 1956 be appropriated for fiscal 1961. The President's budget recommends $7,300,000, and it is our understanding that $1,100,000 of this amount would be available to those States which were unable to request their full allotments in fiscal 1960 and consequently will have balances carried over into fiscal 1961, and $6,200,000 is for matching by the States in fiscal 1961.

In urging the $7,500,000, the association does so for a number of reasons, among them being the following:

(1) In fiscal 1960, 49 States and 3 territories are participating in the benefits of the act. Only one, the State of Indiana, is not yet in the program. It is hoped and expected that the people of that State will be permitted to enjoy the advantages of the Library Services Act in 1961, just as the other States have been doing. Indiana is entitled to an annual allotment of $193,574. It is anticipated also that State legislatures meeting this year will make it possible for some States not now able to match in full to do so.

Mr. DENTON. As I understand, these are 2-year funds.

Miss KRETTEK. That is correct.

Mr. DENTON. There is $193,574 available if Indiana should go in the act this year.

Miss KRETTEK. That is right.

Mr. DENTON. For next year, in order to take care of Indiana, how much would the appropriation have to be?

Miss KRETTEK. The same amount, $7,500,000.

Mr. DENTON. $7,500,000?

Miss KRETTEK. Yes; to make available Indiana's maximum allotment of $193,574.

Mr. DENTON. A good many of us are very hopeful the political climate will change out there, and that the people of Indiana will not be deprived of this program for library services. I suspect you know Members of Congress are working on that. I suppose they have told you that.

Miss KRETTEK. We hope very much that next year Indiana will qualify for the program.

Mr. DENTON. You do not think this library service program is brainwashing the people in any other State where they have the service?

Miss KRETTEK. Judging from the tremendous enthusiasm with which the people in the States have been making use of the programs under the Library Services Act, I doubt that.

Mr. DENTON. You think it is perfectly safe for the people of Indiana to take advantage of this service?

Miss KRETTEK. Yes; because, after all, the strength of the program is that each State makes its own plan and it is left to the individual State to develop a library program for extension of service in that particular State. There are almost a million people in Indiana who have no access to local public library service at the present time.

Mr. DENTON. We are the only State in the Union which is in that category. I think that is all.

Miss KRETTEK. (2) As mentioned in last year's testimony, the $7,500,000 was not a chance figure but one determined by library authorities as a bare minimum, which could not do the whole job of remedying public library deficiencies, but would induce and help the States to do a better job of maintaining better public library service for all the people.

(3) Inflation has shrunk the purchasing power of the $7,500,000 set in 1946. The increase in the cost of books, periodicals, book-

mobiles, equipment, and labor has made it impossible for the States to achieve to date what had been planned to be accomplished in the library extension field when the legislation was first proposed in 1946—13 years ago.

(4) Although State appropriations for public library service to rural areas have increased 54 percent since 1956, there is still need to encourage them to do more. A recent statement from Arkansas is but one of many indicating this development:

> The impetus given the public libraries in our State through the Library Services Act has led to increased citizen support.

The Congress, we feel, has reason to be proud of the progress made with the funds which it is investing in this program of public library development, with the State, local, and Federal governments cooperating. In Florida's rural library development program, for example, both State and local funds are used to match Federal funds. The impact of the program is strikingly demonstrated by the increase in local matching funds over a 3-year period. A recent report from the State shows that the counties which are providing $124,574 for rural library service this year spent only $32,861 for that purpose in 1955–56.

This means that for every dollar spent in 1955, approximately $4 are now being spent.

Throughout the Nation the first 3 years of the Library Services Act show remarkable progress:

1. Thirty million rural people now have new or improved public library service available to them as a result of the State plans under the Library Services Act of 1956.

2. More than 5 million books and other informational and educational materials have been added to the cultural resources of rural communities. A recent report from Rhode Island states, among other things, that a major accomplishment of the Library Services Act program will have been—

> to put carefully selected, cataloged books into 42 public libraries, improving the quality of their holdings, and thereby stimulating local use and local support. * * * Libraries have increased their status and importance in their communities through better book stocks and more hours open. Local support has been increasing with resultant improvements in facilities, equipment, salaries, and book stock * * *.

Mr. Fogarty. Are you satisfied with the progress you are making in Rhode Island?

Miss Krettek. No, sir; not entirely.

Mr. Fogarty. I think you would agree that we have a very good staff running this program.

Miss Krettek. I think Rhode Island is doing very well under the present situation. In order for Rhode Island really to make library progress, however, more financial aid is needed at the State level.

Mr. Fogarty. In what way?

Miss Krettek. There have not been enough State funds available to match in sufficient quantity so Rhode Island could receive all of the Federal funds which are available under this program.

Mr. Fogarty. Would it take just an appropriation? Is that all it would take?

Miss Krettek. Yes; from the State legislature.

Mr. FOGARTY. How much? Will you supply that figure for the record?

Miss KRETTEK. I cannot tell you right now.

(The information requested follows:)

Rhode Island will need $96,784 to match for all Federal funds available if the allotment for fiscal 1961 is again based on the full authorization. At the end of the current fiscal year Rhode Island will have an allotment balance of $41,631.

Miss KRETTEK. 3. Approximately 200 new bookmobiles are traveling rural roads bringing books and information to people in remote areas. Perhaps a senior citizen from Texas (who could have been from any other State) summed up the situation most adequately:

It (the new library service) is almost too much for me. When I look at all these books of knowledge and adventure at my fingertips and think how old I am and of how much I've missed in the past, I'm just desperate to know where to begin.

4. Increases in library use as a result of library development projects under the act are impressive. Many regional and county projects report circulation increases of 40 percent and up. A single new regional library in Colorado, for instance, serving 23 communities, many of which never had library service before, loaned over 71,000 books in the first 6 months of operation.

The replies received in connection with a study made by the Children's Services Division of the ALA regarding the effects of the Library Services Act on children are heartwarming. A typical example is this one from Minnesota:

But I think that perhaps the most startling (from one view) and important (from all views) is the great improvement in the quality of children's and young people's books now available in all the 16 counties which have received grant funds.

This improvement in the quality of reading available to children is, we believe, the most positive and effective way of combating trashy magazines and comic books which many children buy when good books are not easily available to them.

The American Library Association and the librarians and library trustees of the Nation are very grateful to this subcommittee for what it has done for the cause of rural public library service in the past. You have given a needed impetus to the progress of this often overlooked agency for educational and cultural development. Much still remains to be done. We are hopeful, therefore, that you will approve the sum of $7,500,000 for grants under the Library Services Act for fiscal 1961.

Thank you very much for the privilege of appearing before this subcommittee.

Mr. FOGARTY. Thank you very much. That is a very fine statement. We agree with you that this is one of the really fine programs. I have watched it in Rhode Island, and I know what it has done for us, especially in our smaller communities. It certainly has been a great help.

Have you made plans to extend this act?

Miss KRETTEK. Yes. I believe at this particular date there are 17 bills pending in the Congress.

Mr. FOGARTY. What is the overall effect?

Miss KRETTEK. To extend the present Library Services Act for another 5-year period at the same authorization of $7,500,000.

Mr. FOGARTY. Just an outright extension of 5 years under the same provisions?

Miss KRETTEK. Yes.

Mr. FOGARTY. Mr. Marshall.

Mr. MARSHALL. No questions.

Mr. FOGARTY. Thank you very much, Miss Krettek.

LETTER FROM HON. FRED WAMPLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA

Along the line Mr. Denton was discussing, I have a letter from another Indiana Congressman, Mr. Wampler which we shall place in the record. And, following that, a letter the NEA asked be placed in our record.

(The letters referred to follow:)

HOUSE OF REPRESENTATIVES,
*Washington, D. C., February 29, 1960.*

Hon. JOHN E. FOGARTY,
*Chairman, Subcommittee on the Departments of Labor and Health, Education, and Welfare and Related Agencies, House Committee on Appropriations, Washington, D.C.*

DEAR MR. CHAIRMAN: It is highly lamentable, I think, that the State of Indiana currently enjoys the dubious distinction of being the only State in the Union never to have taken advantage of the Federal program of grants to States for rural public library services under the Library Services Act.

With almost 1 million Hoosiers presently without any library service and an equal number with inadequate library facilities, it seems inconceivable that Indiana has elected, since the fiscal year 1957, the first year of operation of the Library Services Act, to refuse to participate, thereby denying new, improved, and expanded library services to the State's rural population.

In fiscal year 1960 Indiana was allotted, on the basis of its rural population, $193,574, which it could have been granted had it decided to provide its full participation share of $195,989, based on per capita State income.

Had Indiana fully participated in the program, it could have received for fiscal year 1957 the sum of $40,000, plus $122,998 for fiscal year 1958, for fiscal year 1959, $151,229, and $193,574 for fiscal year 1960, for a computed total of $507,801.

Although President Eisenhower, for fiscal year 1961, has budgeted only $7.3 million for the continuation of the Library Services Act, I strongly urge you and the members of your committee, Mr. Chairman, to approve the full annual appropriation of $7.5 million.

With warmest regards, I am,

Sincerely,

FRED WAMPLER,
*Member of Congress.*

---

NATIONAL EDUCATION ASSOCIATION,
*Washington, D.C., February 25, 1960.*

Hon. JOHN E. FOGARTY,
*Chairman, Labor, Health, Education, and Welfare Subcommittee, Committee on Appropriations, House of Representatives, Washington, D.C.*

MY DEAR MR. CHAIRMAN: I should appreciate it if this letter, stating the views of the National Education Association on the appropriation for the Library Services Act for fiscal 1961, could be included in the record of hearings before your Subcommittee on Labor, Health, Education, and Welfare.

The 1959 Representative Assembly of the National Education Association, meeting in St. Louis, adopted the following resolution:

"*Rural library services.*—A strong public library system is a vitally necessary adjunct to the operation of public schools. A person's residence should not determine his access to books, periodicals, audio-visual materials, and other published sources of information. The association believes that Federal grants

to assist the States to develop and maintain their rural library services are a necessary step toward the goal of equal educational opportunity for all children. It urges the Congress to appropriate funds for this program in the amount necessary to carry out the objectives of the Library Services Act of 1956."

The National Education Association regards good library service as essential to the development of a responsible and productive citizenry. The stimulus of the Library Services Act has been wholesome and encouraging as evidenced by the degree of participation of our various States. Public libraries have become symbols of our determination that the accidents of geographical location or economic circumstances shall not impede an individual American's opportunity to make his way in the world.

There has been great progress but much remains to be done. The American Library Association has pointed out that 25 million people in our rural areas were still without any public library service in 1959; that 21 million more have no opportunity to benefit directly by cooperative local-State-Federal library development projects under the Library Services Act; while some 253 counties still have no public library service within their borders.

The National Education Association accordingly urges the subcommittee to approve an appropriation of $7,500,000 for fiscal 1961 and also supports legislation which will extend the act for another 5 years.

Respectfully yours,

WILLIAM G. CARR, *Executive Secretary.*

---

MONDAY, FEBRUARY 29, 1960.

## FOOD AND DRUG ADMINISTRATION

### WITNESS

### MRS. RUTH DESMOND, SECRETARY, FEDERATION OF HOMEMAKERS

Mr. FOGARTY. Next, we have with us Mrs. Ruth Desmond, secretary of the Federation of Homemakers. Mrs. Desmond.

Mrs. DESMOND. Mr. Chairman and members of the committee, I am Ruth Desmond, secretary of the Federation of Homemakers. Our federation is most appreciative of being afforded this opportunity to express the views of its membership in support of the budget request for the Food and Drug Administration.

Our Federation of Homemakers, although but recently formed, consists of housewives residing in this area and in many of our States. We also have junior members attending local colleges. Our members are concerned not solely with the health and well-being of our own families, but with the good health of all consumers. One of the objectives of our federation is to acquaint our members with past and future food legislation and the tasks, responsibilities, and financial needs of the Food and Drug Administration in enforcing these laws.

We wish to thank the members of this committee for endeavoring in the past to provide the Food and Drug Administration with needed increases in personnel, equipment, and expanded facilities through substantial increases in appropriations for this agency over those requested for it by the Bureau of the Budget. This indicates to us the awareness of this committee to the fact that modern methods of producing food and the processing of it requires a greatly increased force of FDA scientists and inspectors as well as expanded facilities and modern laboratory equipment.

Last spring before our federation was formed, an interested group (now charter members of our organization) inspected certain of the laboratory facilities of FDA. We were impressed with the dedicated attitude of the scientific staff, but disturbed that these scientists were carrying out their experiments in cramped, congested quarters not even their own! Yet in spite of the disadvantage of limited facilities, these scientists had recently developed analytical methods of detecting minute traces of pesticide residues. We feel informed consumers would be thankful for the scientific curiosity and inventiveness of these dedicated men, and would urge adequate appropriations to provide these scientists with their own well-equipped laboratories.

Therefore our board of directors is delighted that the present suggested budget for FDA proposes staff expansion sufficient to keep pace with the recommendations of the Citizens Advisory Committee, which were presented in 1955; provides for special staffing for increased radiological activities, and to finance the continuation of the scientific equipment and modernization program. Also that it will make possible the modernization and enlargement of laboratory and office facilities in four districts which, we understand, have needed modernization for some time.

We also rejoice that there is a request in the General Services Administration portion of the budget for an appropriation to commence construction of a new FDA laboratory-office building in Washington (Federal Office Building No. 8). All of our members are aware of the critical need for this building which was recommended by the Citizens Advisory Committee in 1955, and our federation urges that this appropriation be made this session. It is our understanding that because of the complexity of this structure it will require at least 3 years to complete it. Therefore it seems to us that construction of this building should not be delayed.

At this point, I am proud to call attention to the fact that Sir Edward Mellanby, G.B.E., K.C.B., M.D., F.R.S., in his Sanderson-Well lecture on "The Chemical Manipulation of Food," delivered at the Middlesex Hospital, May 4, 1951, which appears in the British Medical Journal of Saturday, October 13, 1951, praises the experimental work carried out by the U.S. Food and Drug Administration and the official inquiries held by this agency on specific matters of interest. Sir Mellanby expressed regret that at that time there was no such competent agency in his country carrying on this important work.

Officers of our federation and members of its board attended the recent hearings before the House Interstate and Foreign Commerce Committee on color additives legislation and are attending the present hearing before the FDA examiner relative to proposed delisting of certain lipstick colors. We have been impressed with the scientific background of our FDA staff and the numerous contributions they have made to scientific literature. Our federation is on record that we have complete confidence in the ability, responsibility, and integrity of these FDA scientists to make competent decisions in their respective fields. Nevertheless, our members are concerned that when the color additives bill is passed it will increase the duties and responsibilities of FDA staff and tax further its laboratory facilities. Therefore, our federation looks to this committee to remedy these

future problems with adequate appropriations which will ultimately benefit the American public.

Thank you, gentlemen, for permitting us to present these views.

Mr. FOGARTY. Thank you very much. That is a very fine statement. I am very pleased that you people have formed this organization, because I think you can do the Food and Drug Administration a lot of good. They just do not have many groups like yours working for them.

Mrs. DESMOND. To sort of get the information of what they do across to the public?

Mr. FOGARTY. Yes. They do not have any special voluntary organization and I think the general public does not know what their responsibilities are. I think you deserve a lot of credit for taking the time to come and tell us about what you are doing.

Mrs. DESMOND. Thank you, Mr. Fogarty. We are well aware of your fine record. Our board has a copy of your speech in which you commend the Food and Drug Administration.

Mr. FOGARTY. I found a little fault with the Administration in that talk, too, if I remember.

Mrs. DESMOND. You were very appreciative of its work, and said we could not get any more value for our money in any agency than we do from Food and Drug.

Mr. FOGARTY. I also said I think we ought to be giving them a little better budget to work with.

Mrs. DESMOND. You usually go on record to that effect.

Mr. FOGARTY. Thank you very much, Mrs. Desmond.

## ADDITIONAL LETTERS AND STATEMENTS

We have several statements and letters various organizations have asked be placed in the record. Some are from people who had planned to appear in person but are unable to do so.

These will be placed in the record at this point.

(The material referred to follows:)

### STATEMENT OF MRS. HARVEY W. WILEY

Mr. Chairman and members of the committee, I am the widow of Dr. Harvey W. Wiley, former Chief of the Bureau of Chemistry of the U.S. Department of Agriculture, from 1883 to 1912, who is known throughout the country as the father of the pure food law of 1906. I make this appeal in behalf of a crusade to which my late husband devoted a lifetime, and to which many years of my long life of 83 years have also been devoted. This crusade has one main objective: The assurance to all Americans that the foods, drugs, and cosmetics which they utilize shall be safe and pure.

This goal seems so essential, so basic, and so desirable one wonders why a crusade is necessary to achieve it. Yet, as we well know, the food and drug laws which we have today are the result of decades of unremitting effort and struggle by dedicated men and women. And these efforts are far from over.

As technology advances, new and serious problems in the area of nutrition, drugs, and cosmetics arise, and our Federal Food, Drug and Cosmetic Act must be changed in order to reflect these developments. Some changes have already been made, such as the Food Additives Amendment of 1958. But other important amendments are needed in order to provide legal consumer safeguards against real and potential hazards.

How long will it take for us to make up to the perils arising from the illegal distribution and use of amphetamines and barbiturates and provide the Food and Drug Administration with a more effective means of enforcing the law in

this area? How long will it be before we tighten the law with respect to the labeling of hazardous household substances which annually cause harm to hundreds, if not thousands, of people, mainly children? How long before we require that the new cosmetics be precleared by the Food and Drug Administration before they go on the market, in order to help avoid the damage which some injurious cosmetics inflict upon consumers each year? When will we do the same thing for new therapeutic devices?

These questions, and many more clearly indicate that the crusade for consumer protection is far from over, and it will need the support and efforts of each and every American concerned for the protection, safety, and health of the Nation.

But the amending of the law itself is only part of the story. The crusade must also extend to its enforcement. This committee is charged with the heavy responsibility of providing the funds which finance that arm of the Federal Government—the Food and Drug Administration—whose duty it is to enforce our food and drug laws. As we look back over recent years, the record shows that this committee and its able chairman, Mr. Fogarty, has fulfilled this responsibility in the best interests of the Nation. Funds have been provided FDA to enable a much-needed expansion of its staff and facilities. The consumers of this Nation owe Mr. Fogarty and his committee a debt of gratitude for this enlightened service. But the resources of this agency are still far from adequate to meet its gigantic workload.

It is interesting to note that in 1912 when my husband left the Bureau of Chemistry of the Department of Agriculture—the agency then responsible for enforcement of the pure food and drug law—had a staff of 546 and an annual appropriation of nearly $1 million. In nearly half a century, the Food and Drug Administration has been able to add only 1,114 employees to that staff and about $13 million to the appropriation.

Yet, since that time the Nation's population has grown by over 90 million people, the law has been expanded in scope, our cities have grown infinitely larger, we have become individually far less self-sufficient in the preparation of our food supply, leaving it to mass production, using ever-complex techniques. Literally thousands of new drugs have been developed, thousands of substances for use as food additives have been invented, pesticides have revolutionized our agricultural production, and more and more people are able to spend more and more money on consumer products. The rate of expansion of the Food and Drug Administration has certainly not been commensurate with the increasing complexities of its responsibilities.

As a matter of fact, FDA's resources today permit it to inspect each establishment under its jurisdiction—and there are over 100,000 of them—on an average of once every 5 years. This is inadequate for a Nation with our wealth and sense of social duty.

In 2 weeks time, we Americans spend more money just to store our surplus agricultural products than we provide FDA for a full year of operation. We spend one third as much to guard our public buildings each year—approximately $5 million—as we do to guard nearly 180 million Americans against harmful, insanitary, or fraudulent foods, drugs, and cosmetics. And although the great majority of our producers have the welfare of their consumers in mind, each year FDA, even with its limited resources, uncovers a "rogues gallery" of violations which are enough to shock any American.

For the fiscal year 1961, this committee has for its consideration a budget request of $16,852,000 for the Food and Drug Administration. I am informed that this amount would provide additional staff and improved facilities essentially in keeping with the recommendations of the Citizens' Advisory Committee Report of 1956; recommendations which called for a threefold to fourfold increase in FDA's staff in 5 to 10 years.

To this extent the budget being considered is encouraging. But is it adequate to meet the challenge facing FDA? Will it permit a substantial increase in the number of inspections and considerably reduce the once-every-5-years cycle? Will it enable the modernization and renovation of all FDA district offices in dire need of improvement after years of dilapidation? Will it provide for a truly adequate radiological program to determine the extent to which our foods, drugs, and cosmetics are being contaminated by radioactivity? Will it permit FDA to undertake much-needed research on an adequate scale into problem areas, such as frozen foods, pesticide residues, container waxes, food standards, and re-

heated fats? It does not take a financial wizard to see that the 1961 budget request for the Food and Drug Administration could not fully accomplish these necessary and long delayed measures.

Therefore, I sincerely hope that the Appropriations Committee will add additional funds to FDA's 1961 budget in order that all of us concerned with consumer protection will be able to see, within our lifetime, a pure food and drug enforcement program truly worthy of this great Nation; in order that our long crusade might finally reach its goals.

There is also one more subject of great importance which must be mentioned. It is my understanding that, after almost a decade of effort, the Food and Drug Administration is on the threshold of obtaining a building which will finally house all of the Washington activties under one modern roof. The importance of this to the entire food and drug enforcement program is immeasurable. Present facilities are intolerably bad.

My first contact with food and drug work was in 1898—well over a half century ago—when I joined Dr. Wiley's staff as his personal secretary. At that time, the operations of the Bureau of Chemistry were housed in a small, red brick building, three stories high—I believe it was an old converted house—on the corner of 14th and B Streets SW. It is fair to say that these facilities, in many respects, were better than the temporary World War II prefabricated buildings and converted Army barracks which now house some of FDA's Washington operations. It is unimaginable that after all these years since the first pure food law of 1906, the Food and Drug Administration is still scattered in five different inadequate locations throughout Washington, with many of its Bureaus and Divisions split—even within themselves—and laboratory facilities which are antiquated.

It is my understanding that, finally, the Bureau of the Budget has consented this year to include in the General Services Administration's budget estimate an amount of over $23 million for construction of a new building for FDA here in Washington. Although I realize that this subcommittee is not responsible for this particular appropriation, I hope that the members of the full Committee on Appropriations will support this measure to the fullest extent. The Nation has waited far too long for this necessary project.

In conclusion may I express appreciation for the permission to thus express my beliefs, for consideration before this distinguished committee. I am most grateful and know that you will give this budget your sympathetic consideration. If so, you will be helping to fulfill my dreams of many, many years, a food and drug law adequately enforced for the protection of all of our Nation's consumers.

---

### Statement of the St. Louis Consumer Federation

The St. Louis Consumer Federation has been concerned for many years with the effective operation of the Food and Drug Administration. In our opinion, it is one of the most important agencies of our Government whose chief objective is the protection of the consumer.

On checking the record we find that, although the Food and Drug Administration has had increases in recent years, the total sum provided for that agency is still a long way from the very modest goal that was set by the Citizens Advisory Committee in 1955. It has become clear that the goal of the citizens committee was very conservative because continuing changes in technology in the food and drug industries is adding to the responsibilities of the Food and Drug Administration constantly. Their entire sweep of activities are increasingly complex. An entire new field relative to fallout and nuclear testing has opened up since 1945. Serious repercussions on the food supply have already been noted. This necessitates an enlarged field of activity for protection on the part of this agency.

The St. Louis Consumer Federation has been active for years in pressing for more adequate legal powers and increased appropriations for FDA. We now renew and reemphasize our position in this matter and ask that you safeguard the population of this country by giving this protective agency adequate financial support to investigate the entire field of possible harm from chemicals, pesticides, insecticides, etc.

We respectfully urge that your committee consider the President's recommendation for this agency as a minimum appropriation. Thought should be given to whether additional money should be provided because of recent developments in new foods and drugs, and the urgency of the situation.

NATIONAL CONSUMERS LEAGUE,
*Washington, D.C., March 8, 1960.*

HON. JOHN EDWARD FOGARTY,
*Chairman, Subcommittee on HEW-Labor Appropriations, Committee on Appropriations, House of Representatives, Washington, D.C.*

DEAR MR. FOGARTY: We would greatly appreciate it if the enclosed letter were included in the record of the hearings on Labor-HEW Appropriations.

Thank you very much.

Sincerely,

VERA WALTMAN MAYER, *General Secretary.*

NATIONAL CONSUMERS LEAGUE,
*Washington, D.C.*

HON. JOHN EDWARD FOGARTY,
*Chairman, Subcommittee on HEW-Labor Appropriations, Committee on Appropriations, House of Representatives, Washington, D.C.*

DEAR MR. FOGARTY: We, of the National Consumers League, know we need not convince you and the members of the Subcommitteee on Labor-HEW Appropriations of the importance of approving, and improving, the Food and Drug Administration's budget request for fiscal 1960. You and the members of your subcommittee have long shown your profound understanding of the vital functions performed by the Food and Drug Administration in protecting the health of our citizens. And you have effectively demonstrated your deep concern and sympathy by increasing the appropriations for this very important agency of Government. We hope that you will see fit to do this again, particularly in view of some of the vital new areas which have most recently come within the jurisdiction of the Food and Drug Administration through congressional and executive action.

An area of ever-growing public concern is radioactivity in foods. The main responsibility for devising adequate protection from this tremendous potential threat to our population devolved upon the Secretary of Health, Education, and Welfare through the creation of the Federal Radiation Council. To help fulfill this responsibility, the Secretary of HEW has directed the Food and Drug Administration to determine safe levels of radioactivity and establish tolerances for foods subjected to radioactive substances. For the last year, the FDA has made reports on radioactivity measured in samples of hay, ensilage, fresh vegetables, wheat, cabbage, potatoes, fresh fruits, milk, and alfalfa. All of these items, either through direct or indirect consumption, eventually end up as part of foods for humans.

A numbers game has developed concerning the "permissible levels" of radioactivity in foods. This is fantastically dangerous. The Food and Drug Administration must face the job of doing basic research, reworking standards, accurately informing the public concerning dangers, and instructing the public on simple methods of reducing radioactivity.

This program obviously is vital to the Nation's health. Our generation and future ones can be irrevocably harmed by inadequate activity in this program. The research into and instruction concerning radioactivity therefore deserve the subcommittee's unusually careful consideration. This is undoubtedly one of the areas where the subcommittee should increase FDA's funds over the budget request.

Another area of vital FDA work concerns food additives. The March 8, 1960, deadline for the clearance of the many hundreds of additives in use prior to the enactment of the food additives amendment presents FDA with an administrative problem of tremendous proportions. The fiscal year 1961 budget permits the addition of only 15 people, bringing the total up to 136, to handle the many hundreds of petitions, tests, and letters arising from the amendment. This small increase in staff hardly seems adequate.

These are just two of the very vital areas in which the Food and Drug Administration protects the health of every single American. There are many more.

The expansion of FDA's activity is quite simply a matter of our survival. Funds for this agency are as important as funds for military preparedness and deterence. For in our age of radiological dangers and increasing use of chemicals and additives, the Nation can be harmed as badly by insufficient activity in the field of food protection as by insufficient activity against the danger of attack.

That is why we again urge that you increase the funds of the Food and Drug Administration substantially over the budget request.

Very truly yours,

VERA WALTMAN MAYER, *General Secretary.*

---

THE COOPERATIVE LEAGUE OF THE U.S.A.,
*Washington, D.C., February 29, 1960.*

Hon. JOHN E. FOGARTY,
*Chairman, Subcommittee, Departments of Labor and Health, Education, and Welfare, House Appropriations Committee, Washington, D.C.*

DEAR CONGRESSMAN FOGARTY: Because of our inability to appear in person before your committee, we want to assure you by this means that the Cooperative League highly recommends adoption of the proposed budget for Food and Drug Administration of $17.8 million for 1961 fiscal year.

As you know, the Cooperative League includes some 13 million families in its membership of affiliated cooperatives of many types. All, as consumers, are naturally interested in adequate protection of our food supply. As we have previously stated, FDA protection costs each individual less than the price of a pack of cigarettes. We think this is a samll price to pay for pure foods and drugs.

We would hope that the Congress sees fit to supplement FDA appropriations with legislation to make its work more effective. Certainly, too, there is a crying need for providing enlarged unified quarters to make FDA staff work more efficient.

We respectfully request that this letter be made a part of the hearing record.

Sincerely,

JACK T. JENNINGS.

---

AMERICAN COLLEGE OF APOTHECARIES, INC.,
*March 3, 1960.*

Hon. JOHN E. FOGARTY,
*Representative of Rhode Island, House of Representatives, Washington, D.C.*

DEAR REPRESENTATIVE FOGARTY: It is my understanding that you are chairman of the subcommittee considering the budget appropriation for the Food and Drug Administration. I would like to go on record as fully endorsing the increases provided for in the budget recommendation and in fact I am convinced that the Food and Drug Administration, considering the tremendous responsibilities which are entailed in its operation, is not being provided sufficient funds to properly carry out their responsibilities.

Having had the opportunity to, at least in some degree, become familiar with the work of the administration and the type of loyal employees that are administering the work of this agency, I am very much impressed by the tremendous job that they are doing to protect the health of our citizens. If time permits, I would very much like to testify in favor of increased appropriations for the Food and Drug Administration.

With best regards.

Sincerely,

ROBERT E. ABRAMS, *Executive Secretary.*

---

THE NATIONAL CATHOLIC SOCIETY FOR ANIMAL WELFARE,
*Washington, D.C., February 24, 1960.*

Representative JOHN FOGARTY,
*Chairman, House Appropriations Subcommittee on the Departments of Labor and Health, Education, and Welfare, House Office Building, Washington, D.C.*

DEAR CONGRESSMAN FOGARTY: We enclose a copy of a letter from the National Catholic Society for Animal Welfare to Senator Dennis Chavez, chairman of the Public Works Committee, in reference to Federal office building No. 8, the proposed Food and Drug Administration Building.

We request that the letter be included in the record of the health, education, and welfare hearings recently held by your subcommittee in executive session.

Sincerely yours,

HELEN E. JONES, *Executive Director.*

THE NATIONAL CATHOLIC SOCIETY FOR ANIMAL WELFARE,
*Washington, D.C., February 8, 1960.*

Senator DENNIS CHAVEZ,
*Chairman, Senate Public Works Committee,*
*Senate Office Building,*
*Washington, D.C.*

DEAR SENATOR CHAVEZ: We were pleased to note last week the Senate Public Works Committee's postponement of approval of a proposed Food and Drug Administration Building in the southwest area of Washington.

Before giving you our reasons for being opposed to a southwest Washington location for the Food and Drug Administration's proposed building, I should like to offer some background information about the National Catholic Society for Animal Welfare.

The society's main purpose is to make the teachings of the Roman Catholic Church on the animal world more widely known in this country. The NCSAW is the American counterpart of the British Catholic Study Circle for Animal Welfare.

In addition to its educational work, the NCSAW is concerned with bringing about the active application of the church's merciful teachings to current problems as a means of reducing or preventing unnecessary cruelty. It is not an antivivisectionist organization.

There has been much comment recently about the animal quarters maintained by the Food and Drug Administration in a subbasement of the south building of the Department of Agriculture. As a representative of this society, I visited the FDA's animal quarters on January 27 in the interest of obtaining firsthand information, through personal observation, about the animal quarters.

I found them to be quite inadequate. Dogs are confined for 2 years, and in some cases for 7 years, to cages measuring approximately 30 by 36 inches. No exercise area of any kind is provided. Cages are equipped with wire mesh floors. Metabolic tests are not being made on dogs; thus the FDA has no scientific reason for not providing cages with solid floors on which the animals would be more comfortable.

Nor does the nature of the testing being done on dogs, rats, mice, and rabbits by the Food and Drug Administration offer any scientific reason for the lack of exercise areas and comfortable housing for animals. It is my understanding that humane housing is not being provided because of the high cost of land in an urban location.

The National Catholic Society for Animal Welfare agrees with the Senate Public Works Committee that the new Food and Drug Administration building should not be located in an urban area.

The society's reason is it seems more than likely that the FDA will continue to provide inadequate housing for animals in the proposed Southwest location since land costs will be as high there, if not higher, as they are for the space being used at the present time.

Further, if the FDA locates in any urban location, it is extremely unlikely to provide, or even to be permitted to provide, outdoor exercise areas for dogs.

The FDA's veterinary medicine branch is located at Beltsville, Md. We see no reason why the proposed FDA building should not also be located at Beltsville or in some other rural area.

In an outlying area, the FDA would be relieved of any zoning or economic reasons for not providing adequate quarters for experimental animals. The great burden placed on taxpayers by the unnecessary location of a Federal building on costly urban land would be lightened as well.

We note that in a report on H.R. 6769 which included an appropriation for the Food and Drug Administration, the Senate Committee on Appropriations made this important statement:

"It has come to the attention of the committee that many of the research programs to be operated with appropriations provided in this bill involve the use of animals for experimentation and that in many instances totally inadequate facilities are provided for housing them in a humane manner consistent with the experiments being conducted. The committee strongly urges that every effort be made to provide suitable and comfortable quarters and that these animals not be subjected to the unnecessary cruelty involved in their being carelessly and improperly housed."

The facilities now being provided by the FDA for experimental animals are totally inadequate.

It is our desire to see the present quarters vastly improved and we ask that Congress ensure that the Food and Drug Administration will provide humane housing for animals in its new location. To that end, the Senate Public Works Committee can be helpful in refusing approval of an urban location.

The National Catholic Society for Animal Welfare would like an opportunity to be represented in any hearing which may be held by the Senate Public Works Committee or its subcommittee on building 8, the proposed Food and Drug Administration building.

Sincerely yours,

HELEN E. JONES, *Executive Director.*

---

THE GENERAL BOARD OF TEMPERANCE,
*Washington, D.C.*

LABOR AND HEALTH, EDUCATION AND WELFARE SUBCOMMITTEE, COMMITTEE ON APPROPRIATIONS,
*Capitol Building, Washington, D.C.*

DEAR FRIENDS: Please insert the following statement in the record of the hearings on the budget for the Food and Drug Administration, Department of Health, Education and Welfare.

My name is James Robert Regan, Jr. I am a Methodist minister serving as director of organizational activities and legal affairs, the General Board of Temperance of the Methodist Church. The Board of Temperance is a World Service Agency of the Church concerned with the fields of social welfare. It is located at 100 Maryland Avenue, N.E., Washington 2, D.C. The Methodist Church is a Protestant denomination with a membership of approximately 10 million members.

We wish to speak in favor of adequate budgetary appropriations for the Food and Drug Administration of the Department of Health, Education and Welfare. The protection of the citizens of this country from harmful foods and drugs is essential to the health and welfare of the Nation.

The social creed of the Methodist Church has the following statement:

"The interest of the Methodist Church in social welfare springs from the gospel, and from the labors of John Wesley, who ministered to the physical, intellectual and social needs of the people to whom he preached the gospel of personal redemption. In our historic position we have sought to follow Christ in bringing the whole of life, with its activities, possessions and relationships, into conformity with the will of God."

The desire to have proper regulation over food and drugs is a natural expression of Christian concern for the welfare of all the people. Although the Food and Drug Administration has been expanded considerably in the last few years, it cannot yet begin to handle adequately the need for research and regulation that these industries require. Although appropriated funds have allowed this agency to double its work potential since 1956, it is not yet possible to carry out the work asked for by the 1956 study commission, which called for a threefold to fourfold expansion. We might well ask the question, "How can we speed up the increases in appropriations so that this agency can take care of minimum responsibilities?"

There is nothing more important in this Nation than that of giving proper attention to this agency. The protection of the very lives of citizens of the country are dependent upon a well financed, properly functioning Food and Drug Administration subject to the review of the program congressional committees.

Respectfully submitted.

ROBERT REGAN, Jr.

ST. LOUIS ARCHDIOCESAN COUNCIL OF CATHOLIC WOMEN,
OF THE NATIONAL COUNCIL OF CATHOLIC WOMEN,
*St. Louis, Mo.*

Representative JOHN E. FOGARTY,
*Chairman of the Labor and Health Subcommittee,*
*House Appropriations Committee,*
*House of Representatives,*
*Washington, D.C.*

DEAR MR. FOGARTY: As president of the St. Louis Archdiocesan Council of Catholic Women, I represent, and speak for, some 100,000 women in Missouri who are members of 265 organizations federated in our council. We as housewives, mothers and business women, are vitally interested in the work of the Food and Drug Administration.

In 1955, a Citizens Advisory Committee was appointed who, after careful study, recommended that the FDA staff and facilities be expanded threefold to fourfold over a period of from 5 to 10 years. We feel that when such a committee takes time to thoroughly investigate a situation, as was done, special consideration should be given to its findings. This does not seem to be happening. Last year, for example, the budget committee recommended much less than was requested by the FDA. However, it was gratifying to note that through congressional action, the appropriation was raised, somewhat—although not to the amount needed.

The FDA is charged with the enforcement of the Federal pure food, drug and cosmetic law. In part, this entails compelling observance of the pesticide law enacted by Congress for the prevention of polluting the American food supply. We have become aware of something strongly akin to a chemical revolution in our country. The integrating of some of these chemicals in spraying, by good growers, will undoubtedly benefit the public. But, there is a grave need for careful scrutiny of such chemicals, particularly the policing of how closely the directions for their use are followed. In certain instances, some chemicals should not be used at all. The recent situation with the cranberry growers is a case in point. The FDA needs the support of both Congress and the public in its important work.

The St. Louis Archdiocesan Council of Catholic Women urges that every consideration be given the appropriation recommended by the budget committee for the FDA this year. We strongly recommend that it be considered as a minimum amount. Further, we urge the support of an appropriation for a new food and drug laboratory building in Washington, D.C., to supplant the inadequately equipped facilities of the FDA scattered over five different locations in Washington at the present time.

We feel certain, Mr. Fogarty, that you and your committee will consider our appeal in your deliberations, and we shall await news of the outcome of the scheduled hearings with interest.

Sincerely yours,

VIRGINIA MOONEY
Mrs. Robert H. Mooney.
*President.*

---

## AID TO SCHOOLS IN FEDERALLY IMPACTED AREAS

### WITNESSES

**HON. JOHN F. BALDWIN, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA**
**FRED McCOMBS, COUNTY SUPERINTENDENT OF SCHOOLS, SOLANO COUNTY, CALIF.**

Mr. DENTON. We shall hear now from Representative Baldwin of California. We are glad to have you with us today. You may proceed.

Mr. BALDWIN. Mr. Chairman, first I would like to express my appreciation to you for the opportunity to testify before your subcommittee. Mr. Fred McCombs, superintendent of schools of Solano County, Calif., is also here with me.

Mr. Chairman, I desire to testify in favor of an increase in the amount of funds provided in the budget for Federal aid to federally impacted school districts under Public Laws 874 and 815.

The amount requested in the budget for Federal aid to school districts under Public Law 874 is $126,695,000. This amount is approximately 32 percent less than the amount reqired to meet the entitlements of the various school districts under Public Law 874, as amended. I am informed that an additional sum of $60,505,000 is necessary to pay these entitlements in full. I, therefore, would like to urge this subcommittee to approve not only the sum included in the budget but an additional $60,505,000, or a total of $187,200,000 for Federal aid to school districts under Public Law 874.

There is likewise a sum included in the budget for Federal aid to school construction under Public Law 815. The sum in the budget is $44,390,000. However, it is my understanding that $63,372,000 would be required to meet all entitlements of school districts which would qualify under the provisions of Public Law 815, as amended. I should, therefore, like to urge that this subcommittee approve the sum of $63,372,000 for Federal aid to school construction under Public Law 815.

It is my understanding from the budget message that the Budget Bureau recommended these inadequate sums on the assumption that Congress would pass a bill which was recommended last year by the President, and which would have curtailed the number of students who would have qualified under Public Law 874. However, this bill was made the subject of hearings in the House Education Subcommittee and that subcommittee voted not to act on the bill. Under these circumstances, it is evident that Public Law 874 will continue in force during fiscal year 1961 in its present form.

It seems to me that the Federal Government has strong moral obligations to carry out the implied agreement which was made with federally impacted school districts when we passed Public Law 874 and Public Law 815.

These laws state that if a school district qualifies under the provisions of these laws that the Federal Government would pay to that school district a certain sum based upon a formula authorized by the laws and accompanying regulations. If we do not carry out this implied agreement with the school districts we are not carrying out our moral, if not contractual obligation, and we are leaving school districts in an almost impossible position.

There is one school district in Solano County, Calif., in which 96 percent of the students come from a nearby installation, the Travis Air Force Base. If the Federal Government cuts the Federal contribution to this school district by 32 percent under Public Law 874 it will be impossible for this school district to make up the deficit. Furthermore, it would be completely unfair to ask the families of the remaining 4 percent of the children, who are the only families not living on the Air Base, to pay 32 percent of the cost of educating 96 percent of the children who live on the Air Base. This would be unfair, inequitable, and completely unjust. I have received resolutions from practically every school district in Solano County upon this subject as this county has a large number of very important military installations. The school districts are now making up budgets for fiscal year 1961 and they certainly are entitled to the assurance

that the U.S. Government will live up to its agreement. I should, therefore, like to urge that this subcommittee act favorably upon the funds required to meet the Federal payment under Public Law 874, and under Public Law 815 on a 100 percent basis.

Mr. DENTON. I thank you very much. I have an impacted area in the district I represent, and I know the problem. I know they have made up their budget on the assumption that the Government would pay what it had paid in the past.

In many of these cases you cannot get the money from any other source.

Mr. BALDWIN. That is correct.

Mr. DENTON. As you pointed out, the budget was cut on the theory that a law which was recommended would be passed, but the Secretary admitted he could not find anybody on the legislative committee on either side of the aisle who would recommend it.

Of course, this is the kind of reduction that they know will not stand.

Mr. BALDWIN. By now they should be fully informed it is not going through and they should recognize reality.

Mr. McCombs is the superintendent of schools in Solano County. He has a short statement, Mr. Chairman.

Mr. DENTON. We will be glad to hear you.

STATEMENT OF FRED M'COMBS

Mr. MCCOMBS. I appreciate the opportunity, Mr. Chairman.

Mr. Chairman and members of the committee, I am Fred McCombs, the county superintendent of schools of Solano County, Calif.

I am speaking for 18 school districts who serve 29,388 children. Our concern is the proposed 32 percent deficit in the Public Law 874 money for the school year 1960–61. Unless the Appropriations Committee and the Congress provides the funds to remove this 32 percent deficit, the public school program in Solano County will suffer in general a serious setback, and in some cases a setback that would actually be disastrous. In these particular districts, there is actually a question in my mind as to whether they would even be able to operate the schools because of this loss of revenue.

Solano County is 30 miles north of San Francisco and extends to within 20 miles of our State capital in Sacramento. Within its boundaries are Travis Air Force Base, Mare Island Naval Shipyard, the Benicia Arsenal, and many other Federal installations. When we mention Mare Island and Travis Airbase we are talking about atomic submarines and the Strategic Air Command. Because of the large acreage under Federal ownership, and the rural residential economy of the county, the average assessed wealth per child is only two-thirds of the statewide average. In the western section where most of the federally connected children attend, the average wealth per child is only one-half of the State average. Three elementary school districts have less than $5,000 per pupil and one has less than $2,000 per pupil. The State average assessed valuation is $11,697 for each elementary pupil. Data concerning assessed values per pupil is presented in table I. It is very clear that many of the school districts in Solano County depend on Public Law 874 funds to finance

their school programs. In fact, Solano County is one of the three counties in the United States having the greatest number of federally connected pupils.

It is our contention, and I am sure your wish, that the children of federally connected parents should have available educational opportunities equal to that of the other residents.

Because a significant amount of avilable revenue comes from Federal sources, boards of education, and superintendents in the majority of our districts anticipate receiving their full entitlements as they plan their educational programs. These boards of education are even now starting to set salary schedules and are making plans for the maintenance and operation of their schools for the school year 1960–61.

The deficit, if allowed to stand, would inevitably mean the superintendents would be very much as a disadvantage as they go into what is already a tight market for teachers to serve their children. Necessary maintenance work would have to be delayed at a greater cost later to the taxpayer. Some educational services would have to be withdrawn. The teacher classroom load would have to be increased even though in many cases it is now too great.

Another alternative, if this deficit were permitted to remain, would be to ask the local taxpayer to further support the additional program in the districts. Being realistic and in light of the fact that all of the districts except one are at the maximum legal tax or have by special election exceeded that maximum tax, there is a real question in my mind as to whether or not the school tax could be increased at this point. The California Education Code, section 20751, sets the maximum tax rates on each $100 of assessed valuation for kindergarten and elementary purposes, 90 cents; for high school purposes, 75 cents; for junior college purposes, 35 cents; for unified kindergarten through high school purposes, $1.65; for unified kindergarten through junior college purposes, $1.90.

It will no doubt interest the members of this committee to see what the impact of further property taxation would be if the 32 percent deficit were financed from local property tax resources. Tax equivalents for the deficit for Federal funds would range from a very minor levy in the Rio Vista High School District to 33.2 mills in the Center District. Tax rates would be increased by more than 360 percent in one district; 160 percent in a second district, and between 100 to 200 percent in four additional districts. This is particularly serious in as much as all but one of the districts are presently levying the legal maximum tax rate (see table II).

Due to the Federal installation, in some cases we have had a tremendous growth in certain areas as to school age children with no, and I mean no, additional private taxable enterprises to pay for the school facilities or provide for the program necessary to take care of these children. We have one example where the Center District grew from a pupil population of 12 children in 1957–58 to 590 during the current year. Ninety-six percent of these children come from the Travis Air Force Base (see table III). We can't say these children of servicemen would be here anyway, because such is not the case. They are here, having come from all parts of our country because of this Federal installation.

In all, Solano County schools served 12,177 federally connected pupils in average daily attendance during 1958–59. This represents

42 percent of the total county school population. Twelve of twenty-one elementary districts, all of the high school districts and all of the unified districts have children that qualify them for Federal funds during the current year. Forty percent of the total school population of seven districts have parents or guardians who are employed by the Federal Government. In the Center and Crystal elementary districts with 2,243 children, 90 percent are dependents of servicemen.

To further emphasize our situation let us assume that current expenses per pupil in the Vallejo Unified District do not increase next year. If the deficit is not eliminated this will mean a loss of funds for a complete year of schooling for 661 children in this district alone.

It is easy to appreciate why many local school boards as well as the Solano County School Board of Education have passed resolutions requesting appropriation for full entitlement under Public Law 874.

Gentlemen, I do not expect you to go through these graphs and charts at this time. They are here for your consideration later if you care to look at them.

However, at the bottom of each of these charts I have summary of the significance.

Mr. DENTON. Let us make them part of the record.

(The charts referred to follow:)

TABLE I.—*Estimated average daily attendance, grades served, estimated assessed value per pupil, and estimated percent of federally connected pupils (first count), Solano County, Calif., 1959–60*

| District | Estimated average daily attendance, 1959–60 | Grades served | Assessed value, 1959–60 | Estimated assessed value per pupil | Estimated percent of federally connected pupils, first count, 1959–60 |
|---|---|---|---|---|---|
| Elementary: | | | | | |
| Browns Valley | 75 | 1–8 | | 5,752 | 28 |
| Center | 590 | K–8 | | 1,726 | 96 |
| Crystal | 1,682 | K–8 | | 3,145 | 90 |
| Dover | 54 | 1–8 | | 20,035 | 21 |
| Elmira | 70 | 1–8 | | 21,699 | 18 |
| Fairfield | 2,806 | K–8 | | 4,858 | 61 |
| Falls | 53 | 1–8 | | 24,965 | 33 |
| Green Valley | 211 | K–8 | | 12,444 | 15 |
| Rio Vista | 598 | K–8 | | 29,288 | 7 |
| Suisun Junction | 151 | 1–8 | | 19,341 | 28 |
| Tolenas | 82 | 1–8 | | 5,966 | 43 |
| Vaca Valley | 2,898 | K–8 | | 5,845 | 50 |
| High school: | | | | | |
| Armijo | 1,097 | 9–12 | | 25,932 | 54 |
| Rio Vista | 379 | 9–12 | | 124,041 | 5 |
| Vacaville | 898 | 9–12 | | 23,030 | 46 |
| Unified: | | | | | |
| Benicia | 1,486 | K–12 | | 4,612 | 46 |
| Dixon | 1,274 | K–12 | | 14,646 | 8 |
| Vallejo | 15,267 | K–14 | | 4,188 | 45 |

Summary: 18 districts average 29,671 children in attendance, 18 districts average $7,674.41 assessed value per pupil, 7–96 percent range of federally connected pupils.

TABLE II.—*Estimated impact of a hypothetical 32 percent deficit in Public Law 874 funds on estimated current expense of operation and on property tax rates in school districts of Solano County, Calif., 1959–60*

| District | Estimated current expense of operation | Amount of deficit in Public Law 874 funds | Estimated percent reduction in operating expenses | Tax rates (in mills) [1] | | Percent increase in tax rate | Total assessed value of district |
|---|---|---|---|---|---|---|---|
| | | | | Operating tax rate, 1959–60 | Tax rate required to finance deficit | | |
| | (1) | (2) | (3) | (4) | (5) | (6) | (7) |
| Elementary school districts: | | | | | | | |
| 1. Browns Valley | $11,910 | $525 | 4.4 | 8.0 | 1.2 | 15 | $431,380 |
| 2. Center | 175,225 | 33,772 | 19.3 | 9.0 | 33.2 | 369 | 1,018,200 |
| 3. Crystal | 488,950 | 76,198 | 15.6 | 9.0 | 14.4 | 160 | 5,290,350 |
| 4. Dover | 23,377 | 358 | 1.5 | 14.5 | .3 | 2 | 1,081,915 |
| 5. Elmira | 23,347 | 352 | 1.5 | 8.0 | .2 | 3 | 1,518,940 |
| 6. Fairfield | 849,350 | 50,329 | 5.9 | 9.0 | 3.7 | 41 | 13,715,400 |
| 7. Falls | 16,873 | 596 | 3.5 | 9.0 | .5 | 6 | 1,323,130 |
| 8. Green Valley | 80,300 | 980 | 1.2 | 11.8 | .3 | 3 | 3,625,730 |
| 9. Rio Vista | 246,082 | 1,397 | .6 | 12.4 | .1 | 1 | 17,514,420 |
| 10. Suisun Valley Joint Union | 48,908 | 1,343 | 2.7 | 8.0 | .5 | 6 | 2,920,505 |
| 11. Tolenas | 27,372 | 1,019 | 3.7 | 8.0 | 2.1 | 26 | 489,190 |
| 12. Vaca Valley Union | 953,501 | 42,765 | 4.5 | 12.2 | 2.5 | 20 | 16,938,600 |
| High school districts: | | | | | | | |
| Armijo Joint Union | 597,472 | 42,902 | 7.2 | 9.0 | 1.5 | 17 | 28,447,220 |
| Rio Vista Joint Union | 336,880 | 887 | .3 | 7.0 | ---------- | ---------- | 47,011,690 |
| Vacaville Union | 469,500 | 32,868 | 7.0 | 11.0 | 1.6 | 15 | 20,681,210 |
| Unified districts: | | | | | | | |
| Benicia | 515,874 | 25,116 | 4.9 | 16.5 | 3.7 | 22 | 6,853,405 |
| Dixon | 528,480 | 3,710 | .7 | 20.0 | .2 | 1 | 18,658,655 |
| Vallejo | 6,623,082 | 245,800 | 3.7 | 30.0 | 3.8 | 13 | 63,933,600 |

[1] A 1 mill tax rate is equivalent to 10 cents per $100 of assessed value of property.

Summary: Range in reductions of operating expenses, 0.3 to 19.3 percent; range of increases required in tax rates, 1 to 369 percent.

TABLE III.—*Average daily attendance of federally connected pupils in Solano County, Calif., 1958–60*

| District | 1958–59 | | | | 1959–60 | | | |
|---|---|---|---|---|---|---|---|---|
| | Residing on Federal land, 3(a) | Not residing on Federal land, 3(b)1 and 3(b)2 | Total | Percent of all children attending | Residing on Federal land, 3(a) | Not residing on Federal land, 3(b)1 and 3(b)2 | Total | Percent of all children attending |
| High school districts: | | | | | | | | |
| Armijo | 194 | 386 | 580 | 56 | 158 | 428 | 586 | 54 |
| Rio Vista | ---------- | 16 | 16 | 4 | ---------- | 18 | 18 | 5 |
| Vacaville | 22 | 229 | 251 | 36 | 145 | 280 | 425 | 46 |
| Elementary districts: | | | | | | | | |
| Browns Valley | ---------- | ---------- | ---------- | ---------- | ---------- | 18 | 18 | 5 |
| Center | 352 | 10 | 362 | 97 | 559 | 14 | 573 | 96 |
| Crystal | 1,080 | 316 | 1,396 | 91 | 1,107 | 340 | 1,447 | 90 |
| Dover | ---------- | 17 | 17 | 32 | ---------- | 12 | 12 | 21 |
| Green Valley | ---------- | 45 | 45 | 19 | ---------- | 33 | 33 | 15 |
| Fairfield | ---------- | 1,503 | 1,503 | 60 | ---------- | 1,687 | 1,687 | 61 |
| Falls | ---------- | 18 | 18 | 37 | ---------- | 20 | 20 | 33 |
| Suisun Valley Joint Union | ---------- | 49 | 49 | 33 | ---------- | 45 | 45 | 28 |
| Rio Vista | ---------- | 45 | 45 | 8 | ---------- | 47 | 47 | 7 |
| Tolenas | ---------- | 38 | 38 | 45 | ---------- | 34 | 34 | 43 |
| Vaca Valley Union | ---------- | 1,310 | 1,310 | 48 | ---------- | 1,433 | 1,433 | 50 |
| Unified districts: | | | | | | | | |
| Benicia | 22 | 639 | 661 | 46 | 23 | 679 | 702 | 46 |
| Dixon | 8 | 68 | 76 | 6 | 9 | 89 | 98 | 8 |
| Vallejo | 723 | 5,958 | 6,681 | 47 | 597 | 5,896 | 6,493 | 45 |

Summary: 1958–59—total federally connected living on Federal property, 2,401; total federally connected not living on Federal property, 10,647; total federally connected, 13,048; 1959–60—total federally connected living on Federal property, 2,598; total federally connected not living on Federal property, 11,073; total federally connected, 13,671.

*Percent of pupil populations and percent of current expenditures for education of federally connected pupils, by school districts, Solano County, Calif., 1959–60*

| District | Estimated percent of federally connected pupils, first count, 1959–60 | Percent of total estimated operating expenditures financed by Public Law 874 funds |
|---|---|---|
| Elementary: | | |
| Browns Valley | 28 | 13.8 |
| Center | 96 | 60.4 |
| Crystal | 90 | 48.8 |
| Dover | 21 | 4.7 |
| Elmira | 18 | 4.7 |
| Fairfield | 61 | 18.5 |
| Falls | 33 | 11.0 |
| Green Valley | 15 | 3.8 |
| Rio Vista | 7 | 1.9 |
| Suisun Valley Joint Union | 28 | 8.5 |
| Tolenas | 43 | 11.6 |
| Vaca Valley Union | 50 | 14.1 |
| High schools: | | |
| Armijo | 54 | 22.5 |
| Rio Vista Joint Union | 5 | .9 |
| Vacaville Union | 46 | 21.9 |
| Unified: | | |
| Benicia | 46 | 15.3 |
| Dixon | 8 | 2.2 |
| Vallejo | 45 | 11.6 |

Summary: Range of federally connected pupils, 5 to 96 percent; range in Federal support, 1.9 to 60.4 percent. Note lag in support compared to responsibility.

Mr. McCombs. I would like to mention the last page in terms of the total impact in the county where we have a range of 5 percent to 96 percent of federally connected children and a range in Federal support of operating budget from 1.9 to 60 percent.

I appreciate the opportunity of appearing.

Mr. Denton. Thank you very much.

Mr. Baldwin. Thank you very much for your courtesy in allowing us to appear, Mr. Chairman.

Mr. Denton. Is there anyone else?

Mr. Baldwin. That is all, Mr. Chairman.

WITNESSES

HON. JOHN R. FOLEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

MONTGOMERY COUNTY

DR. C. TAYLOR WHITTIER, SUPERINTENDENT OF SCHOOLS
HAROLD F. BREIMYER, MONTGOMERY COUNTY BOARD OF EDUCATION
BRIAN BENSON, DIRECTOR OF FINANCE
DAVID CAHOON, COUNTY COUNCIL

WASHINGTON COUNTY

LEM E. KIRK
HARRY C. SNOOK

FREDERICK COUNTY

DELBERT S. NULL
C. BURTON CANNON
GOODLOE E. BYRON
DONALD A. WOODS

Mr. DENTON. We are glad to have you with us, Mr. Foley, as our neighboring Congressman.

Do you have a statement to present and do you have some witnesses you would like to call?

Mr. FOLEY. Mr. Chairman, I want to thank you for the privilege of appearing here. It is my privilege, also, to present a sort of united front, and I mean a rather large one—Dr. C. Taylor Whittier, our superintendent of schools; we have the Honorable David Cahoon from the county council; Harold Breimyer from the Board of Education of Montgomery County.

Then we have representatives from Washington County, the Honorable Lem Kirk, who is the county commissioner.

We also have Commissioner Snook from Washington County, and also we have the Honorable Delbert Null, chairman of the county commissioners of Frederick County, and the clerk of the Frederick County Board of Commissioners, the Honorable C. Burton Cannon, and other distinguished guests including Goodloe Byron, the Frederick County attorney, and Donald Woods, the county accountant of Frederick County.

Mr. Chairman, I will submit for the record, without reading it, a statement which I have prepared which is protesting the Federal Administration's reduction in the impacted area program for 1961 fiscal year.

I am submitting it for the record without reading it in the interest of saving time because I have these distinguished witnesses who will present to you their statements.

(The statement follows:)

STATEMENT OF REPRESENTATIVE JOHN R. FOLEY

Mr. Chairman and members of the subcommittee, I appreciate your courtesy in permitting me to appear here this afternoon in opposition to the proposal, as outlined in the President's budget message for 1961, to cut $54 million from the present level of assistance to schools in Federally affected areas under Public Law 815 and Public Law 874. From the estimated 1961 expenditure level of $207 million, the President recommends a new obligational authorization cutback to $171 million. This, sadly enough, has been done under the program entitled "Promotion to Education." The implementation of this recommendation would seriously affect the operation of school systems in three of the Maryland counties I have the honor to represent in the House of Representatives. The distinguished constituents who are with me will indicate in detail.

During the last session the Congress defeated an attempt by the administration to whittle away significant features of the program rendering aid to Federally impacted area schools through tampering with the formula established to carry out the provisions of Public Laws 815 and 874. In hearings conducted by Representative Bailey of West Virginia last August, justifications for the full continuation of these vital programs were presented that are valid today. The basic tenet supporting these justifications was the necessity to make up for losses in local tax revenues resulting from the tax exempt status of Federal installations. In my considered judgment there does not exist now any rationale for cutbacks that would penalize counties in which much of the shortage of adequate school facilities is clearly the result of the rapid expansion of the Federal Government.

On June 11, 1953, Dr. Rall I. Grigsby, Acting Commissioner of the Office of Education testified as follows:

"Awareness of the existence of the educational problem toward which Public Law 874 was directed came during World War II, but attempts at solution then were only partial in scope, temporary in duration, and inconsistent in their application to like situations. It has become increasingly apparent that the problem is not temporary and its solution cannot be accomplished through isolated attacks by the various agencies of the Federal Government upon the scattered segments encountered in their areas of activity.

"Public Law 874 recognizes the dual burden placed on school districts by Federal activities. The two dominant features of Federal activity in relation to the public school program of a community are: First, the tax-exempt status of property acquired by the Government which lowers school revenues, and second, the employment by the Federal Government of substantial numbers of workers whose children add to the normal school population.

"Of course, the property where parents are employed provides tax benefits only to the school district in which it is located, and other districts may have to educate the children of the workers with only the properties of the workers' residences added to their tax roles.

"Public Law 874 recognizes this situation with respect to federally owned property, since assistance is given on the basis of the children connected with such property for whom a school district must provide free public education, rather than limiting such aid to the district in which the property is located."

What Dr. Grigsby so succinctly stated in 1953 remains today an apt and reasonable description of our problem in the Sixth District of Maryland. The population explosion has detonated Montgomery County. Many of my colleagues in the House have witnessed this phenomenon as residents of the county. I will not presume upon your time by repeating statistical data which I am certain will be provided by Dr. Whittier, Mr. Breimyer, and Mr. Cahoon. Since the end of World War II, the number of federally connected children has grown in geometric proportion. The tax-exempt Federal installation has grown steadily in the three Maryland counties of my district. At the same time, the local taxpayer has been paying a higher and higher school bill annually.

The President's proposal would cut approximately one-third of the present estimated level of authorization to the State of Maryland. From $8.4 earmarked for Public Laws 815 and 874 the administration proposal would lower Maryland's level to $5.5 million, thus we lose $2.9 million. If there is a justification for this outlandish proposal, the administration has failed to make it apparent to those coping with the problem on a day-in-day-out basis.

The people of Maryland are acutely aware of the equity of Federal aid to federally affected areas in our State. We in Maryland believe that the Federal Government has a responsibility to assist school districts where the local tax base is restricted by the existence there of Federal property, or where the public schools' enrollments are materially increased by virtue of the existence of Federal installations within the area serviced by the school. The counties will continue to pay the greatest portion of the tax cost and this is proper. Unfortunately, the budget proposal is tantamount to abdication of Federal responsibility and this is improper.

Mr. Chairman, I am grateful to the subcommittee for allocating its valuable time.

Mr. FOLEY. Also I have a statement by Dr. David R. Brewer, president of the Board of Education of Washington County, Hagerstown, Md., and will present that for the record.

(The statement referred to follows:)

STATEMENT OF DR. DAVID R. BREWER, PRESIDENT, BOARD OF EDUCATION OF WASHINGTON COUNTY, HAGERSTOWN, MD.

As the president and official representative of the Board of Education of Washington County, Md., I wish to go on record for the board as opposed to the recommendation for a $54 million cut in the budget for the vital programs under Public Law 874.

Public Law 874 has been of vital assistance to Washington County. Over 13 percent of the pupils in daily attendance for the school year 1959–60 are children of parents who work on or live on federally owned property. The payment of $248,316.04 received for 1958–59 represented approximately 25 cents on the local property tax rate.

Washington County is dependent upon the property tax for support of its school system and loss of these Federal funds would necessitate an increase in local taxes or curtailment of the present school program.

To reduce the present rate of support provided by Public Law 874 would seriously hamper Washington Country's economy, affect the school system, and hinder the county's orderly growth. Therefore, we wish to go on record as vigorously opposed to any reduction in support of the provisions under Public Laws 874 and 815.

Mr. FOLEY. In closing I would like to say we would like to present for the record a statement from the Board of Education of Frederick County which we have not yet received.

I understand it is in preparation and is being forwarded.

I will ask Mr. Breimyer, a member of the board of education, to proceed first.

STATEMENT OF MR. HAROLD F. BREIMYER

Mr. BREIMYER. I have a prepared statement which has the detail of our situation which I will leave with you and make a couple remarks about Montgomery County.

(The statement referred to follows:)

Mr. Chairman and members of the subcommittee, I am Harold F. Breimyer, vice president of the Montgomery County Board of Education, Maryland.

We would like to take this opportunity to thank the Appropriations Subcommittee for the privilege of appearing today to present the views of the Board of Education of Montgomery County, Md., on the proposed reduction of $54 million in funds to be distributed by the Federal Government under Public Law 874 and Public Law 815.

The proposed reduction in appropriations will reduce the funds that Montgomery County is to receive from the Federal Government for both operating and construction purposes. The effects of the reduction to the county for construction purposes (Public Law 815) are difficult to determine at this time due to the fact that the formula for determining distribution of these construc-

tion funds involves factors of growth and need, which are not easily projected at this time. The effect of the reduction of the distribution of operating funds under Public Law 874 to Montgomery County are more readily determinable.

Payments to the local areas under Public Law 874, in reality are payments by the Federal Government in lieu of their paying the normal taxes which any private employer would be required to pay on his place of business. The proposed reduction in appropriations would result in a decrease of funds available to the local areas under Public Law 874. In Montgomery County the reduction would be about 42.4 percent of the total Public Law 874 funds received. Had this same reduction been in effect in fiscal 1959–60, the effect on Montgomery County for operating purposes would have been as follows:

| | |
|---|---|
| Estimated Federal assistance 1959–60 | $2,153,880 |
| Less 42.4 percent | 913,245 |
| Estimated Federal assistance 1959–60 after reduction | 1,240,635 |

It should go without saying that such a large reduction is a serious matter to our school system.

However, in addition to realizing the serious nature of such a reduction, we should also ask if the reduction is fair. Perhaps the best way of doing this is to take another look at this matter of considering Public Law 874 funds to be in lieu of taxes on the employer's place of business.

The estimated assessed valuation of all Federal property in Montgomery County in fiscal 1959–60 is $168 million. The county tax rate for schools in the same fiscal year is $1.80 for each $100 of assessed valuation.

Had the Federal property been subject to county taxes, revenue in the amount of $3,024,000 would have been available to the schools. Estimated receipts under Public Law 874 for the same year are $2,153,880, which is $870,120 less. Had a reduction of the proposed type been in effect in 1959–60, the Public Law 874 receipts would have been reduced 42.4 percent or $913,245 and would then have equaled $1,240,635. This would be $1,783,365 less than the $1.80 tax rate would have produced for the schools. Looking at the same facts in a different way we have the following situation for 1959–60.

For each $100 of assessed value, the tax rate on the place of employment would have been:

| | |
|---|---|
| For the local businessman | $1.80 |
| For the Federal Government under existing rates for Public Law 874 distribution | 1.28 |
| For the Federal Government had the proposed reduction been in effect in 1959–60 | .74 |

The reason, as given above, for our opposition to the proposed reduction are really objections which could be fairly raised by any area having a substantial local tax rate for schools. In addition we are opposed to this proposed reduction for a reason which we believe to be more pertinent to areas adjacent to the District of Columbia than to any other areas in the country.

The reason is that the proposed reduction is to be met, in part, by reducing the reimbursement rate for federally connected pupils not working in the local area where they are employed. This, we feel, puts a particular hardship on the nearby areas because of the large concentration of Federal employment in the District. Essentially what this amounts to is a small politically separate area with a great concentration of Federal employers. Due to the size limitations of the area in which employment takes place, these Federal employees must of geographic necessity live in a politically separated area—in this case in other States. Thus it does not seem fair to penalize the local area for what is in fact a geographically necessary way of living.

In conclusion then the Board of Education of Montgomery County, Md., would like to express its unanimous opposition to the proposed reductions.

Mr. BREIMYER. Montgomery County is a large populous county north of the District. It is one of the four-bedroom counties of the district for the Federal Government, as I think also is well known.

About a third of our children are children of Federal workers.

As with other counties in somewhat similar situations, we know that our total tax revenue is less than it would be if the same people were working instead of for the Federal Government rather for

private employers within our area. It would make an appreciable difference in our revenue.

Three or four things about our county. As a school board member, we can also say it is a schoolroom county because it seems in the last few years, when our population has doubled, our school population has gone up even faster. In fact, our school population has gone up even faster. In fact, our school population has increased half again as fast as has our total population. It has tripled in the last 10 years.

This has meant a very heavy load of school expense, and along with it our people have a great interest in education. They want good schools. We have very few drop-outs. Most of them complete their schooling.

We try to do the best for them we can. We have even innovated a proviso that the highest salaries were conditional upon passing other district tests of performance. We think we can improve our schools in this way.

I would say, also, that we have increased our own taxes a great deal in the last 6 years. Our taxes for schools have increased almost half.

Even with that, the fact we do lose potential revenue has meant quite a difference.

Then as a last point, although we understand the nature of these laws which affect us, it is true we have a lot of Federal property in the area. If it happens to be calculated out on the basis of $168 million, our normal tax rate, it would provide more revenue than we would receive through 874, so actually Public Law 874 fully implemented would be less than the equivalent tax on Federal installations.

I appreciate the opportunity to appear.

Mr. DENTON. What Federal property do you have? Is it the National Institutes of Health?

Mr. BREIMYER. Atomic Energy Commission out of Germantown, the Bureau of Standards is moving out and I could give you a list. I think there are about 15 or 20.

Mr. DENTON. They are not there yet.

Mr. BREIMYER. AEC is there. For schools the tax rate is $2.19. Total county tax rate is $2.61, plus local subdivisions which in many cases go above $3.

At the same time——

Mr. DENTON. Is that just for schools?

Mr. BREIMYER. Between $2.61 and something over $3 varying by locality.

Mr. DENTON. What do you think I pay? I have a $8 tax rate.

The thing that worries me about the low tax rate here is that many people who make out our Federal budget have lived here so long that they do not realize what the rest of the country is up against. When they say let the States do this and that, they just do not realize that in some places they can't.

Mr. BREIMYER. Our tax base is assessed fairly high by Maryland standards. That makes some difference.

Mr. DENTON. That is right.

Mr. FOLEY. Mr. David Cahoon is next, Mr. Chairman.

STATEMENT OF MR. DAVID CAHOON

Mr. CAHOON. Mr. Chairman, my name is David Cahoon. I am a member of the County Council for Montgomery County. This year I am serving as secretary to that body.

They have taken an interest in this appropriation problem and have passed a resolution which I would like to present to the committee.

(The resolution referred to follows:)

RESOLUTION NO. 4–1317, RE SCHOOL AID TO FEDERAL IMPACTED AREAS

Whereas the county council has been informed that it is proposed in the Federal administration budget to reduce by some $54 million the Federal funds available for school aid to Federal impacted areas; and

Whereas on August 19, 1959, the county council, represented by its president, expressed before the Subcommittee on General Education of the Committee on Education and Labor, House of Representatives, its opposition to proposed drastic modifications of Public Laws 815 and 874 which provide for Federal school aid, as set forth in H.R. 7140 which was subsequently defeated; and

Whereas one child in three attending public schools in Montgomery County is federally connected and these children who reside in Montgomery County are educated in county schools regardless of whether their parents or guardians are employed by the Federal Government in the District of Columbia or Montgomery County; and

Whereas Montgomery County is a federally impacted area due to its location contiguous to the District of Columbia and the location within its borders of many Federal employment centers; and

Whereas the county council is opposed to a reduction in Federal aid to school funds which would adversely affect the financial aspects of providing a high standard of public education for federally connected schoolchildren in Montgomery County: Now, therefore, be it

*Resolved by the County Council for Montgomery County, Maryland*, That the council strongly opposes the reduction of Federal funds for school aid, since a significant part of the demand for educational service is for the children of these persons who reside in the county and who are employed by or affiliated with the Federal Government.

Attest; a true copy:

LAWRENCE E. SPEELMAN,
*Clerk, County Council for Montgomery, County, Md.*

FEBRUARY 25, 1960.

Mr. CAHOON. I would like to make a few remarks about the problem we have. I should also like to call the attention of the committee to the hearings on H.R. 7140, particularly on Wednesday, August 19, 1959. At that time Congressman Foley, Mrs. Werner, president of the county council, Edna Cook, from our delegation to our General Assembly of Maryland, Mrs. Cramer, president of the board of education, and Dr. Whittier made extended remarks about that proposed bill which relates to this appropriation.

They submitted a great deal of statistics and data concerning our situation and the impact of the Federal installations on our school problem.

Summarizing them, it points out that one-third of our pupils in our school system are federally connected. It points out that we have had a pattern of growth in the last decade, we have had a doubling of our population and a tribling of our assessable base, and a 400 percent increase in our school population.

This pattern of a third being federally impacted has prevailed through that whole period so we are getting an impact of growth from Federal installations.

We calculate that on the basis of land which is in Federal hands, if it were put to prevailing land uses, this would constitute about 15 percent of our assessable base.

As Mr. Breimyer pointed out, this would result in something in the neighborhood of $3 to $4 million in revenues to the county at the current tax rates.

This amounts to a new high school.

In the year 1959, under Public Law 815, in the capital program we received about $1.258 million out of a total capital budget of $12 million, so Federal assistance there constituted about 10 percent of our capital effort.

Under 874 the operating budget gave us $1,750,000 out of a total effort of $30 million. This is about 6 percent of our local operating efforts.

The total Federal assistance would be in the neighborhood of $3 million.

The question of whether or not these Federal institutions are within our jurisdiction or not points out that with about 15 percent of the assessable base they would give us about $4 million in revenues if they were in private hands, so the Federal assistance program as it has been operating has just about met the situation if the land were not owned by the Federal Government.

At the same time, it is nowhere near the one-third impact that we have had in the way of the population. We are concerned about any drastic changes in our revenue pattern.

We have just had a group of local bankers give us a review of our financial structure in the county. We find that on the basis of estimates for the future that the board of education will request some $75 million from us in the next 5 years for capital construction.

This happens to coincide with what we spent in the last 8 years. It means if we will maintain our current capacity we have to grow as much in our assessable base in the next 5 years as we did in the last 8.

They estimate that our current expenditure effort of $50 million total will be $112 million by 1965.

What is happening is that we are trying to finance it on an ad valorem property tax basis, which as you gentlemen can understand, has a flat bottom. It adjusts slowly to growth and inflation. We are caught in that squeeze.

We are searching for additional sources of revenue. We have expanded our rates to meet the tremendous growth in the past. This means we cannot have any serious dislocations in our revenue patterns.

We feel here locally under the present circumstances that as long as the legislation has been rejected, or will be rejected, there ought to be full implementation by appropriation.

On the question of a long-term basis that is something else again.

What I am trying to say here is that we are making an optimum effort in our community and we would hope that the Federal Government will not curtail any of its support at the moment so we can continue to provide for the school system we want to have and which this country needs.

Mr. FOLEY. Dr. Whittier, Mr. Chairman, superintendent of schools.

Dr. WHITTIER. I have no further statement, Mr. Foley.

Mr. FOLEY. With that, Mr. Chairman, we want to thank you very much. We will reserve the privilege of filing a statement from the board of education.

(The additional statement referred to follows:)

HOUSE OF REPRESENTATIVES.
*Washington, D.C., March 1, 1960.*

Hon. JOHN E. FOGARTY.
*Chairman, Appropriations Subcommittee on Health, Education, and Welfare, Washington, D.C.*

DEAR MR. CHAIRMAN: Enclosed is the statement prepared by the superintendent of schools of Frederick County, Md., in opposition to the administration's proposed reduction in finances for Public Law 874, in the 1961 fiscal year.

You are kindly requested to enclose this statement in the official records of the hearings.

Thanking you for your courtesy, I am,
Sincerely yours,

JOHN R. FOLEY.
*Member of Congress.*

BOARD OF EDUCATION OF FREDERICK COUNTY.
*Frederick Md., February 26, 1960.*

The Hon. JOHN R. FOLEY,
*House of Representatives,*
*Washington, D.C.*

MY DEAR MR. FOLEY: It has been brought to our attention that Congress is considering a reduction in the funds allocated for Public Law 874, which vitally affects the Frederick County school system.

For the school year 1958–59 we received assistance of approximately $125,000. The represented 95 percent of our entitlement. At 100 percent of entitlement we anticipate the sum of approximately $160,000 will be available for Frederick County for 1959–60. On Frederick County's present tax structure, this would amount to over 8 cents on the tax levy.

We feel the Federal Government has a financial obligation for the education of children of federally employed parents, since the properties owned by the Federal Government are not taxed, as would be the case were the same centers of employment privately owned.

We appreciate your interest in our problem and urge your support of Federal assistance as established over the past years.

Sincerely yours,

JAMES A. SENSENBAUGH, *Superintendent.*

## AID TO SCHOOLS IN FEDERALLY IMPACTED AREAS

### WITNESS

### HON. JOEL T. BROYHILL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA

Mr. FOGARTY. Next we shall hear from Representative Broyhill of Virginia. Proceed, Mr. Broyhill.

Mr. BROYHILL. Thank you, Mr. Chairman, for this opportunity of appearing before the committee. Of course, I am appearing on the same subject as the previous witnesses and hope that the committee will consider favorably appropriating the full amount provided for under Public Laws 815 and 874.

I have here, Mr. Chairman, in the interest of trying to conserve time, a prepared statement which I would like to insert in the record.

(The statement referred to follows:)

STATEMENT BY REPRESENTATIVE JOEL T. BROYHILL (REPUBLICAN, VIRGINIA)

Mr. Chairman, before coming over here to testify, I glanced through some of the proceedings of the hearings on this issue last fall. I was appalled by the vast array of figures, many of them my own, that were presented, and which you gentlemen have been called upon to digest.

Accordingly, I will not add more. Actually, all of these figures add up to three simple statements that can be made in plain English without a single statistic being mentioned:

1. The affected areas have been receiving certain money from the Federal Government under the federally affected areas school assistance program. If the program is discontinued or materially reduced, the affected areas will have less money for schools.

2. The amount involved is a significant portion of many of the school budgets, particularly in areas where rapid growth is forcing an expansion program that is driving the communities further into debt even with the money presently being received through this program. If it were discontinued or materially reduced, they would have to find money to replace it, or cut back their school program.

3. A significant amount of property within the 10th District of Virginia is owned by the Federal Government and therefore tax exempt. It can be assumed that if this property was privately owned, the resulting increase of revenues to the communities would be considerable.

I don't believe anyone will disagree with these statements, since they are simple matters of fact.

Having established this, we come next to the question as to why such a program should exist at all.

The money disbursed through this program is commonly called Federal aid and the act itself called it assistance. I think much of the opposition to this program stems from these names, and I also think neither of these names are the correct ones to use. Both of them convey the idea that this is something the Federal Government is doing out of the kindness of its heart to help struggling communities wtih their school problems. Nothing is further from the truth. The money disbursed to the communities through this program is a payment by the Federal Government of a just obligation owed by it to a local community by reason of the fact that the Federal Government is a member of that community and directly or indirectly conducts business operations in that community. And I might add, the amounts of these Federal payments, as compared to what they would be if they were from a private business, places the Federal Government in a most favored taxwise position indeed.

Actually, the Federal Government can be compared to a powerful medieval nobleman who could drop in on any of his vassals, stay as long as he wished, and then pay as little or as much for his entertainment as he chose—and nothing at all if that suited him. This is not the Middle Ages, and I don't believe any one, including the Federal Government has the right to settle in any community without assuming rightful obligations to that community.

I said at the beginning that I was not going to burden you with more figures, but I would like to remind you of one or two included in my testimony before the legislative committee last August. According to the best available estimates, the annual real estate tax revenues of federally owned property in the 10th Congressional District would be approximately $12 million if the same property were privately held. As you know, the proportion of the real property tax that is allocated to schools in my district is very large and the proportion of the $12 million lost from the tax rolls through Federal ownership that otherwise would be allocated to schools accordingly would considerably exceed the $4 million allocated to the 10th District during fiscal 1958–59 under the Public Law 874 program.

Few, if any Members of this Congress have objected more than I to paternalistic handouts by the Federal Government. But programs such as this one, by which the Federal Government meets legitimate obligations to the local communities, is quite another matter. I believe that this Congress not only should approve the maximum program possible under the Public Law 874 program, but should insist upon it. I therefore urge this committee to report this bill out on that basis.

Mr. Broyhill. I know the chairman has done more than possibly any other Member of the Congress in trying to keep this program alive and fully funded.

If you will recall, during my first term in Congress, during the Republican 83d Congress, I called on the chairman asking his help and advice of how I could be of assistance in restoring funds that then were cut by the committee. I called upon the chairman rather than a membe of my own party because I learned early in my service in Congress that the chairman had been very active in this field.

One of the points I would like to emphasize, and one which seems to cause a good deal of confusion in understanding the purposes of Public Law 815 and 874, is that this is not a Federal responsibility to help the communities in the operation and maintenance of the schools per se. It is the responsibility of the Federal Government as an industry.

I fully realize that it is our problem locally to take care of our schools, our storm sewers, our sidewalks, parks and playgrounds, and so on. I supported the position taken by the Appropriations Committee last week in not appropriating Federal funds for maintenance of parks and playgrounds in the Washington area.

However, I feel there are certain responsibilities that any industry here has to the community in which it operates, and since the Federal Government is our principal industry in the 10th District of Virginia, in fact is practically our only industry, I feel it should assume some of the responsibilities of this commmunity. For lack of having a better formula I believe the provisions of H.R. 815 and H.R. 874 serve as a fair and reasonable formula for the time being.

I said in my statement I didn't want to deal with too many figures and statistics because I know the committee has been burdened with them. It might be well to refer to just a few of them to give an example of the problems in our community, and I know the chairman has similar examples from other communities, bearing on the question as to whether or not these funds should be fully restored.

In referring to the Federal Government as an industry, if we could receive taxes from the Federal Government for all of its properties on the same basis other industries pay in northern Virginia, we would receive around $12 million a year.

Under this law this year, if the committee fully restores these funds, we will receive approximately $4 million, or approximately one-third of what we would receive if we could tax the Government as any other industry.

Fifty-one percent of our school population comprises children of parents who work on nontaxable Federal property.

The reduction of the appropriation formula as proposed by the administration would reduce the 50-percent formula of those who either live or work on Federal property, to 25 percent and 40 percent, respectively in the two categories that include the vast majority of the children affected in northern Virginia.

The Secretary of Health, Education, and Welfare has stated that he cannot understand why the Federal Government has the responsibility to educate the children of people living, for example, in Bethesda where he lives, but who work in the District of Columbia. It seems clear to me that this responsibility results from the fact that

few communities can finance their school systems entirely from residential property taxation, but depend in considerable part upon the taxes from properties in which the residents of the community work. In the Washington metropolitan area, where so many of these properties are tax exempt because owned by the Federal Government, the local communities have no recourse but to place the entire burden upon the residential property unless the Federal Government assumes part of the burden in some way.

One seemingly obvious solution would be for all Federal property in the area to be assessed on the same basis as other industrial or commercial property, and for the Government then either to pay taxes or make other payments in lieu of taxes. I do not believe this would provide the full answer, however, for not only do I oppose generally the concept that local governments should be allowed to tax the Federal properties, but believe if this were done that many inequities would result. Furthermore, this would not benefit many communities that are hard hit by the Federal impact. I can cite, as an example, the city of Falls Church which is almost all residential and has no Federal property within its boundaries though thousands of its residents work on Federal property outside its boundaries. Public Law 815 and Public Law 874 provide for this situation, which is why I repeatedly have said that I think the present formula is the best that has so far been devised.

I repeat once more, I do not know how we could come up with a fairer formula to provide for those who live and work in different school districts in a metropolitan area such as this. I think the formula incorporated in Public Law 815 and Public Law 874 is the fairest and most reasonable formula we can come up with.

If we had a formula based on the valuation of the property, which I say would give us more, it would not be nearly as fair to some communities as the formula we use in these acts, in which appropriations are based upon the number of schoolchildren. That is the primary factor on which cost to the community is based.

I hope that the committee will agree to reducing that formula for the reasons I have given. I am for improvement and revision but not for a sweeping reduction such as has been proposed and by which both the local needs and the real responsibilities of the Federal Government are disregarded.

Mr. FOGARTY. This committee would not reduce the formula. That would be an act to be taken by the Legislative Committee.

Mr. BROYHILL. I understand the request by the administration is pretty close to the formula proposed by the Legislative Committee.

Mr. FOGARTY. That is right. The appropriation is on the basis of their recommendations to the Legislative Committee.

Mr. BROYHILL. I wanted to make that point.

Mr. FOGARTY. Until the Legislative Committee makes the change we feel it is our responsibility to go along with the present legislation.

Mr. BROYHILL. There also have been some statements in the past about the primary purposes of this act originally to assist the community in absorbing some of the impact. Certainly an inference has been drawn that it was temporary legislation and the impact was something which would eventually die out.

Mr. DENTON. I have an impacted area in the district I represent. I remember when they first brought up the law there was provision it did not apply to larger communities. The theory was they could absorb the expansion where smaller communities could not.

Mr. BROYHILL. I think it is a good point, sir. Of course, if the Federal industry is a large percentage of the operation of the industry of a community, it is a problem, whether it is a small or a large community. We are a large community.

Mr. DENTON. This one I have is a township. Forty percent of the property is owned by the Government, a very large powder mill. If the Government paid taxes on that, they would pay a great many times——

Mr. BROYHILL. They would be better off.

Mr. DENTON. There is no way they can absorb that.

Mr. BROYHILL. Maybe your community is quite similar to mine, sir. I was going to make reference here to the fact that in the whole northern Virginia area as a whole, we have had an increase in school population of 338 percent since World War II. That is quite a substantial growth. That is for the community as a whole. Fairfax County I think has had somewhere in the neighborhood of 450-percent growth.

Mr. DENTON. You have had a tremendous growth in the value of property there.

Mr. BROYHILL. That is correct. Yet at the same time, in order to provide all the improvements that growth requires, including not only schools but storm sewers, sewer and water facilities, and things of that sort, we have bonded our community in the amount of $71 million. We have actually come to the point where bonds are unmarketable at favorable rates.

Mr. DENTON. Of course, many communities are bonded up to their limit.

Mr. BROYHILL. Yes, but we are way behind on many of the needed improvements out there because of this growth.

Mr. DENTON. What tax rate do you have?

Mr. BROYHILL. It varies slightly, sir. It averages from $2.84 per hundred to $3.75 per hundred in different communities. We have four municipalities out there.

Mr. DENTON. What sort of assessment value do you have?

Mr. BROYHILL. Forty percent. In order to transfer that into laymen's language, you would find that the average tax yield is approximately 1¼ to 1½ percent of the market value of the property. That is about what the average tax is in the community. In other words, a $20,000 house would yield from $250 to $300 per year.

Mr. DENTON. The only places I know which are better than that are the Virgin Islands and the District of Columbia.

Mr. BROYHILL. We also have personal property tax added to that.

Mr. DENTON. I live in Virginia, and I pay that.

Mr. BROYHILL. You live out there?

Mr. DENTON. Yes.

Mr. BROYHILL. Many of us feel we should abolish the personal property tax and add it to the regular real property tax rate. Of course, we also pay an income tax, and the tax rate on the lower and middle income ranks with the highest in the country.

(Off the record.)

Mr. Broyhill. I can conclude my testimony, Mr. Chairman. I was going to mention the cost of our schools out there.

Mr. Fogarty. You may elaborate on this, if you wish, for the record.

Mr. Broyhill. Suppose we do that.

(The additional statement referred to follows:)

I think the story of what is happening in northern Virginia can most effectively be illustrated by recent changes in Fairfax County. On August 12, 1959, I testified before the General Education Subcommittee of the House Committee on Education and Labor. Included in this testimony were certain statistics relating to the school situation based upon information available as of that date.

In this statement, I indicated that $71,955,196.29 in bonds had been issued by the northern Virginia communities for school purposes since World War II. Included in this figure was a total of $43,500,000 for Fairfax County. As of this date, the Fairfax County school authorities are preparing estimates to substantiate another bond issue, and informal estimates indicate that these authorities will request approximately $30 million in new bonds to meet the requirements for new schools for the next 5 years.

Another figure indicates the pace with which new construction is going on. Within the northern Virginia figure of $93,879,588, given in my testimony as the total cost of all new school construction since World War II, the Fairfax County portion was $44,752,697. Now, only a few months later, the total that has been expended by Fairfax County is $54,586,865, or nearly $10 million more. This tremendous program, mostly resulting from demands due to Federal activities, certainly would tax any community. It is only right and reasonable that the Federal Government, as the agency most responsible for the growth that makes the program necessary, should share in its cost.

LETTER FROM HON. CHARLES E. BENNETT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. Fogarty. We will place in the record at this point a letter from Congressman Bennett on this same subject.

(The letter referred to follows:)

House of Representatives,
*Washington, D.C., January 26, 1960.*

Hon. John Fogarty,
*Chairman, House Appropriation Subcommittee,*
*The Capitol, Washington, D.C.*

Dear Mr. Chairman: I am advised that the amount requested by the administration in its 1961 budget for carrying out the Public Law 815 and Public Law 874 programs is $66 million less than necessary to carry out these programs under current authorizations; that the administration last year offered amendments to the laws authorizing the programs which were rejected by the House committee with jurisdiction; that, nevertheless, the administration has requested funds in its budget on the basis of the amendments which it submitted and which were rejected.

I would appreciate your subcommittee's serious and careful consideration of the need for the $66 million which is required to carry out these programs as authorized. Please let me know if I may be of any assistance to your subcommittee in its consideration of this matter.

With kindest regards, I am

Sincerely,

Charles E. Bennett,
*Member of Congress.*

MONDAY, FEBRUARY 29, 1960.

## CYSTIC FIBROSIS

### WITNESS

**DR. ROBERT H. PARROTT,, PHYSICIAN IN CHIEF AND DIRECTOR OF THE RESEARCH FOUNDATION, CHILDREN'S HOSPITAL OF THE DISTRICT OF COLUMBIA**

Mr. FOGARTY. Next, we have Dr. Robert H. Parrott associated with the Children's Hospital of the District of Columbia. Dr. Parrott, you may proceed.

Dr. PARROTT. I am Dr. Robert H. Parrott, physician in chief and director of the Research Foundation of Children's Hospital of the District of Columbia. I am also a trustee of the National Cystic Fibrosis Research Foundation.

I felt most of the committee was familiar by now with the name cystic fibrosis and recognize it for what it is, one of the most devastating childhood illnesses. What I want to do now in contrast to the previous year is to comment on the pleasure of all of those interested in the disease at the past interest of this committee, and the hope that you will continue that interest.

Mr. FOGARTY. As far as I am concerned, we are going to continue it.

Dr. PARROTT. I wanted to comment on three points primarily. One is the intramural program. Here, as you know, Dr. Paul A di Sant' Agnese has been appointed as Director of the Metabolism Unit.

Mr. FOGARTY. He is considered to be a good man in this field, is he not?

Dr. PARROTT. He certainly is. I think everyone is pleased at his appointment and is hoping that he will indeed, as many good investigators do, outstrip their present space and budget before long. I would predict that this will happen. I would predict that next year you will want to look at the question of an increase in the budget as related to his intramural work.

I do notice that NIAMD anticipates an increase in the budget in general, and also in relation specifically to cystic fibrosis. I hope your committee will support the budget as proposed.

Mr. FOGARTY. I hope it goes over it.

Dr. PARROTT. Yes. Even though he has been on duty but a few months, this extremely competent physician and investigator has organized a fine research unit and has begun both laboratory and clinical investigation. He is working collaboratively with the National Institute of Allergy and Infectious Diseases on the infectious aspects of the disease and with our own unit at Children's Hospital on several metabolic and infectious aspects.

As with all very active research units I predict that Dr. di Sant'Agnese's team will soon outstrip its present space and budget. And I am pleased to note that the National Institute of Arthritis and Metabolic Diseases budget mentions increased obligations related to cystic fibrosis in future years. Presumably some of this will be for extension of Dr. di Sant'Agnese's work. I hope that you gentlemen will support that very likely eventuality.

(2) Extramural National Institutes of Health grants: Secondly, may I recall my prediction of last year that you would see a large upswing in research grant requests related to cystic fibrosis, perhaps up to 50 percent. Apparently this is being borne out, particularly in the metabolic diseases area. For example, the National Institute of Arthritis and Metabolic Diseases is anticipating twice its previous expenditures and grants to twice as many investigators as in the past year. This trend should and will increase. I hope that you will support the National Institutes of Health in these and future anticipated obligations related to cystic fibrosis.

(3) Evidence of progress. Already in scientific publications there is evidence of a payoff from increased interest and research on cystic fibrosis. In the National Library of Medicine's index of scientific publications one can note increasing numbers of publications directly related to cystic fibrosis as follows:

| | |
|---|---|
| January to June 1958 | 24 |
| July to December 1958 | 20 |
| Total for the year | 44 |
| January to June 1959 | 32 |
| July to December 1959 | 46 |
| Total for the year | 78 |

Gentlemen, you should be proud of the part you are playing by your interest and support for the attack on this disease but you should know that you have powerful allies in your interest. You may be pleased to know that the National Cystic Fibrosis Research Foundation, a voluntary organization, now has over 100 chapters from coast to coast. Its budget for 1960 anticipates expenditures of $354,000, 55 percent of which will go directly into research grants and a total of 85 percent of which will go into research, medical education, and public education. Currently this foundation intends to appoint a full-time director of medical affairs among whose purposes it will be to stimulate research related to cystic fibrosis. One of his objects, I am sure, will be to evaluate how best to make use of the foundation funds for research as related to National Institutes of Health funds for research. Hopefully the National Institutes of Health and National Cystic Fibrosis Research Foundation and the growing thousands of individuals and scientists interested in cystic fibrosis will see increasing inroads made against that disease.

Now, gentlemen, my own segment of research interest in cystic fibrosis concerns the frequency with which these unfortunate children are thrown into attacks of severe lung disease by common virus infection, particularly viruses which attack the respiratory tract. May I then try to stimulate your interest in the progress and problems of new viruses and respiratory tract illness.

You have, I am sure, heard that in the past several years there have been uncovered 10 or more large groups of viruses including far over 100 individual viruses and that these have been linked, to some extent, with respiratory tract illness.

Do you have any idea what it takes to isolate and identify even one of these viruses? (1) Material from a human source must be placed in some living host, either an animal or currently living tissue culture. Usually this material must be put in more than one such animal

or culture. (2) Investigators must observe the host or culture for some effect on it. Some virus effects are reasonably specific, others are far less specific. Whether the effect on the animal or tissue culture is specific or not it is necessary to check this effect for its true specificity against antibody-containing serum of the other 100 viruses. This means that someone has to keep representative strains of all these viruses growing and frequently has to inoculate appropriate animals in order to prepare a specific antiserum against each one. Then each one of these animal antiserums must be cross-checked against all the other virus types. (3) Given that all this has been accomplished for each new virus, portions of the same processes must be repeated each time that a virus is isolated or that a potentially new virus is found. (4) Next, if one really wants to link these viruses with respiratory tract illness or any illness for that matter, thousands of individuals, both with illness and without illness, must be tested, not only for the presence of the virus but for whether they developed antibody against it. (5) Now at this point it would be possible to make some sense about the association of a virus with illness. But still, for the full value of such studies, any one laboratory would have to be able to concentrate on all the known viruses at one time and the same kind of studies would need to be done over a long period of time and in many places in order to learn whether the results in one area and one period of time are representative.

Now gentlemen, this sounds like and it is an overwhelming job. It is difficult and it is expensive. For this very reason too few groups are getting into this kind of work. However, the goals are worth it.

To show you what can be done even under limited circumstances may I mention results from our own laboratory at Children's Hospital of the District of Columbia. In a 2-year period our laboratories have tested by tissue culture methods approximately 2,500 specimens from children with respiratory tract illness and 2,000 from control patients. In addition, serum studies have been conducted on 700 patients with illness and 500 controls. These studies enable us to estimate that respiratory tract illness in children was associated in the following percentages with respective viruses: Influenza A, 5.2 percent; influenza B, 1 percent; parainfluenza 1, 8.2 percent; parainfluenza 2, 1.8 percent; parainfluenza 3, 12.2 percent; adenovirus, 6.7 percent; respiratory syncytial virus, 9.6 percent; primary atypical pneumonia virus, 10 percent; unidentified viruses, 6.8 percent. With most of these viruses the association was of etiological significance, meaning that the virus did cause the illness, although this is not necessarily true of respiratory syncytial and certain adenoviruses in these particular studies. Now these results are helpful and bring us closer to being able to estimate percentagewise which viruses cause what segment of respiratory tract illness. Most importantly, they provide a background for decisions on vaccine therapy. But they cost about $50,000 a year. In addition, we have a valuable collaborative association with Drs. Huebner and Chanock of the Laboratory of Infectious Diseases.

You can, if you will, stimulate more groups to get into this kind of study by encouraging the following:

(1) Support for training in clinical-epidemiological virology;

(2) Heavy, long-term financial support for the Laboratory of Infectious Diseases of the National Institute of Allergy and Infectious Diseases and any extramural laboratory or clinic which proves its capabilities and willingness to attack the problem;

(3) Investigation with National Institutes of Health officials into the possibility of large-scale, long-term support for a national virus identification center which would make available to competent laboratories the viruses and serums which would enable these laboratories to study more than one virus at a time.

Gentlemen, here is a problem which is readier to be solved than any other research problem of which I am aware. And yet, the budget for the National Institute of Allergy and Infectious Diseases is standing essentially where it did last year. I think you may want to look into it before our research efforts in these fields fall behind those of the Russians.

That is the extent of my testimony, Mr. Chairman.

Mr. FOGARTY. Thank you, Dr. Parrott.

Mr. Denton?

Mr. DENTON. No questions.

Mr. FOGARTY. Thank you very much, Doctor.

---

MONDAY, FEBRUARY 29, 1960.

## HOSPITAL CONSTRUCTION

### WITNESS

### HON. KENNETH A. ROBERTS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ALABAMA

Mr. FOGARTY. Next, we have Representative Roberts of Alabama. Mr. Roberts, we shall be glad to hear you at this time.

Mr. ROBERTS. Mr. Chairman and Mr. Denton, I appreciate the opportunity of talking to you a few minutes. This has to do with supplying the funds for implementing section 803 of Public Law 86–372, which is the Housing Act of 1959. This section authorizes the sum of $7,500,000 for each of the fiscal years ending June 30, 1960, and June 30, 1961.

The purpose of that section is to extend and fulfill the program initiated by the Defense Housing and Community Facilities and Services Act of 1951, Public Law 82–139, with respect to construction of hospital facilities in critical defense areas.

This section grew out of the impact which was created by virtue of the Korean war. Under this section there were 36 applications received by the Public Health Service for hospital construction funds, but only 6 of the projects were approved, and only $1,650,238 was paid out under the section.

Before the remaining 30 applicants could be considered, the funds ran out.

In the 84th Congress it was extended, and $5 million was authorized for each of the fiscal years 1957 and 1958, but no appropriation was made.

I have a list here, Mr. Chairman, and with your permission I should like to include this list and my formal statement in the record at the proper time.

Mr. FOGARTY. That may be done.

Mr. ROBERTS. One of the hospitals which applied is in my district at Anniston, Ala. It was denied consideration because of the unavailability of funds. We have in this area a rather heavily impacted defense situation, growing out of the activities at Fort McClellan, which is the home of the Chemical Corps training center and of the Women's Army Corps. Then we have a rather large ordnance installation at Bynum, Ala. These two together gave the city of Anniston a rather heavy impact.

One of the difficulties with the various communities which some of us feel may be entitled to relief is that under the criteria which has been adopted by the Public Health Service, they say that if in the meantime and since this date you have had certain additions made to the hospital under Hill-Burton, that should discharge the obligation.

I would like to call to the attention of the chairman and the members of the subcommittee what actually happened. At Anniston, we had this wartime construction which we had to have to take care of these people, because the hospital facilities at Fort McClellan were inadequate even for the military.

The Anniston Memorial Hospital is the hospital in which I am interested. It has applied for funds and has indicated it will reapply in case the legislation is implemented with funds. The maintenance costs at that hospital in 1950 were $9,779.29. In 1958, the maintenance costs had jumped to $48,426 annually—in other words, an increase of almost 500 percent. The reason for that is the fact that, at the time this construction had to be done to take care of the impact because of the acute bed shortage, we could not get steel for the buildings. It was simply brick and mortar without any steel in it. We are constantly having to do a lot of repairs.

It is my feeling that since we have paid off some of these hospitals the other eligible hospitals should not be forced to suffer because of circumstances which were beyond the control of the local authorities.

I might say, too, that at my request the Public Health Service has recently made a survey of the 30 hospitals which were left out of the program originally, and that 16 of them have indicated that they still have a critical defense need and would reapply if funds were made available.

Also, I would like to impress one other thing upon the chairman. In reading section 804, the chairman will note that the authorization goes only to fiscal 1960, which means if we do not get the money this fiscal year, we are pretty well out of the picture. That is not only my construction of it, but it is the construction of the legal staff of the Banking and Currency Committee which handled the original legislation last year, and also of the legal staff of the Public Health Service.

With the permission of the Chair, I will put this statement in the record.

Mr. Stubblefield, a Member from Kentucky, also has a hospital in his area and wishes to testify. I originally wrote the letter to apply to all of us who are affected by this.

Mr. FOGARTY. Thank you very much, Mr. Roberts. As you know, I am sympathetic to your problem, and we shall do all we can for you.

Mr. ROBERTS. I appreciate the Chairman's feelings.

(The material submitted by Mr. Roberts follows:)

STATEMENT OF REPRESENTATIVE KENNETH ROBERTS

Mr. Chairman, I appreciate the opportunity given me to appear here in support of an appropriation in accordance with section 804 of Public Law 86–372, the Housing Act of 1959. This section authorizes the sum of $7,500,000 for each of the fiscal years ending June 30, 1960, and June 30, 1961.

The law passed in the 84th Congress limited eligibility for these funds to those public and nonprofit agencies which had applied for funds prior to June 30, 1953, but were denied aid because funds were not available. The Housing Act of 1959, about which I am now appearing, carries a similar stipulation.

The 30 applicants who, prior to June 30, 1953, applied for aid under Public Law 139 but whose projects were not approved are listed in a report I have obtained from the Public Health Service. I will not read them, but ask that they be included in the record at this point.

(The list of applicants follows:)

APPLICANTS WHO, PRIOR TO JUNE 30, 1953, APPLIED FOR AID UNDER PUBLIC LAW 139 BUT WHOSE PROJECTS WERE NOT APPROVED

Name and location:

Wentworth and Dover City Hospital, Dover, N.H.
Lower Bucks County Hospital, Bristol, Pa.
Lexington Park Hospital Committee, Lexington Park, Md.
Jennie Stuart Memorial Hospital, Hopkinsville, Ky.
City of Paducah, Paducah, Ky.
County of Cumberland, Fayetteville, N.C.
Clarkesville Memorial Hospital, Clarkesville, Tenn.
Huntsville Hospital, Huntsville, Ala.
Anniston Hospital, Anniston, Ala.
Barnwell County, Barnwell, S.C.
Allendale County, Fairfax, S.C.
Aiken County, Aiken, S.C.
Roper Hospital, Charleston, S.C.
Medical College of South Carolina, Charleston, S.C.
Hospital and Training School, Charleston, S.C.
Dorchester County Hospital, Summerville, S.C.
Beaufort County Hospital, Beaufort, S.C.
Pike County Hospital Association, Waverly, Ohio.
Jackson General Hospital, Inc., Jackson, Ohio.
St. Joseph Hospital, Wichita, Kans.
Wesley Hospital, Wichita, Kans.
City of Wichita, Wichita, Kans.
Bennett Memorial Hospital, Rapid City, S. Dak.
St. Mary's Hospital, Tucson, Ariz.
Pima County Hospital, Tucson, Ariz.
Eden Township Hospital, Castro Valley, Calif.
Pittsburg Community Hospital, Pittsburg, Calif.
Douglas Community Hospital, Roseburg, Oreg.
Harrison Memorial Hospital, Bremerton, Wash.
Queens Hospital, Honolulu, Hawaii.

Mr. Chairman, one of the hospitals which applied for assistance under this program but which was denied consideration solely because of the unavailability of funds was a hospital in the Fourth District of Alabama.

In order to give the committee an idea of the kind of situation which this legislation covers, I would like to describe the hospital in my district.

Anniston Memorial Hospital is a public facility in Anniston, Ala., which was built by the Federal Government with funds appropriated under the Lanham Act during World War II. It was one of the measures taken by the Government at that time to protect the health of people in crowded defense communities.

Anniston is the home of Fort McClellan, the home of the Chemical Corps Training Command and the Women's Army Corps; and of Anniston Ordnance Depot, a very active ordnance facility operated by the Department of the Army

The impact of these Federal installations is considerable upon Anniston Memorial Hospital.

In 1952, the city of Anniston applied for $500,000 under Public Law 139 of the 82d Congress to assist in the construction of a two-story addition very desperately needed. Due to lack of funds after six other applications were approved, Anniston's application was not approved. When the 84th Congress revived this act, Anniston Memorial Hospital again expressed an interest in reapplying; but again, no funds were available to carry out the original intent of Public Law 139.

Recently, at my request, the Surgeon General of the Public Health Service surveyed the 30 hospitals which were left out of the program initiated by Public Law 139. Sixteen of these original, eligible applicants indicated they still have a critical defense need, and would reapply if funds are made available.

It is down to a point then where we are asking the Federal Government, through this committee, to keep faith with 16 hospitals which are scattered over 9 States.

This Congress already has recognized its obligation to these hospitals by passage of the Housing Act of 1959 and section 804.

We all realize, of course, that if these funds are made available it will not mean that this group of left out hospitals will automatically receive any appropriation. There would have to be the proper survey made by the Public Health Service to determine whether there was a need for beds to serve an immigrant population due to defense activities and whether existing hospitals had sufficient beds to meet this need.

But I do believe that the Public Health Service should be given funds to allow it to assist these hospitals which do still labor under the added impact of Federal and defense installations.

I respectfully request this committee to appropriate funds adequate to implement the provisions of section 804 of Public Law 86–372.

---

ANNISTON MEMORIAL HOSPITAL,
*Anniston, Ala., February 3, 1959.*

THOMAS E. BRIDGES, M.D.,
*Anniston, Ala.*

DEAR DR. BRIDGES: Pursuing our recent conversation, this is to advise that Anniston Memorial Hospital was opened for use in 1944 with 105 beds. It was built and equipped during World War II by the Federal Works Administration to protect the health of the people of this crowded defense community. The city of Anniston then purchased the hospital from the Government for $326,000. The building is of wartime construction and there was no structural steel used. The plumbing and steam lines available at that time were of a quality which has not well endured constant use.

The results of wartime construction, plumbing, and steam lines, combined with heavy utilization, are now being reflected in the soaring cost of maintenance. In 1950 maintenance costs were $9,779.29. In 1958 maintenance costs were $48,426. The estimated cost of maintenance for 1959 is $49,420.

In 1950 and 1951 it became evident that additional beds were needed immediately to alleviate the acute bed shortage which had developed and which was due in part to the greatly augmented activities of the military installations in the Anniston area.

Excavation and renovation was made in the basement area under blocks 4, 5, and 6. This project was completed in September 1953, at a cost to the city of Anniston of $194,000, giving the hospital a total of 159 beds.

The attached schedule will show the increase in activities of Anniston Memorial Hospital for the past 13 years in affording service, care, and treatment for the people of this area.

We are also enclosing for your information a copy of "A History of Anniston Memorial Hospital," by Miss Louisa Nonnenmacher and a copy of "The Hospital Story," which includes a report of the survey of Anniston Memorial Hospital and recommendations of Hospital Consultant Jacque B. Norman.

We will be glad to furnish any further information which you may require.

Yours very truly,

GEORGE C. SCHNEIDER,
*Acting Administrator.*

*Schedule of activities—13-year period, 1946–58*

| | 1946 | 1950 | 1955 | 1958 | Increase in 13 years |
|---|---|---|---|---|---|
| Number of admissions: | | | | | |
| Adult and pediatric | 3,798 | 5,261 | 8,049 | 8,829 | 5,031 |
| Newborn delivered | 964 | 1,285 | 1,871 | 1,996 | 1,032 |
| Days of hospital care: | | | | | |
| Adult and pediatric | 23,659 | 29,905 | 39,868 | 46,526 | 22,867 |
| Newborn | 5,744 | 4,334 | 5,904 | 6,707 | 963 |
| Surgical procedures | (1) | 2,279 | 2,894 | 8,022 | [2] 5,743 |

[1] Not available.
[2] 9-year period.

---

MONDAY, FEBRUARY 29, 1960.

## HOSPITAL CONSTRUCTION

### WITNESS

### HON. FRANK A. STUBBLEFIELD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KENTUCKY

Mr. FOGARTY. Now we come to Representative Stubblefield of Kentucky. Mr. Stubblefield, we shall be pleased to hear your statement.

Mr. STUBBLEFIELD. Mr. Chairman, I appreciate this opportunity. My story, very briefly, is substantially the same as Mr. Roberts'. The Jennie Stuart Memorial Hospital is located in Hopkinsville, Ky., which is in a severely impacted area 14 miles from Fort Campbell, Ky.

The 1960 survey showed that the bed capacity is 102 acceptable beds which meets only 40 percent of the needs of the area. They submitted an application for Federal aid under this bill in August 1952, and a revised application in September 1956, for $1,500,000. They have a very high priority—7th. In 1948, they received $70,000 under the Hill-Burton Act, and matched it with $140,000 locally, to add 25 beds. They are unable to qualify for additional Hill-Burton funds because they are unable to raise the funds locally.

Very briefly, that is the situation. The need for these funds is real and is urgent. I would like to have permission, If I may, to file a more detailed statement.

Mr. FOGARTY. You may do that.

Mr. STUBBLEFIELD. Thank you.

Mr. FOGARTY. Thank you.

(Mr. Stubblefield's additional statement follows:)

ADDITIONAL STATEMENT BY CONGRESSMAN FRANK A. STUBBLEFIELD, FIRST DISTRICT, KENTUCKY

The Jennie Stuart Memorial Hospital, Hopkinsville, Ky., was incorporated in 1913 as a not-for-profit, 30-bed hospital. This hospital serves the city of

Hopkinsville, the county seat of Christian County, and also serves part of the needs of surrounding counties. In 1940, Hopkinsville's population was 10,746 with the Christian County total population a little over 36,000. Then, Fort Campbell was built, 14 miles from Hopkinsville, and the population has increased by immigration largely as a result of Fort Campbell, until the city has a population currently estimated at over 30,000 and the county more than 60,000. The great 101st Airborne Division and attached units are stationed at Fort Campbell, and also a substantial contingent of naval personnel.

The population growth of Hopkinsville and the surrounding area, primarily as a result of the national defense activities at Fort Campbell, and the demand for services concomitant with this explosive rate of growth has strained the resources of the area to the limit, despite aggressive and dedicated efforts of the residents.

Dr. Grant Gaither, president of the hospital board of the Jennie Stuart Memorial Hospital, and Mr. W. C. Byers, administrator, have done an outstanding job of providing medical services for the area with the limited facilities available, but they are keenly and painfully aware of the fact that the facilities are adequate to meet only 40 percent of the needs of this severely impacted defense area. These needs cannot be met in the foreseeable future from local resources. It is, therefore, the part of sound public policy that the Federal Government which created the explosive need should assist in filling the need.

I strongly urge that the committee appropriate the funds requested to meet the needs of this and other similarly situated areas.

## Hospital Construction

### WITNESS

### HON. L. MENDEL RIVERS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF SOUTH CAROLINA

Mr. Fogarty. We shall now be happy to hear from you, Mr. Rivers.

Mr. Rivers. I think Mr. Roberts, in his statement and the material he submitted for your record, has covered the general problem well. In view of this I am not going to impose further on your time except to ask that these letters from the hospitals in my district be placed in the record. These will show the specific problems we have.

Mr. Fogarty. We shall place those in the record.

(The letters submitted by Mr. Rivers follow:)

Roper Hospital,
*Charleston, S.C., February 15, 1960.*

Re appropriations authorized under section 804 of Public Law 86–372, the Housing Act of 1959, for hospital construction in defense areas.

Hon. L. Mendel Rivers,
*House of Representatives,*
*Washington, D.C.*

Dear Mr. Rivers: Thank you for your letter of February 12, 1960, with information concerning appropriations under the above cited public law authorizing Federal funds for hospitals in defense areas.

The Roper Hospital submitted an application for assistance under Public Law 139, 82d Congress, to obtain funds for the construction of a new wing under date of October 2, 1952. The application was processed through the hospital construction section of the South Carolina State Board of Health.

I believe the above is the information you desire; if there are any further inquiries, I shall be happy to reply.

Very sincerely yours,

C. A. Robb, *Administrator.*

STATE OF SOUTH CAROLINA,
HOUSE OF REPRESENTATIVES,
*Columbia, February 19, 1960.*

Re appropriations authorized under section 804 of Public Law 86–372, the Housing Act of 1959, for hospital construction in defense areas.

Hon. L. MENDEL RIVERS,
*House Office Building,*
*Washington, D.C.*

DEAR MR. RIVERS: We are still very much interested in securing an appropriation for our hospital under the Defense Housing and Community Facilities and Services Act. We have an urgent need for additional facilities and wish to renew our application, which was made before June 30, 1953. We appreciate your interest and trust you will be successful in having funds made available for this purpose.

With kindest regards, I remain,

Yours very truly,

ROBERT E. MCNAIR.

---

MEDICAL COLLEGE OF SOUTH CAROLINA,
*Charleston, S.C., February 23, 1960.*

Hon. L. MENDEL RIVERS,
*House Office Building, Washington, D.C.*

DEAR CONGRESSMAN RIVERS: Your letter to Dr. Lynch concerning our application under the Defense Housing and Community Facilities and Service Act of 1951 (Public Law 82–139) has been referred to me.

The medical college applied on July 30, 1952, for $1,119,995.96 for the purpose of restoring to the plans the sixth and seventh floors of the Medical College Hospital because it was necessary to remove these floors when bids were received. Subsequently funds were obtained by appropriation from the General Assembly of South Carolina for this purpose.

In the light of renewed interest in this opportunity, we have conferred with representatives of the hospital construction section of the State board of health in the hope that opportunity may be provided for a much needed expansion of the psychiatric floor of the Medical College Hospital and a critical need for enlargement and reorganization of our outpatient facilities. It is estimated that these two projects will cost at least $700,000.

It is hoped that this is the information you desire.

We are grateful for this latest example of your continuing interest in the medical college.

Sincerely yours,

JOHN T. CUTTINO, M.D.,
*Executive Vice President, Dean, School of Medicine.*

---

BEAUFORT MEMORIAL HOSPITAL,
*Beaufort, S.C., February 23, 1960.*

Re appropriations authorized under section 804 of Public Law 86–372, the Housing Act of 1959, for hospital construction in defense areas.

Hon. L. MENDEL RIVERS,
*House of Representatives, Washington, D.C.*

DEAR MR. RIVERS: Your letter of February 12, 1960, addressed to Mr. Lengnick and Mr. Harley, has been referred to me in the absence of Mr. Nicholson.

We did make application under the above prior to June 30, 1953. Please advise if any further information is desired and Mr. Nicholson will be glad to furnish it when he returns to the office on March 1, 1960.

Very truly yours,

MELVA L. COLLUM, *Secretary.*

MONDAY, FEBRUARY 29, 1960.

## MENTAL HEALTH PROGRAM

### WITNESS

**DR. FRANCIS J. BRACELAND, PSYCHIATRIST-IN-CHIEF, INSTITUTE OF LIVING, HARTFORD, CONN.**

Mr. FOGARTY. Now we shall hear from Dr. Francis J. Braceland of the Institute of Living, Hartford, Conn.

Proceed Dr. Braceland.

Dr. BRACELAND. Mr. Chairman and Mr. Denton, I am here with my colleagues, Dr. Jack Ewalt of the American Psychiatric Association, and Mr. Judd, who is the chairman of the board of the National Association for Mental Health. I know you will be glad to know that we are working in unison, the great organization of the professional people and of the lay people, now in this cause.

Mr. FOGARTY. All lay groups and all professional groups.

Dr. BRACELAND. Yes, sir. We are working in a very pleasant symbiosis, I am glad to say. It was not always that way.

Pericles used to get on with people because they only saw him occasionally, and I hope I do not wear out my welcome with this committee coming down here so often.

Mr. FOGARTY. You are always welcome here. We enjoy listening to you.

Dr. BRACELAND. Thank you, sir.

Mr. FOGARTY. We want you to give us some encouragement, too. It is getting tougher and tougher to get money. The President has to balance the budget.

Dr. BRACELAND. I sort of suspected that.

Fourteen years ago we appeared first, when the Nation was just coming out of a rather devastating war. We appeared before your committee in uniform to testify for the mental health program, and I had the privilege of being among that group. We were awfully distressed about the situation, because we had no help. I think in the Navy we had something like 15 psychiatrists at one time. I note that when General Marshall was sending a general around to see what was going on, more people were being discharged from the service than were being sent over to fight the Japanese.

There is no need for me to recount that for you or the committee, sir, but we have made tremendous strides since then and when all is said and done this change is traceable solely to the fact that you folks provided the money to establish a broad mental health program. No one knows better than we do that we have not met all the problems, and many of them are with us, but we have made a great beginning.

Originally, our attitude was one of helplessness. We just did not know what to do, but then when we got started it was like a large body of water that started to churn. It took a great deal to get this into action. We were 40 years behind the rest of medicine, and today there is unbelievably widespread interest in mental health, an interest which has penetrated every level of our society.

Also, the mental hospital has improved so. There was a drop of residence in mental hospitals again last year, 2,142 fewer than the

year before. The fact that this great trend upward has been changed is extremely important. While 2,000 is pitifully small in view of the whole problem, nevertheless it is really a great advance. What is most heartening is that again last year the net release rate went up by 7.7 percent. This is cumulative. We have had about 15 percent net release in 2 years. This is indeed a great change.

We are now treating people vigorously, people whom we just gave up as hopeless before.

There are so many factors involved in this that it is hard to ascribe any single cause to it. One thing is certain, no matter what is causing it; that is, the money which you have appropriated for the mental health program has been seed money. It has been an investment. It has gotten its stake in the municipality, and everybody else has tried to do something. Therefore, we appear before you this year to ask you with the greatest sincerity to continue to help us. Now that we are beginning to pay off on what you have already done, we cannot yield to any temptation to relax our efforts.

This happened in France. They figured that they had the drugs now and they could get people out. They cut down the rate, and pretty soon they were right back where they had been.

We still have a great deal to learn about mental illness, but our knowledge already has outstripped our possibilities of utilizing what we have. There are still too many people, too many problems, too many patients. There is too much of everything except help to get them well. Severe shortages have made it necessary for us to curtail a lot. Therefore, I shall speak today largely to ask you not to withdraw your supporting hand as regards mental health personnel. This was one of the main requests when we came to you originally 14 years ago. I detect outside some feeling around that maybe we have gotten started so well we can let up, but we really cannot.

For confirmation of the grave shortages of mental health manpower, one has only to read Dr. George W. Albee's book to see the situation. When we began back there, we had fewer than 4,000 psychiatrists. At the latest count we have 11,250, and we could well do with twice as many. The shortages in trained clinical psychologists and the people who help also are noteworthy. After making an exhaustive study of the needs and the current trend in the future, Mr. Albee concluded unless there is a major change, not only will we not be able to catch up with the demand, but we will begin to lose ground in the next 15 years. The present rate is not keeping up with the population growth.

This may sound a little bleak, but it is so much better than ever before that it is difficult to contemplate what we really have done. As a matter of fact, when we appeared before you, as I remember in some small meeting room, we knew you were sympathetic and your committee was sympathetic, but I do not think any of us at the time came out really with the seriousness of the problem, the size of it, for fear someone might think, "This is so vast that we had better look to something else first."

That is all changed now. Everybody knows the size of it, and your committee and Senator Hill's committee, by your willingness and understanding, have certainly been of the greatest help in this.

The family doctors are interested. We train them now at nights.

The Academy of General Practice is coming into our various programs.

Personally, while I regret, in a way, to see family doctors taken from some people unless they are replaced, nonetheless there is a great need for them, and the greater need is for all of them to learn how to handle the minor, the ordinary, everyday emotional problems which come in to their offices masked with physical symptoms, so they are able to recognize these people.

That, I think, also we are accomplishing by this program which you put through for general practitioners.

Five years ago the average family doctor had nothing to do with it, but today this whole situation has changed.

Also, the training grants to the medical schools have been bringing training to the physicians. You see, the medical schools do not get the top men as they used to. Now there is much more glamour in physics and the physical sciences.

There is great need now to expand the various types of psychiatric education and to teach the principles of human behavior in the medical school. As a hospital director, I am mostly interested to get men to work in the hospitals with the patients who are in there.

I know that occasionally there is some unrest about the men who are trained under public health stipends and who go into private practice, but those men keep a lot of patients out of mental hospitals. The steps now are: These men keep them out, then the general hospitals have small units and wards, and then finally, if they cannot handle them, they come on to us in the mental hospitals.

There is no need for me, sir, to estimate for you what it costs to keep a person in a mental hospital, but I would say that by avoiding hospitalizing patients we are making tremendous savings. Any cutback now in the training of men I am afraid would see us back where we were before the war, because the examinations which the foreign physicians have to take, the various accreditation examinations, everything is conspiring against getting great numbers of men and, therefore, we cannot afford to cut down the number of trainees that we have.

We need more people for research and graduate training programs, clinical psychologists, and social workers.

Many excellent programs are in operation, but there is one point in connection with these I would like to respectfully call your attention to. That is large-scale support of training on some special problems. Hospitals and universities usually go along constantly seeking money, as is everyone else, obligating themselves for bringing men on in the first part of July and then sometimes one gets some men in an approved program and finds that there is no money to pay them. He may not get the funds to pay them until September or October, depending on budget conditions, and because the amount of funds appropriated for training grants is not sufficient to cover all of the approved residences one might sometimes have men aboard and not know how he is going to pay them.

Mental health teaching staffs are in short supply and will not wait around for you and, therefore, sometimes we lose some of these men. It seems urgent that a way be found to—whether it be forward financing or whatever—to make an adjustment whereby, perhaps, we could

tell pretty definitely by the time we hire the men that we will be able to pay them.

Therefore, I would like to respectfully call your attention to an item in the budget figure that the citizens will present to you which will permit this type of financing on the Advisory Board of the National Institute for Mental Health, of which I am a member, and we hope that the sum of $5 million will be allotted each year for 3 years. But, the budget proposed by our citizens' group has a single item of $16 million for this purpose, and I believe if this will be possible it would be best to institute this.

There are one or two other areas of training which I would like to stress, that of biological and social sciences which need research workers. Some programs have been initiated to train mental health programs by using these various approaches and we hope to expand the ranks of trained personnel.

Another area in which increased efforts should be made is in the training of pharmacologists to do research work. There is a great deal of interest now, as you know, in pharmacology and it is a very fascinating thing. When we started this program, and even up to 5 years ago when we came before you, we thought that chemistry and pharmacology had shot its bolt. It looked as though it was all going in a different direction entirely, only to find a volcanic eruption of psychopharmacological things moving in every sort of new direction. Undoubtedly, this has been a great step forward.

One of the things which is difficult for me to communicate, and one has to feel it by living in mental hospitals, is the great difference in the mental hospitals today.

The disturbed wards are no longer disturbed as they were. This is due not only to drugs which have treated the patient, but also to the training of doctors.

When I began 28 years ago in mental hospitals we had sedatives and hydrotherapy and hope—not too much hope, either—but this whole whole picture has changed. We know the great effect of social surroundings on people in mental hospitals. When there is an upset in a ward now, we know that the people in charge have something to do with it and something is wrong, and we look in different directions. We do not give up on people. We treat patients who heretofore were regarded as hopeless and now we know that a certain number of these people will come out.

We train also old people whom we used to discard—many of them 65 years of age. We used to think that was the end of it. I am glad that that no longer holds. We are getting within striking distance of patients now up into the 80's, and we find that rather than organic changes in their brain, many of them are sick because of what the culture does to them. It casts them aside. A man who was once a person of parts is now pushed aside. Therefore, many of them are depressed, rather than organically ill, and we have no hesitancy at all about treating them. We therefore get a fair percentage of them out.

I would like to mention an additional thing here directly attributable to congressional support of mental health work, and that is the great interest in the field of aging. One gets this not only in psychiatry but in every branch of medicine—the general practitioner and

the family doctor has become infected with it, and they know that simply to be able to talk to some of these people and for them to know that they have a friend, is much more important than a hastily written prescription and dismissal after a few minutes.

In work on the elderly, I do not think that Congress should be hesitant for 1 minute in taking credit for the fact that it was willing to appropriate money to the National Institute of Mental Health to tackle that problem.

Another problem which your committee directed the National Institute of Mental Health to pay attention to when everybody else was beating his breast and saying "Woe is me," is this problem of juvenile delinquency. I can see from the energetic approach that these men are taking who report to our Committee and Advisory Board that something will come out of that, and something will be done.

Also, as a member of the Advisory Board of the National Institute of Mental Health we get an opportunity to see the research projects which are submitted. I can assure you, sir, that we are very jealous, too, of public funds, but we would like you to know that these projects are given the most rigid scrutiny and inspection. A great deal of very important work is being supported by research grants and we are beginning to amass a great deal of knowledge. The men in the mental hospitals are so busy with custodial care, their housekeeping and their administrative duties being so great, that it is not possible sometimes to utilize the knowledge that we have. But, we have made great strides in the past 10 or 15 years. We have moved in all directions and, there are a great many bright young people now devoting themselves to research in this field. When some of us went into it, that was not so, but it is now.

I shall not burden you with the technical details about the structure of the nervous system, new findings in biochemistry, because you know that all very well. The whole field of mental health is like a vast glacier, and it has started to move. I do hope we will not let it freeze up again, because of lack of funds. There has been a veritable revolution, within the past 8 to 10 years, and I would like to assure you gentlemen that you have no idea how much can be done for patients today—so many things that we never thought of before.

I am not going to lean heavily on the opening of institutions, because while that is a part of it, there are some people who are so sick that for a time they need a closed corridor as a protective device. However, the idea is to get them out of the closed part as quickly as possible. New treatments and procedures are coming thick and fast, and we have to choose among them.

A great benefit of pharmacology has been that it has allowed us to get at people that we could not get near before. I speak psychologically. One of the most important therapeutic tools that has come along, and I cannot help but stress along with it the attitude of the people who are administering the drugs, is the manner in which they go about it.

This is exceedingly important. If the doctor has hope that the patient will recover and he stays at it, then the patient frequently catches his enthusiasm.

Now, these can only be applied in institutions that have sufficient personnel, and we can do this work only if we have sufficient people to put our findings into effect.

I would like to speak to you for a moment, sir, about title V, because that has encompassed some remarkable things and provides invaluable help in improving hospital care. While I only know personally of a few of the things, I see the reports on the others.

For instance, one that I am well acquainted with is young children who were so sick that they could not be in school—preschool children who could not go to kindergarten. Yet they were not mentally retarded. They had mental diseases. Now, under title V I know of one or two institutions which are treating these children and slowly but surely is putting various ones of their pupils into the regular kindergarten class and early grade-school classes—children who otherwise would have been lost—most certainly lost.

There is a great deal to this. Initiate emergency psychiatric service, plus providing out-patient treatments for former patients. That is the fifth step of the rehabilitation of a person, and it is the weakest. The first is the relationship of the doctor and the second is continuing his education while he is sick, if possible, particularly a young man. The third is not allowing him to withdraw sociologically and socially, and the fourth is preparing the patent to go outside. In the fifth we have been unable to do anything about preparing the community to receive the patient, and it does him no good at all if he goes out and the community will not receive him, and he cannot get a job, especially where there is nobody to superintend him or supervise his taking drugs. He will be back in the hospital most certainly. It is extremely important that people under title V are getting into this.

They also show how to use better existing facilities in bringing psychiatric care to underdeveloped areas and setting up small units in mental hospitals which are therapeutic. This is really a very good project, of that I am convinced.

Another area that needs support is the whole field of community mental health, because many communities lack this. There are 1,300 psychiatric clinics in the United States, and 50 percent of them are in Northeastern cities, and 67 percent in cities over 50,000 population. We need to double that number of clinics. We need 3,500 full-time clinics if we are to reach the goal for every 50,000 people in the country.

Again, the Institute is doing a good job in the poorer States in getting these programs going and furnishing them with technical assistance, and some important things are beginning to happen. I would urge that a great deal more needs to be done to get the people to realize that mental illness is not an all-or-none affair. There is a great feeling around that one is either sick or well. If we can get people to realize that all of us at times have anxieties and depressive feelings, then it would be easier for them to seek help. They have to be made to know that, once mentally ill, one is not always necessarily mentally ill. Much more needs to be done through rehabilitating persons, in placing people in productive occupations, and so forth.

In summary, I would like to urge increased support for these tremendously important mental health programs.

The recommendation for the field of research is $36.8 million for grants and supported activities. This covers the regular research grants as well as grants in psychopharmacy in title V.

I would urge serious consideration in an amount allotted for research fellowships. I think we could use $3 million for this purpose, and use it wisely and well.

I respectfully urge your very favorable consideration of sizable increases for training activities. The total being recommended by the citizens' group for this purpose is $46 million, of which $16 million is a nonrecurring item to adjust project period dates.

I would urge that you give favorable consideration to increasing the amount appropriated for State control programs to a total of $6 million.

This would bring grant-supported activities to $92 million.

I would urge favorable consideration of moderate increases in direct operation. The intramural research program which is being conducted at the National Institute of Mental Health offers one of the greatest opportunities in the country today to make noteworthy advances.

They can do things that no one else can do up there, because of their relationship to all of the great advances in medicine, and the opportunity they have to have things sent to them from all over the country. Also, the review and approval of grants is a mammoth task and a very important one.

This work has to be done carefully in order to insure success. The training and the professional and technical assistance activities conducted by the National Institute of Mental Health staff are likewise extremely important. I would urge that you give favorable consideration to a proposal set forth by the citizens' committee for a total appropriation of approximately $105 million for the next fiscal year, 1961.

Before I conclude, I would like to say something which disturbs me personally. No one has talked to me about it, but I see it as I go up to the Institute—shortage of space has been a problem for so long—and while they are going to get a new building, I am afraid it is going to be like LaGuardia Airport. It is going to be outmoded by the time we get it.

Three years ago when you were good enough to hear me, I asked that you stay with us for a decade. I always felt badly about that afterwards. There was an implied promise in it. But, I would like to repeat that now, and reiterate that request because things have gotten started, and I know that with your interest that you folks will not be leaving us, but that you will keep the program going at the level it needs.

The work that is being done with your help holds out great promise for the mentally ill and, certainly, for their families.

It has always upset me that as we roll off those figures, we are sometimes unmindful that behind each one of those statistics is the heartbreak of a family, a loved one, and sometimes one who is the breadwinner.

With your permission, sir, I would like to ask that my testimony be put in the record.

Mr. Fogarty. Very well, sir.

(The statement referred to follows:)

My name is Francis J. Braceland. I am psychiatrist in chief at the Institute of Living, a mental hospital in Connecticut and one of the oldest in the Nation.

I have been president of the American Psychiatric Association, president of the Association for Research in Nervous and Mental Disease and chairman of the section on nervous and mental diseases of the American Medical Association. I have had the honor of appearing before you on various occasions and today I speak for the American Psychiatric Association and also as one of the representatives of the National Association of Mental Health. I am appreciative of your courtesy in permitting me to testify.

Fourteen years ago when the National Mental Health Act was passed, our Nation had just emerged from a devastating war. At that time a number of us appeared before you in uniform to testify about the great need for a Federal mental health program and I had the privilege of being among the group. Those of us who had served in the medical department of the Armed Forces during World War II were terribly distressed by the shortage of psychiatric personnel and by our lack of knowledge in this field, both of which seriously interfered with effective military operations. There is no need for me to recount for you any of the distressing details of those days—you know them well. Since that time, fortunately, we have made tremendous strides in our ability to cope with mental diseas. When all is said and done and all factors considered, we can safely point out that this change is traceable directly to the funds that Congress has appropriated during the intervening period to establish and develop a broad mental health program in the United States, centered in and directed by the National Institute of Mental Health. No one knows better than those of us here that we have by no means solved all the problems—many of them, most of them, are still with us. But we have made a noteworthy beginning.

When we did come before you to testify in favor of the National Mental Health Act in 1946, the general atmosphere was largely one of helplessness in the face of a problem so immense that one hardly knew where to begin to tackle it. We were fearful of even disclosing its size lest people get discouraged and turn their attention to something else. Today we have a great mental health movement in progress. This movement is like a large body of water that has begun to churn and to flow. It took a great deal to get this inert mass into action, to bring it to the point of motion, but today, there is an unbelievably widespread interest in mental health and mental illness throughout our country, an interest which has penetrated every level in our society. Today, we have a favorable climate in which constructive mental health work can be done effectively.

The situation in the mental hospitals has improved vastly in the past decade. During 1959, for the 4th consecutive year, there was a drop in the number of resident patients in public mental hospitals in the United States. At the end of 1959, there were some 2,000 fewer patients in these hospitals than at the end of 1958. This is a small decrease, perhaps in view of the money spent one might think it pitifully small, but it is an important decrease. It marks once again the trend of the reversal of the curve which heretofore had led to larger and larger mental hospital populations year after year. One thing that is exceptionally interesting about these decreases is that they are taking place in spite of an expanding population and rising admission rates. What is most heartening is the fact that net releases are going up—by 8.5 percent between 1958 and 1959, as compared with 7.7 percent the year before. (In 1957 there were 150,413 releases; in 1958, 161,972; and in 1959, 175,727). This is the most heartening change in our mental hospital statistics. There is something else happening which I find hard to define for you—one must feel it. Those of us who have lived in mental hospitals for years sense it. It is a feeling of hope, of activity, even of bustle. The old apathy is disappearing, people are now trying to outdo one another in advancing the cause of sick people. They are willing to treat vigorously those who heretofore would have been considered lost.

So many factors are involved in bringing about these increased improvements that it is hard to ascribe them to any single cause. However, one thing is certain, no matter what individual improvement factors are elicited it could not have been done with the seed money which you have appropriated annually to the mental health program. In the final analysis, this has been the spur which led to these advances. The investment of this seed money has also impelled many States and local communities to appropriate funds and to make the necessary efforts to establish and develop their own mental health programs. There is a danger, though, in all of this. Now that we have reached the point where our investments are beginning to pay off, we cannot yield to the temptation to relax our efforts. This happened in France. It is spurious reasoning to believe that now that things are brightening and drugs are helping we can ease our efforts.

If this were to happen, it would indeed be most tragic. Having once started the forces moving, we must keep them going; we must keep applying the necessary impetus.

Although we still have to learn a great deal about mental illness, our knowledge in this field has already far outstripped our ability to apply it. I am particularly distressed by the fact that the shortage of personnel in our mental hospitals makes it impossible for us to apply the knowledge that we have been able to acquire at the expense of long and arduous research. Severe shortages of personnel have made it necessary for us to concern ourselves so much with custodial problems that we have not had the chance to keep up with the new advances. Research and new findings cannot help the mentally ill unless there are doctors, nurses, and other needed personnel to apply these findings and to treat the patient. I therefore strongly urge the Congress not to withdraw its supporting hand with regard to training mental health personnel, particularly personnel concerned with the care of the mental patient. This was one of our main requests when we came before you originally. During the war we had to train our physicians in 90-day courses.

If confirmation of the grave shortages of mental health personnel is needed, one has only to review the bleak picture contained in Dr. George W. Albee's analysis of mental health manpower trends as published by the Joint Commission on Mental Illness and Health. At the present time there are some 11,250 psychiatrists in the United States. It is conservatively estimated that we need at least twice that number. The shortages of trained clinical psychologists and psychiatric social workers are also severe. The shortage of trained psychiatric nurses is particularly acute. The ratio of nurses in general hospitals is one to every three beds; in psychiatric hospitals the ratio is 1 nurse to every 53 beds. After making an exhaustive study of the needs and of our current trends in training psychiatric personnel, Dr. Albee concludes that, unless there is a major change, not only will we not be able to catch up with the demand for trained psychiatric personnel, but we will begin to slip back and lose ground in the next 15 years. The present rate at which we are producing new psychiatric personnel is not keeping up with the population growth.

Although this is a bleak picture, it is a better picture than we saw 14 years ago when the National Mental Health Act was passed. At that time we had only 4,000 psychiatrists. We have increased that number 2½ times, so that we now have one psychiatrist to every 16,500 people. But it takes a long time to produce psychiatrists and other professional mental health workers. Support for their training must go on over a number of years and it must be continuous. Such training also presupposes appropriate training centers adequately staffed with qualified teachers. The past 14 years have seen important advances in this area too. There are many more graduate training programs in psychiatry and psychology, more residents are being trained, and the total supply of trained mental health workers is increasing. These advances have been made possible by the Federal grants which have enabled training centers to establish teaching departments, employ faculty, and provide stipends for trainees.

As someone who is very close to the situation, I can personally assure you of the great good that is being done by some of these various training programs—including the general practitioner training program. This program has met with a tremendous response from family doctors eager either to enter the field of psychiatry or to increase their skills in handling mental and emotional disorders in the course of their regular practice. Personally, I prefer to see them in the various courses which their academy sponsors. I am reluctant to take family doctors from the villages and towns where they are badly needed, but I see the wisdom of some of them entering the field and all of them gaining knowledge enough to be able to handle the ordinary emotional problems which they encounter. This program has untold possibilities for helping us cope with the drastic shortage of personnel in this field.

Today there is widespread interest among physicians in treating mental and emotional disorders and other conditions that 5 years ago the average family doctor would not have touched. The previous skepticism toward psychiatry that was manifest among so many physicians is now almost a thing of the past. Most of the credit for this change can be attributed directly to the fact that you appropriated funds which made it possible to provide psychiatric orientation for all interested physicians. In 1946, when the National Mental Health Act was passed, the well-developed departments of psychiatry in medical schools were not numerous. Some schools had no departments, others had de-

partments which one could not point to. Today virtually all of the medical schools in the United States have well-developed departments of psychiatry, many with full-time staffs. Training grants to the medical schools have been responsible for this great change which is bringing training in psychiatry to practically all future physicians. These grants have also served as seed money, attracting other sources of support. They have pointed the way and encouraged university support, from other funds, for departments of psychiatry. The result has been that in a little over a decade, funds provided by Congress have helped to do more than move mountains—they have helped to move men's minds and their hearts.

There is great need now to expand the various types of psychiatric education, to develop programs designed to teach more about the principles of human behavior in the medical school. A start has been made in this direction, but much more needs to be done if the general physician of the future is to be equipped with the scientific background required to treat emotional disorders in their patients. Again, as someone who is very close to the field of educating mental health personnel, I can assure you that any money spent for educating general practitioners in this field is money very well spent.

As a hospital director, I am particularly interested in men being trained for hospital work. We need them by the thousands. I am aware of some unrest about men being trained for private practice but I assure you that men in private practice can keep many people out of the hospital, and the more people we can keep out, the further ahead we are. Rashi Fein, who prepared the report on "Economics of Mental Illness" for the Joint Commission, estimates that the direct cost of keeping a person in a mental hospital for 1 year is close to $2,000. This does not count indirect costs, such as loss of earnings, welfare payments to dependents, etc. Even leaving aside the humanitarian aspects involved, the savings that can be effected by avoiding mental hospitalization in the first place are tremendous. Any cutback in training funds now would soon see us back as we were in prewar times. I say this advisedly, for just as medical schools today compete for men with the more glamorous physical sciences, so, too, does psychiatry compete with medicine for candidates.

We need to train more people to do research in the field of mental health. We need more graduate training programs to produce more psychiatrists, more clinical psychologists, and psychiatric social workers. We need to train special personnel to do mental health work in the community; to work in special problem areas such as juvenile delinquency, alcoholism, aging, and retardation. Many excellent training programs are already in progress in all of these areas, but much more needs to be done.

There is one point in connection with these training programs that I would like to respectfully call to your attention. Large-scale support of training has brought with it some special problems which are working hardships for universities and training centers, and which may jeopardize their ability and willingness to participate in this work. Universities and hospitals, as we know, plan their programs on an academic year basis. They obligate themselves with regard to staff and other commitments during the spring for the year beginning July 1. The Federal Government, though, working on a July 1 to June 30 fiscal year, frequently is unable to make funds available before September or October of the year in question. Because the amount of funds appropriated for training grants is not sufficient to cover all of the applications which have been approved by the National Advisory Mental Health Council, the schools themselves are not sure exactly how much help they will receive until it is too late for them to make adequate plans. Under the circumstances they are faced with one of two alternatives. They can either employ staff late in June on the basis of notification of approval of grants by the National Advisory Mental Health Council and take a chance of overextending themselves if there are insufficient funds to pay the full amount of their grant. Or they can play it safe, and wait until they know exactly how much they are getting. If they do this, if they wait until August or September before making their final plans, they then run the risk of not being able to get the needed staff. Mental health teaching staff is in short supply and they will not wait around. If the second alternative is followed, the result may be that the money appropriated for mental health training will not be used to best advantage and that the whole year's time may be lost.

It seems urgent that some way be found to adjust the periods of grants so that the first payment on a continuation grant for any given year could be paid out of the preceding year's funds. I am not familiar with the administrative details that would be involved in this, and I am sure they would be involved, but

it seems to me that this could be a matter of adjustment that the staff of the National Institute of Mental Health might be instructed to make. I am sure that any administrative discomfort resulting from the necessary adaptation would be repaid many times over in the increased strength of training programs and the increased encouragement we could give to training groups to do more and more in this field.

I would therefore like to respectfully call your attention to an item which is in the budget figures proposed by the citizens' group. This is a nonrecurring item that would permit such forward financing of training grants. The National Advisory Mental Health Council of which I am a member suggested sometime ago that a sum of $5 million be allotted each year for a period of 3 or 4 years in order to provide the necessary backlog with which to begin forward financing. The budget proposed by the citizens' groups has a single item of $16 million for this purpose, and I now believe that if this is possible it would be best to institute this plan all at once.

There are one or two other areas in the field of training that I would like to stress. One is the need for support of training in the biological and social sciences. This kind of training is necessary in order to produce qualified research workers. Some programs have already been initiated to train mental health personnel in the research techniques of the biological and social sciences, and to train biological and social scientists in the field of mental health. By using both of these approaches, we can hope to expand the ranks of trained personnel who can carry on mental health research. One of the reasons that research in this field has been so neglected in the past is that people who were trained to do clinical work did not have the necessary skills to do research, and trained biological and social scientists did not have the necessary mental health background.

Another area in which increased efforts need to be made is in the training of pharmacologists to do research in the field of mental health. The new psychopharmacological agents have opened up tremenous vistas, tremendous opportunities for rapid advancement. We need to follow up in the many new exciting leads. We need to refine our knowledge about drugs useful in treating mental and emotional disorders. We need to learn more about the drugs we already have and to discover new and more effective drugs. In order to do this we need trained pharmacologists. The National Institute of Mental Health has already announced support for training along these lines, training programs in which universities, medical schools and pharmaceutical companies would cooperate. Great good would be done if we could stimulate further development of training programs in neuropharmacology, behavioral pharmacology, and related areas in order to build a strong core of research workers to study all of the complicated relationships between biochemical activity and behavior.

Before I begin to talk about the needs in the field of research, I would like to mention in passing two additional important developments which I believe are directly attributable to congressional support of mental health work. One is the great interest in the whole field of aging in the United States today. One meets this interest at every turn in the practice of medicine and in the community, in the medical societies and in all types of local civic organizations and other groups that are preparing for the White House Conference on Aging next year. A great deal of the interest and enthusiasm for activity in this very important field can be directly related to funds made available by Congress and to the work of the National Institute of Mental Health on mental health of the elderly. The Congress also should not be hesitant in taking credit for the fact that they were willing to appropriate money through the National Institute of Mental Health to tackle the very difficult problem of juvenile delinquency. Congress was not content to sit and wring its hands like Cassandra. Instead, you felt that something could be done and started planning for necessary activities in this field. And though it is only in its early stages, I can see from the energetic approach that the investigators are taking that something will be done about juvenile delinquency, which at present is a disheartening blot upon our escutcheon, not only for now but for what it portends in the future.

I would like to talk briefly about research. As a member of the National Advisory Mental Health Council, I have had the opportunity to go over a great many of the projects which are now being supported by mental health research grants. As a taxpayer I am just as jealous of the public funds spent for this or any other purpose as is the next person. I would like you to know that these projects are all given the most rigid scrutiny by very competent boards of review. A great deal of very, very important work is being supported by research grants and we are beginning to amass a great deal of knowledge. How-

ever, much more support is needed. We just do not have sufficient funds to support all of the excellent applications now being received. If we merely payed all the grants that were approved last year we would exhaust this year's funds and not be able to support any new projects. I have seen many instances where projects were approved, applicants were notified that their projects had been approved, and then we just did not have the funds to cover them. This is particularly serious in view of the potentialities for advancement. We have made very rapid strides in mental health research during the past 10 to 15 years. The whole field of psychopharmacology has developed during this period, a field which has had far-reaching effects in terms of treatment of patients and in providing tools for research. I will not burden you with all of the technical details about research in neurophysiology, new knowledge about the structure and function of the brain and central nervous system, new findings in the fields of biochemistry and neurophysiological correlates of behavior. You have heard all of these details from the witnesses who have preceded me. Suffice it to say that both in the extramural grant program and in the intramural research programs conducted by the National Institute of Mental Health there are many, many fascinating leads, many exciting beginnings which must be pursued. The whole field of mental health research is like a vast glacier which has begun to thaw and has started moving, which must not be allowed to freeze up again for lack of necessary funds. Instead, we must try to get this glacier moving even faster.

During the past decade, there has been a veritable revolution in the quality and amount of care given to mental patients. This field of patient care is one in which I can really discourse at length. I would like to assure you gentlemen that you have no idea of how much can be done for the mental patient today. The change that has taken place in the last 10 or 12 years has been tremendous. I am not leaning too heavily upon the opening of many institutions alone but also upon the opening up of more parts of closed-type institutions. Of course, some people are so sick that, temporarily, they need the protection of a closed corridor during the acute phase of their illness. However, the idea should be to get them out of the closed ward as soon as possible. New treatments and new hospital procedures have been inaugurated, and great stress is placed on making the hospital a therapeutic environment. Mental hospitals have improved so much that today the disturbed ward in a first-class institution looks as good as the convalescent ward used to look. Undoubtedly a great part of the reason for this great change is the advent of the tranquilizing agents. This whole field of psychopharmacology has been or will be ably discussed by witnesses who either have or will appear before you. I would like my testimony on this subject to rest on what they have said but I do want to add the following: This is one of the most exciting things that has happened in the field of mental health. After World War II we settled down to the feeling that drugs and chemistry had nothing further to add to this field, and then there was this tremendous explosion. The discovery of these new drugs, which have untold value for treating patients, has put remarkable therapeutic tools in the hands of doctors everywhere. And one of the most important things about these drugs is that they have given the doctors hope. I cannot stress too much the importance of a hopeful attitude on the part of the doctor in encouraging improvement on the part of the patient. If the doctor is hopeless the patient knows it, he feels that he will never get well, and he doesn't. If the doctor has hope that the patient can recover, this enthusiasm is communicated to the patient and it almost invariably results in improvement. There is no doubt of the great value of these adjuncts in the treatment of mental illness.

These drugs are used at my own institution constantly and judiciously, and they are of the greatest assistance. Those of us who have been around mental hospitals for the past 30 years can see the great difference they have helped bring about. We are now able to control a person in the throes of an attack of mania without the great danger to his health and to the welfare of others that used to be the rule. Also we can help to preserve the great dignity of the human being and spare him the humiliation which these illnesses used to bring with them or in their wake.

But all of these important developments—new treatment methods, a therapeutic environment, an open-type hospital, etc.—can only be applied in institutions which have sufficient personnel. Given sufficient personnel and funds, there is a wealth of things we are already able to do for the patient. I will not burden you with details about night hospitals, day hospitals, halfway houses, convalescent care

and aftercare treatment plans, sheltered workshops, and other rehabilitation techniques; you already know about them. I can assure you, though, that all of these things do work if we have the money and the people to put them into effect. All of them mean fewer patients going into the mental hospitals there to regress, and more patients getting out into the community faster than ever before.

There is great need for encouraging all of these new developments in rehabilitation of the mentally ill, in the integration of community and hospitals facilities, in improved methods of treating mental patients both in and out of the hospital, in providing emergency psychiatric care, and so on. The mental health project grants that have been made possible under title V of Public Law 911 have encompassed some very remarkable things. They provide invaluable help in improving hospital care and treatment. They support the trial and development of new community programs which emphasize prevention and early detection of mental illness. Project grants support demonstrations aimed at better use of existing facilities and the creation of more effective alternatives to hospitalization—for example, bringing psychiatric care to underdeveloped areas, initiating emergency psychiatric service programs, providing outpatient treatment for former hospital patients, establishing and expanding day and night hospitals, setting up small units in mental hospitals where the environment can be more therapeutic. One application that I know about has to do with treating psychotic children of preschool age. Though the number of such children is not very great, the distress they cause their parents and other children is very, very great indeed. Instead of wringing our hands about this problem and lamenting the tragedy of it, we now try to treat these children. A number of them are eventually able to join other children in regular classes. In any case we are not just writing them off. There are all sorts of possibilities for important work under this title V grants and I would urge you to give it greater support.

Another area that needs increased support is the whole field of community mental health. Many States still lack basic mental health facilities. Of the 1,300 psychiatric clinics in the United States, 50 percent are in northeastern cities, and 67 percent in cities over 50,000 population. Many broad areas of the country have no clinics at all and no ready access to psychiatric treatment. We need 3,500 full-time clinics if we are to reach our goal of one clinic for every 50,000 people in the United States. Some of the poorer States need funds to set mental health programs going. They need increased technical assistance. The National Institute of Mental Health is doing an excellent job in providing States with the consultation they need to develop effective community programs, and these I would remind you, are the programs which stress early detection and prevention of mental illness. Some very important things are beginning to take place in this field. States are beginning to develop mental health programs in the schools, residential treatment centers for emotionally disturbed children, and programs in the field of alcoholism, aging, juvenile delinquency. All of these State-controlled programs need continued and increased support.

Another extremely important area that needs attention is the field of rehabilitation of the mentally ill. I have spoken to you about this before. This is a matter which has a very tragic aspect. It does the patient no good to get well in the hospital, if his family and the community are not willing to accept him. It is still an unfortunate fact that many employers are unwilling to hire former mental patients. Funds are needed to acquaint people throughout the country with the abilities of former mental patients. We need to launch a broad program as was done in the case of physically handicapped people and which has produced such wonderful results. We need to get across to the public the knowledge that mental illness is not an all-or-none affair. The symptoms do not last forever. As a matter of fact, every one of us has had some symptoms of emotional distress at one time or another. The public must be made to realize that it is absolutely not true that "Once mentally ill, always mentally ill." Much more needs to be done by rehabilitation personnel in placing former patients in productive occupations. I would also urge that a great deal more be done to acquaint the public with the facts about mental illness in order to create a favorable community climate in which the final rehabilitation of the patient can proceed at a rapid rate. The National Institute of Mental Health, mental health volunteers, and many types of citizen's organizations are disseminating information about mental health and mental illness, and are conducting public education programs. These activities have helped to

correct many of the misunderstandings, but much more needs to be done. Especially with the current emphasis on rehabilitation and on treatment in the community, there is greater need for community acceptance of the mentally ill, for jobs for recovered patients, and for tolerance of former patients during their convalescent period.

In summary, I urge increased support for these tremendously important mental health programs. The recommendation in the field of research is for a total of $36.8 million for grant-supported activities. This covers the regular research grants as well as grants in psychopharmacology and title V grants. I would also urge serious consideration for an increase in the amount allocated for research fellowships. I think we could well use close to $3 million for this purpose. I respectfully urge your very favorable consideration of sizable increases for training activities. The total being recommended by the citizen's group for this purpose is $46 million of which $16 million is for a nonrecurring item to adjust project period dates. I also urge that you give favorable consideration to increasing the amount appropriated for State control programs to a total of $6 million. The good that can be done with these funds is tremendous. This would bring the total appropriation for grant-supported activities to $92 million. I also urge favorable consideration of moderate increases in direct operation. The intramural research program conducted by the National Institute of Mental Health offers one of the greatest opportunities in this country today to make noteworthy advances. This activity should be well supported. Review and approval of grants is a mammoth task and a very important one. This work must be done very carefully in order to insure the success of the research and other grants programs. The training and the professional and technical assistance activities conducted by the National Institute of Mental Health staff are likewise extremely important, both in terms of community mental health programs and the total psychopharmacology program. I strongly urge that you give very favorable consideration to the proposal set forth by the citizen's group for a total appropriation of approximately $105 million for NIMH for fiscal year 1961.

Before I conclude, gentlemen, there is one further matter that I would like to discuss. It is a problem which disturbs me quite considerably, to which I would like the Congress to give its careful attention. This is the matter of the inadequate quarters, the almost impossible working conditions under which the staff of the NIMH has to operate. Shortage of space has been a problem for some time. Now I understand that a new building is in process of construction. However, as far as I can see, it probably will not be large enough to house three-quarters of the people now on hand, let alone any additional staff that may have to be employed to take care of further program expansions. I am not, of course, familiar with the details of the construction now going on, and no one has told me about it. However, from what I have been able to observe, I am afraid that it will not even be possible to bring back the people from Silver Spring to Bethesda. This works a considerable hardship. With the various program elements separated from one another, it is very difficult to plan and carry out an integrated program. Much very valuable time is lost, there is unnecessary waste motion, and it really is most unfortunate that such a vital program should be hampered because of lack of adequate office space for personnel. If the laborer is worthy of his hire, he is also worthy of fit surroundings in which to do his work. I hope that Congress will consider this whole problem favorably and take needed action.

Three years ago I appeared before you and asked that you stay with us for another decade. Perhaps I was a little foolhardy at that time in predicting that some wonderful things would happen in science in general, and in psychiatry in particular during the next 10 years. I would like to reiterate that request. Having gotten us well started, don't leave us now. Don't withdraw your support. Keep the program going at the levels it needs. The work that is being done with your help holds out great hope for the mentally ill and, indeed, for all people—hope for the welfare and dignity of sick people and hope that we can ultimately prevent many mental and emotional illnesses.

Mr. FOGARTY. Are you in favor of the citizens' budget?

Dr. BRACELAND. Yes, sir; very strongly.

Mr. FOGARTY. Why do you suppose the administration and the Bureau of the Budget held down the budget in this area the way it did this year?

Dr. BRACELAND. Mr. Fogarty, I wish I knew, sir; I do not know. I am not a popular man with the Bureau of the Budget, and anything I say does not hold much weight; but I do not know.

Mr. FOGARTY. I do not think I am, either, Doctor. That does not stop me from finding fault with them once in a while.

Dr. BRACELAND. I do not know. My colleagues, Dr. Ewalt and Mr. Judd, can tell you this is certainly money which will pay off in the long run. It is much better to pay it in preventive measures than to pay for keeping hordes of people in distressed conditions in mental hospitals.

I do not know why. It is shortsightedness. It is a form of philosophy, really, which is hard to understand.

Mr. FOGARTY. Just based upon the economics of it—they are interested in economics and balacing the budget—I have noted in the past that if you spend a few more dollars on research, especially in this area, you get back many dollars for every dollar you spend.

Dr. BRACELAND. In 1957 there were 150,413 net releases from mental hospitals. In 1959 there were 175,727 net releases from mental hospitals. Again, economically, in addition to the heartbreak in each one of those, this is in the face of a rising population and in the face of a rising number of admissions, I think the figures in there are themselves evidence to us to really justify asking for a budget of this kind.

Mr. FOGARTY. Mr. Denton?

Mr. DENTON. No questions.

Mr. FOGARTY. Thank you, Doctor.

Dr. BRACELAND. Thank you very much for hearing me, sir.

---

MONDAY, FEBRUARY 29, 1960.

## NATIONAL INSTITUTE OF MENTAL HEALTH

### WITNESS

### DR. JACK R. EWALT, PROFESSOR OF PSYCHIATRY, HARVARD MEDICAL SCHOOL, BOSTON, MASS., REPRESENTING THE AMERICAN PSYCHIATRIC ASSOCIATION

Mr. FOGARTY. We have with us now Dr. Jack R. Ewalt representing the American Psychiatric Association. Dr. Ewalt, we shall be glad to hear from you at this time.

Dr. EWALT. I am Dr. Jack R. Ewalt, professor of psychiatry at Harvard University Medical School, and director of the Massachusetts Health Center, a research and educational institution.

My testimony will be very brief and will follow Dr. Braceland's in content. I will not repeat what he said. They have asked for a great deal of money—Dr. Braceland and the citizens' committee. When you look at my part of the budget, you will see that I thought they were rather conservative, and to be peaceful I asked for a very little bit more, but where I am the problem is really very great.

Now, in asking for a lot of money, I think first you have to ask two questions as I asked myself: Could the NIMH intelligently spend more money, and from where I sit I know the answer is "Yes; a great deal

more." I know, and can give you specific examples of projects that have been approved by their own Advisory Mental Health Council, which I think is too conservative, but even the projects that they approved could not be financed because they would not have sufficient funds in the current year. I know of trainees who wanted to be trained in psychiatry but who could not obtain stipends, both students just out of internship or general practitioners who wanted to come into the program. So, I am sure they can intelligently spend more money.

Second, in spite of the great need, can the economy stand these anticipated or immediate expenditures? We read a lot in the paper about economy and economists. I am not an economist, but I went to one. I found some statements by one who unfortunately, or fortunately, works for the Council of State Governments at times, and at times for a congressional committee. So, I picked out another economist to quote, one Rashi Fein. He made a study on the cost of mental health and mental illness. I think you have a copy of it in your office. He states:

> An economy can afford to spend whatever it desires to spend. All that is necessary in order to spend more on one thing is that we spend less on something else.

He is not talking about Government budgets. He is talking about national expenditures as a whole.

Resuming the quotation:

> We would have to give up something in the short run if expenditures on mental illness were increased. As pointed out previously, the long run situation might be far different. It is not for us to suggest the proper allocation of tax money nor is it our place to suggest what the tax rate should be. What society can spend and ultimately what society should spend depends on the value system that society holds to. It is obvious that society can spend much more on mental illness or on anything that it presently is doing. Whether or not it chooses to do so is another question.

Now, as he has pointed out, society does have to make choices, but it seems to me in looking at our total economy that society is not going to have to give up much. I hope you will not think this is disrespectful, but I read statistics by the hour because I somehow like them, and I found in the statistical abstracts of the United States some figures that I thought might be of interest. This, in excess of $100 million we are asking for, is just a little bit more than Americans spent on trips to Italy in 1957. It represents one-sixth the amount that we spent in 1957 on flower seeds and potted plants. Admittedly, that is a great industry but also admittedly perhaps, we do not need quite so much as we need some parts of health. One-tenth they spent on books, and maps, and one-fourth the reported profits—and I emphasize the reported profits—on parimutuel betting in 1957.

I merely put these figures in there not to draw any invidious comparisons, but to remind you of the really vast power of our economy and the fact that we are asking not for very much money.

To view these budget requests in terms of their significance, in terms of what may or may not be related problems to mental health, this request represents about $2 per student in public schools in the United States in 1957, and of course, as you well know, it is less than 10 percent of the total expenditures of the States and the Federal Government for the care of the mentally ill in any year. Industries, for the most part, spent this much or more on research.

In discussing this budget, I could use my testimony from last year almost verbatim, but I will not do so.

The President's budget for this year in general represents the same items in the same amounts for 1961 as the current program level. I pointed out at considerable length last year, and in fact, it is well known to you and, therefore, I will not repeat it now, to hold the appropriation level in a given year means a further cutback in the program because in the first place there are step rate increases for employees' salaries and there are inflationary trends in our economy, and the only new projects you could start this year would be those that happen to lapse in the current year. For this reason I have calculated that next year about one-third of the projects will be expired. Most of them give rise to new projects, and in seriousness, one ought to keep the staff and programs going and, therefore, you will have to increase it by about one-third on that basis.

I am sure that there will be at least a 30-percent increase in research projects that should be financed in the next year that will not be if you do not give them some money. I did not put them in here because I do not want to burden you with the details. For example, you have stimulated them to work a little bit in the field of mental retardation. This program is just beginning to roll, but if you do not pour some money into this, there will not be anything for it to roll with.

You are having now, once again, interest in delinquency. It just happens that it coincides with the President's White House Conference. The big emphasis on this, I believe, is going to be in the area of juvenile delinquency. These two things are going to point up the need for other projects. You will have to have money to finance these research projects and you have to give them a little money.

You are about to have a White House Conference on Aging, but there will be no funds available for further research in the aging area if some funds are not made available. Furthermore, there was and there will be requests that somehow the total cost of research being figured into these projects and various percentages are quoted which I do not approve of. I think there has to be some method whereby it is easy to figure out the total cost, but I think probably a little money ought to be appropriated for that.

Frankly, I do not know just how to come up with a figure and so I took about 30 percent, because I drew a graph of the expenditures and this is about the same it came out to.

Under "Research fellowships" I will not bother you with the details, but in general, I have asked for an increase in research fellowships. There is a new item in there that I put in and I am not sure the Citizens' Committee will or will not put it in. But, I think I persuaded them that they should, and that is you have to start setting up some type of thing to give a little more permanency and a little more stability to the research program.

I could talk at length about the problem of research personnel lacking continuity of position. These research staffs have a 3- or 5-year terminal period. So, these people get very edgy at the end and begin looking for further grants. We need to begin to build a small amount of sort of regular support of research so that you do not spend your

time on paperwork and scrounging for money. I suggest $1 million, and later, for clinical research units, $2 million.

This would, roughly, coincide, I think, with some of the recommendations I believe the Cancer and Heart people have made for regional research institutes. I had somewhat the same program in mind.

With reference to the training programs it is true that certain places in the country cannot fill residence quotas but this is usually, sir, due to something wrong with the program and if further progress goes in training teachers and whatnot, these places will get residents. A place like ours turns down dozens of young men every year. If they would go somewhere else in psychiatry, this would be good, but some of them do not. Some of them go into medicine or something else. Actually, when I got through playing with this, I came up with $93 million for operation of the program.

Then there is this forward financing, or however you want to call it, of readjusting their budget period so you can make commitments now to people coming in July, instead of waiting until July, August, or September, is from an operator's point of view very important. It may not be very important for you gentlemen, but I hope you will accept it.

We could spend a lot of time giving you examples of how this can be very important to us. It will probably take about $16 million as a one-shot operation. I actually had $16 million which I thought should be put into it, but my figure was so far off, and to my great surprise—over the Citizens' Committee figure—that I trimmed it back to $12.5 million.

I think last year you gave them money to get the psychologists, or they had enough to do this, but this I think would get most of the lower echelon psychiatric residents in this program. You would still have to pick up another $4 million or $5 million to get the advanced psychiatric echelons into the program.

Interestingly enough, when I came down here and went over to the APA offices, they handed me a report from the committee which is studying acceptable standards of psychiatric hospitals in the country. This is not really related to your work at all, but I brought a copy and will leave it with you because I thought it was directly the influence your activities in the past have had on the whole phase of American psychiatry. What has happened is that there has been so much improvement and progress made that the old standards of judging hospitals are woefully inadequate and they made no sense. The whole way of taking care of these mental illnesses, instead of these "bastile" places which there are still too many of, is beginning to change. They have to review the standards. I marked through here where research needs to be done for which there has been no provision in the planning of the NIMH budget which would be the kinds of projects that I know come up every year that I had hoped might be financed out of this 30 percent. I more or less rounded it off and put it in.

Mr. FOGARTY. This graph on the back shows the President's budget and the present budget; does it not?

Dr. EWALT. Yes, sir.

Mr. FOGARTY. It shows that the President's budget is down below the present one.

Dr. EWALT. Just a little bit, sir—a few hundred thousand dollars. The present operating program in 1960 is $67,956,000 and the President's is $67,563,000.

Mr. FOGARTY. If you took into consideration the increased costs it would be less than that.

Dr. EWALT. Then, it is really away below.

Mr. FOGARTY. What is this APA? Is that the American Psychiatric Association?

Dr. EWALT. Yes, sir; that is Dr. Braceland and I, and I will have to apologize because——

Mr. FOGARTY. Their budget is considerably higher than the Council's budget?

Dr. EWALT. This is the National Advisory Mental Health Council. In the first place, they made this, I think about 9 months ago and, in the second place, with all due respect to them there are a great many of them that are research people but do not have a very good concept of budgeting cost of operation of additional programs. They are there because they know research design and different areas of research. They may be a bunch of conservative people or not. I do not know, but the American Psychiatric Association does not see how you could operate a budget that they recommend except if you look closely and took out the recommendations that I had made with reference to this business for the full-time research positions and this business for clinical research units or $3 million, and took out the $12 million for Federal financing, neither one of which they had. We would not be too far apart then. I think the other difference is principally in the research and fellowship grants.

Mr. FOGARTY. Did you make any suggestion to the Secretary of the Department of Health, Education, and Welfare?

Dr. EWALT. Sir, I do not believe I am one of his confidants, or consultants. No, sir; I did not. He did not ask me. I have made recommendations to Dr. Felix.

Mr. FOGARTY. What did he say?

Dr. EWALT. He said "What can we do?"

Mr. FOGARTY. They at the Institute of Mental Health, have to do what he tells them?

Dr. EWALT. Well, I have operated State institutions for a long time in Massachusetts, and you make your request and then the Governor tells you what you can request. Then you go to the Ways and Means Committee and hope they will ask you "What did you ask for?" and then, of course, the lid is off, but up until that point you cannot say anything.

Mr. FOGARTY. I gave Dr. Felix every opportunity. I asked him 10 times, I guess, what he asked for, and what he needed to do a good job.

Dr. EWALT. Well, maybe somebody is standing behind him.

Mr. FOGARTY. I think sometimes they are under strict orders, more so than the people in the various States.

Dr. EWALT. Maybe they think they may have more to lose than we have.

Mr. FOGARTY. Do you have any questions, Mr. Denton?

Mr. DENTON. I was interested in your figures comparing the money spent for research in this field with the money we spend for books and maps and flower seed, and potted plants, and the reported profits from parimutuel operations.

One thing I never could understand is why some people holler "balance the budget" so loud and long in matters of this kind, but when it comes to raising the interest on our national debt, they are not a bit concerned. Of course, the interest on the national debt has increased more in the last 7 years than this entire budget of the Department of Health, Education, and Welfare.

Dr. EWALT. Yes, sir.

Mr. DENTON. I am not against foreign aid, but those same people do not seem to be a bit worried about the waste and extravagance in that program, which would support the research in this program many times over.

Dr. EWALT. Yes, sir.

Mr. DENTON. And those same people do not worry about the waste and extravagance in procurement and storage policies which would run the whole research program many times over. But they get very concerned about the expenditures for a program of this kind.

Dr. EWALT. Yes, sir.

Mr. DENTON. I do not know why it is these so-called economists always hit these programs that benefit so many people, but those that benefit a few, they do not worry about them.

Dr. EWALT. I think some of the economists do, but the ones who get quoted by at least the current administration are the ones that do this other. I would agree with you. I do not know enough detail of the operations of the other Federal agencies to say that, and I am certainly not suggesting that another one be cut in order to benefit this one. My thought is that we are a wealthy country and if we can do all these things—we obviously are a wealthy country—we certainly can support a small amount of money to improve the health and welfare of our citizens. I would not hesitate to ask you for $500 million, except we could not spend $500 million intelligently this year.

I think we could spend about $110 million, but I am not going to stand all by myself on this.

Mr. DENTON. That is all.

Mr. FOGARTY. Is there anything else you would like to say, Dr. Ewalt?

Dr. EWALT. No, sir; except they need money, and I just do not see how this administration figure can be given anything other than the casual respect it is due. But, to be taken seriously as a way of operating an institute, I do not believe it, and I do not care who says otherwise.

Mr. FOGARTY. They have had several news conferences saying to the general public, "We are still advancing, and we are going to increase the spending on research in all these areas." The general public has been led to believe that this budget, that is presented by the present administration, is one of progress.

Dr. EWALT. Dr. Braceland and I help to represent the general public, and Mr. Judd will tell you about the position of the National Association for Mental Health, and I believe Mr. Gorman represented different citizens' groups, and we are not very far apart on our figures

in this area. If you can get any one of them to say that the President's budget is enough to intelligently operate the Institute of Mental Health, I will come back here and apologize to you.

I think they will be wrong.

Mr. FOGARTY. Thank you, Doctor.

Dr. EWALT. Mr. Chairman, I would like to offer for the record at this time my prepared statement.

Mr. FOGARTY. Without objection, it will be inserted in the record at this point.

(The statement referred to follows:)

TESTIMONY OF DR. JACK R. EWALT

The gentlemen who testified before me have asked for a large increase in the budget of the National Institute of Mental Health. In my opinion the increases requested are, if anything, on the conservative side, but before discussing the specific amounts I would like to make some general comments.

In increasing funds for an organization one must sincerely ask two questions. First, can the agency intelligently spend the increased funds requested? The answer to this is certainly in the affirmative. Through the wisdom of the Congress and the administrative effectiveness of the National Institute of Mental Health, great programs in research and training are going forward in the Nation. While one despairs of ever entirely catching up with the need, at least we have made great strides in this direction, and it would be shameful indeed if we allowed the momentum to decrease. I personally know of projects approved by the council that could not be financed in this year. I know of suitable candidates for training in psychiatry who could not obtain a stipend. Second, in spite of the great need, can our economy stand these increased expenditures? Not being an economist, I find it more comfortable to quote one.[1] "An economy can afford to spend whatever it desires to spend. All that is necessary in order to spend more on one thing is that we spend less on something else. We would have to give up something (in the short run) if expenditures on mental illness were increased. (As pointed out previously, the longrun situation might be far different.) It is not for us to suggest the proper allocation of tax money nor is it our place to suggest what the tax rate should be. What society can spend (and ultimately what society should spend) depends on the value system that society holds to. It is obvious that society can spend much more on mental illness (or on anything) than it presently is doing. Whether or not it chooses to do so is another question."

As Dr. Fein has pointed out, society must make many choices. However, one feels that perhaps the choice here is not too difficult. The total amount suggested here, in excess of $100 million, is just a little more than U.S. citizens spent in travel to one European country (Italy) in 1957, and represents only one-sixth the amount we spent on flower seeds and potted plants, one-tenth that spent on books and maps, and one-fourth the reported profits on parimutuel betting in 1957.[2]

To view these budget requests in terms of their significance in terms of what may or may not be related problems—this budget represents about $2 per student in public schools in the United States in 1957; it represents less than 10 percent of the total expenditures of the State and the Federal Governments for the care of the mentally ill in a year.[2]

BUDGET RECOMMENDATIONS

In discussing the budget recommendations I could use my testimony from last year almost verbatim but I will not do so. The President's budget of this year in general represents the same items in the same amounts for 1961 as the current program level. I pointed out at considerable length last year a fact well known to all of you—to hold the appropriations at the same level means a general cutback in the operation of research projects because of the step-rate increases for

[1] Economics in Mental Illness. Rashi Fein, Basic Books, 1958, p. 137.
[2] Statistical Abstract of the United States. U.S. Department of Commerce, 1959.

employee salaries, the present inflationary trends in our economy, and no new projects could be started except as substitutes for those from which support is withdrawn.

RESEARCH

I have calculated for the research projects that approximately one-third of the budgets would be expiring this year on their current programs, and to continue would require an increase in the appropriation by 33 percent. A further increase of 30 percent is indicated to provide for expansion beyond that presumably planned.

RESEARCH FELLOWSHIPS

We have recommended approximately a million dollar increase in research fellowships. This, I believe, is a minimum figure. I have recommended a million dollars for providing full-time research personnel. I could talk at length about the problem of research personnel lacking continuity of position. I believe a few key places must receive some subsidy for full-time, tenure, research people. This program should be initiated with about a million dollars per year, while the staff of the Institute explores this area.

TRAINING PROGRAMS

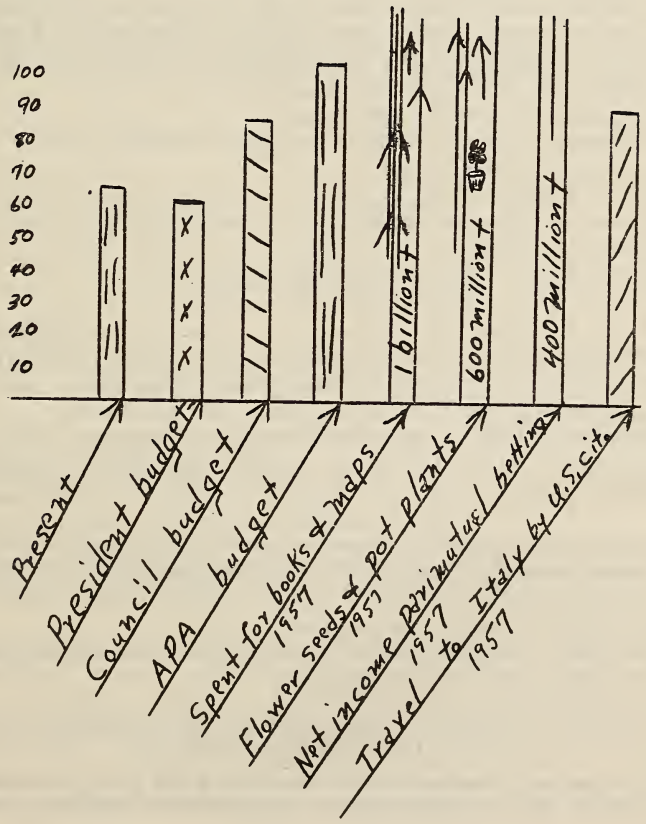
The regular program has been increased by about 30 percent. Intensified training programs, the need for revision upward of stipends, makes this 30-percent increase a minimum increase to carry out the needed program. The general practitioner program has been expanded by $2,200,000 in this recommendation. I am confident that this can be constructively spent. The program instituted by this committee some several years ago has already begun to pay dividends. Training programs for people in psychopharmacology is just getting underway and I recommend an appropriation of $1,200,000. One item of $12,150,000 will enable the Institutes of Health to make training grant allocation approximately 9 months in advance. This is an essential feature in appointing trainees. Physicians apply for training for July 1961, in August and September of 1960. Appointments are usually made in that time, but under the Federal grant it is impossible to make a specific commitment until after Congress acts. This would merely roll the dates forward so that moneys appropriated this year would actually, after a couple of years' adjustment, be used to award stipends to grantees coming in July 1, 1962, instead of 1961. If in some year Congress reduced or abolished training stipends, the Institutions would not be embarrassed by having persons there without funds to pay them, nor would they be required to make pious hope commitments to persons during the previous October in anticipation of obtaining Federal funds. Because of the urgent need for training people in this area, the fact is obvious that we should not discourage applications.

My total recommendations come to $106,330,000. This includes $93,180,000 for operation of the program and $12,150,000 for adjusting the time of payment of training stipends without slowing the training. This is substantially above the $67 million represented by the President but, in my opinion, is a much more realistic schedule of expenditures for the Institutes of Health.

*Grants*

[In thousands]

| Research projects | 1960 program | Recommended by President 1961 | Organization recommendation 1961 |
|---|---|---|---|
| Regular programs | $12,682 | $14,660 | $20,486 |
| Psychopharmacology | 6,500 | 7,200 | 10,300 |
| Clinical research units | 500 | 500 | 2,000 |
| Title V | 3,800 | 4,300 | 6,500 |
| Total research grants | 23,482 | 26,690 | 39,286 |
| Research fellowships | 1,996 | 1,996 | 2,994 |
| Full time research positions | 0 | 0 | 1,000 |
| Training: | | | |
| Regular programs | 18,832 | 18,832 | 24,481 |
| General practitioners | 2,300 | 2,300 | 4,500 |
| Psychopharmacology | 300 | 300 | 1,200 |
| Interdisciplinary training (Biol. and S.S.) | 924 | 924 | 1,848 |
| Adjustment of dates | 3,850 | 0 | 12,150 |
| Total training | 26,206 | 22,356 | 48,179 |
| State control | 5,000 | 5,000 | 6,000 |
| Total grants | 56,684 | 56,042 | 100,459 |
| Direct operation of NIMH | 11,281 | 11,521 | 12,781 |
| Grand total | 67,965 | 67,563 | 106,330,000 |



MONDAY, FEBRUARY 29, 1960.

NATIONAL INSTITUTE OF MENTAL HEALTH

WITNESS

STUART E. JUDD, PRESIDENT, MATTATUCK MANUFACTURING CO., WATERBURY, CONN., REPRESENTING THE NATIONAL ASSOCIATION FOR MENTAL HEALTH

Mr. FOGARTY. We shall hear now from Mr. Stuart E. Judd representing the National Association for Mental Health.

Mr. Judd, will you please proceed?

This is your first appearance before this committee, is it not?

Mr. JUDD. That is correct.

Mr. FOGARTY. Will you please tell us who you are, and what your background is?

Mr. JUDD. I would like to identify myself, sir. I am Stuart E. Judd of Waterbury, Conn., and I am the owner and president of the Mattatuck Manufacturing Co., which operates a 315-employee plant making automobile parts and bicycle coaster brakes. I am chairman of the Board of Trustees of the Undercliff Mental Hospital in Meriden, Conn., and president of the Waterbury Mental Health Association; member of the finance committee of the Connecticut Association for Mental Health and a member of the Board of Governors of Menninger Association of Kansas, and I am chairman of the Board of the National Association for Mental Health.

Mr. FOGARTY. You really get around.

How is that training school for boys up at Meriden, Conn.?

Do you know where that is?

Mr. JUDD. Yes, sir; I do.

Mr. FOGARTY. I helped build that in 1931, or helped build some of the additional buildings.

Mr. JUDD. Yes. They have a lot of boys there.

Mr. FOGARTY. You may proceed, Mr. Judd.

Mr. JUDD. I appear before today as representative of the National Association for Mental Health and I speak officially in behalf of some of the 800 affiliate mental health associations in 43 states, and the voluntary and enrolled membership of more than 1 million.

I further would like to feel that I speak in the name of hundreds of thousands of ill individuals in our mental hospitals and communities who because of their mental incapacity are unable to speak for themselves.

I have prepared a full statement representing the position of the National Association for Mental Health with regard to the budgetary appropritaions for the NIMH. This, with your permission, I will submit for full inclusion in the record.

Mr. FOGARTY. All right; we will put it in the record at this point.

(The statement referred to follows:)

TESTIMONY BY STUART E. JUDD, CHAIRMAN OF THE BOARD, NATIONAL ASSOCIATION FOR MENTAL HEALTH

Mr. Chairman and members of the committee, I am giving testimony before your committee today as representative of the National Association for Mental

Health, the national voluntary citizens organization dedicated to the conquest of mental illness and the advancement of the Nation's mental health. I speak officially in behalf of some 800 affiliated mental health associations in 43 States, and in behalf of an enrolled membership and volunteer corps of more than a million.

While the millions of Americans suffering from incapacitating mental disorders—in the mental hospitals and out—have not charged my organization to speak in their behalf, it is fundamentally in their interest that my organization functions, and it is therefore, in their behalf, too, that I speak.

May I say at the outset, that my organization applauds the great contribution made by the National Institute of Mental Health in the fight against mental illness, and credits it directly with having initiated many of the improvements which have taken place during the past 10 years. We have endorsed each year the increased budgetary appropriations made by Congress for this agency's program. And we recommend now that the National Institute of Mental Health be granted an appropriation of $104,857,000 for its program requirements for 1961.

We make this proposal after a review of the 1961 budget recommendation of the National Advisory Mental Health Council, a recommendation calling for a total appropriation of $90 million. The substantial difference between our recommendation and that of the Council, lies in the item for adjustment of project period dates. This item I will discuss in greater detail later on in my statement. I will now speak with reference to the budgetary items which are of greatest concern to my organization.

RESEARCH

The item in the budget of the National Institute of Mental Health which has shown greatest growth over the years is the item for support of research projects. And this is justly so, for it is on the research front that most of the important victories will be won in the Nation's fight against mental illness. It is in research that we will find the decisive answers concerning the nature of the scores of different mental illnesses and their effective treatment and control: as to the causes of these illnesses and their prevention; as to the effects of these illnesses and the methods of rehabilitation of their victims; as to the essential psychological ingredients for good mental health and the methods for their acquisition.

As Congress continues to grant increasingly larger sums of money for research, year after year, it should gain great gratification from the progress which has been made in psychiatric research in just the past few years. It must be remembered that psychiatric research is a young science and that, as an organized discipline, it did not begin to make itself known and felt until about 20 years ago. In fact, I am told by research scientists that more research progress in the field of mental illness has been made in the past 15 years than in all the preceding centuries.

The immediate effects of this research are beginning to make themselves felt in the way that means most to us, and that is in the relief and the recovery of the victims of mental illness. We know, for example, that today, patients suffering from some of the psychoses, have a 60- to 75-percent chance of partial or total recovery. Twenty years ago, the chances of partial or total recovery were only between 35 and 45 percent.

The difference, we are told by our professional people, may be attributed to the discovery of new treatment methods, and the refinement of old ones—developments coming out of the research laboratories.

They may be attributed also to administrative changes, and changes of the role of treatment personnel, changes in views as to practical goals of treatment; changes in the physical aspects of the mental hospitals and of mental hospital life.

The new insights and the new knowledge which stimulated these changes and which were instrumental in bringing them about, did not spring full blown out of the head of any one man or any number of men. They came out of laborious, painstaking, careful, controlled research in the laboratories, in the universities, and medical schools, and in the hopsitals and clinics.

And so we observe that the first investments in research in this field have already begun to pay handsome dividends in terms of human lives saved and dollars saved—in terms of the tens of thousands of human beings who have already been rescued from the tortures of mental illness, and in terms of the

hundreds of millions of dollars already saved in hospitalization costs. A mental hospital patient who does not recover costs the taxpayer about $20,000 for care and maintenance during the course of his illness. Every patient discharged as a result of short-term, intensive treatment, represents a savings of part or all of the $20,000, depending upon how lasting the recovery is. An increase in the recovery and discharge of just 1,000 patients—out of a total of 750,000—could mean a savings of up to $20 million. The figures become particularly impressive when we take cognizance of the fact that during the past 4 years mental hospital discharges have risen sharply—increasing each year by about 10,000.

The introduction of the tranquilizing and antidepressant drugs in the treatment of mental illness, the improvement in individual psychotherapy, and the development of other psychotherapeutic methods such as group therapy, and psychodrama; the introduction of completely new trends in the treatment of severe mental illness as in the day hospitals and night hospitals, and in the psychiatric wards of general hospitals; in the development of multipurpose outpatient clinics as diagnostic centers and centers for treatment of a wide range of emotional and mental disorders, utilizing, in some cases, intensive treatment methods heretofore used only in the traditional mental hospital setting; the emergence of the general practitioner as a first line of defense in the prevention of mental disorder; the emergence of the open hospital concept, and of its resulting benefits—all of these developments came about and were put into use only after trying and testing and experimenting—only after careful research.

With all of these developments, however, we cannot say that psychiatric research has even begun to approach the level of understanding of the causes of the mental and emotional disorders that would be comparable to the discovery of the bacterial cause of physical illnesses. It is also true that existing methods of treating the mental illnesses are still far from a stage comparable to that reached with the introduction of antibiotics or insulin in the treatment of infectious and metabolic diseases. Nor has science yet been able to devise methods of prevention that could compare to those used in preventing smallpox or vitamin deficiency.

Nevertheless, research scientists working in projects financed by NIMH grants, in concert with others, are now building a solid foundation out of which such discoveries can be made.

This, gentlemen, is a very far cry from the situation 25 or even 15 years ago. Certainly no one need ever again refer to mental illness as hopeless—and certainly the outlook for those suffering from mental illness is today incomparably brighter than it was for those stricken 15 or 25 years ago.

But, a built-in characteristic of research development in any field, is that the further it progresses the more it costs, and the cost rises not by additional even increments, but in a sharply rising curve. This is inevitable.

I would like to elaborate briefly on this point. Being a layman, I would feel very uncomfortable resorting to an explanation based on technical and professional data. I know that our good friends, Drs. Braceland and Ewalt, appearing here for the American Psychiatric Association will represent the profession quite eloquently. However, the psychiatrists in my own organization have told me that it will be perfectly safe for me to resort to illustrations having to do with such easy-to-handle concepts as sugar, orange juice, and coffee.

When research is in the stages where it has only crude techniques and instruments to work with, the cost will obviously be low. But as soon as these techniques and measures become improved and refined—the more dependable and reliable they become—and in any good research program this progress is inevitable—then the more costly will the research become. We have as an illustration, a particular research project investigating the way in which schizophrenic patients mobilize energy in stress situations, and the manner in which the body utilizes sugar to create this energy. Heretofore, the manner and extent of utilization of sugar by the body could be measured only crudely—through interaction with other chemicals. Recently, however, through the use of tagged atoms—atoms of sugar made radioactive—it has become possible to make infinitely finer measurements, and to trace the sugar atoms right through the entire process. The chemicals used in these tests in the past might have cost a few dollars. A teaspoon of radioactive sugar costs $10,000.

And concomitantly, increased reliability in methods demands more highly trained researchers, and many more of them.

Also, in the early stages of research, it is not too difficult to pose crude questions and get crude and not altogether useful answers. But the minute we start getting down to real cases, then the research process increases in complexity, requiring a hundred fine, sharp answers instead of one crude one.

This has been pointedly illustrated in a particular line of investigation having to do with body chemistry in mental illness. There have been a number of studies which appeared to show the presence, in the body fluids of schizophrenic patients, of some chemical substances which were absent in the body fluids of normal patients; or the presence in much higher degree, or much lower degree of substances found in normal quantities in the bloodstream of normal people. Two of these studies led to some very exciting speculation about the meaning of these discoveries, until further research showed that the differences were caused, in one research project, by the amount of coffee consumed, and in another project, by the amount of orange juice consumed by the subjects under investigation.

It became apparent, therefore, that in further studies, these irrelevant factors or variables had to be ruled out—or controlled. In an exact research study, it is mandatory that all irrelevant variables be ruled out or controlled, and this complicates the research immeasurably, making it much more costly to execute. Thus, another inevitable gain in research method—the elimination or control of variables—results in another inevitable rise in expense.

Also, every research scientists is very painfully conscious of the fact that every new discovery he makes will require checking and rechecking by 2, or 5, or 10 other research investigators in their own research projects. Thus we find still another, inevitable, built-in rise in expenses going along with progress in research.

Finally—in connection with this point, it is quite obvious that there is no value whatever in making useful discoveries in the research laboratories if we do not have well-equipped, well-organized, well-staffed treatment centers and preventive services to put these findings into use * * *. This point I will touch on later, in connection with the budget items on training and community services.

### REGULAR RESEARCH PROGRAMS

Thus, as the regular research projects financed by NIMH grants continue to push back the frontiers, to make new discoveries, to provide new clues as to the causes of the many different mental illnesses, as to the interaction between the physiological and psychological factors in mental illness; as they continue to test and to provide the treatment centers with new treatment tools—we will have to expect that the number of worthy research projects will multiply rapidly, and that additional hundreds of applications will be made to the NIMH for financial support.

It is, therefore, urgent that increased funds be made available to the NIMH so that it can meet these increased demands, and it is our recommendation that $18,340,000 be appropirated for grants in the regular research program, instead of the $14,660,000 proposed in the President's budget.

### PSYCHOPHARMACOLOGY

The NIMH research program in psychopharmacology has been in existence only 3 years, but it is already beginning to provide some positive answers concerning the effectiveness of the tranquilizing and the antidepressant drugs, as to the relative merits of a number of different groups of drugs in these two large classifications, and of individual drugs within each subgroup. Already, partial answers are beginning to emerge to such questions as—Are these drugs as effective as it is claimed? Some of them? Which ones? Are any of them harmful? Can the side effects of some of these drugs be eliminated and if so, how? Do these drugs do the job best by themselves, or in concert with other treatment methods such as psychotherapy; shock-therapy? Do patients need to continue to stay on drugs after leaving the hospital? If so, how long? Which drugs are most effective in preventing relapse? Are these drugs useful in treating neurotic patients on an outpatient basis?

A number of different projects supported under this program are also developing early clinical screening of new chemical compounds about which too little, thus far, is known to warrant extensive study. Many of these drugs are also being studied preclinically with normal patients in order to reveal special properties which might make them useful in treatment.

We are all mindful of the sweeping changes which have developed in the treatment of the hospitalized mentally ill as a result of the introduction of chemotherapy, and we are mindful, too, of the extent to which chemotherapy is a factor in the treatment of less severe mental and emotional upsets and disorders in the general population. A substantial incraese in the funds appropriated for this program is, in our opinion, highly justified and we would therefore strongly recommend an increase in this item from $6,500,000 to $8,500,000.

TITLE V

The title of the next research program I am going to discuss—title V—has an air of mystery, excitement, and adventure about it. It gives one a sense of exploration and discovery—and this, I have found—is to a large extent what this particular research program is about. Its aim is to encourage and support projects which test new methods of treating the different mental illnesses, and of dealing with them on a practical, rather than a theoretical level—not only in the treatment centers but in the course of daily life in the community. It is what might be called action research, and there is one phase of it that is of particular interest to my organization—the phase having to do with the development of preventive and rehabilitative services in the community. This is the area in which our 800 affiliated organizations carry on most of their activity, and in which they contribute their major efforts.

We are especially interested in the emphasis being given in this program to the critical social problem areas of the aging, alcoholism, and delinquency.

It is one thing to express grave concern about the problems of the aging and of their need for reintegration into the mainstream of our social and economical life. It is another to give support to projects which are attempting to find out how this can be done—how hundreds of thousands of aged people can be saved from the corrosive mental and emotional disturbances arising out of their current plight. The mental health projects program—the title V program, that is—is to be applauded for supporting this line of exploration.

In the same vein, we might comment that while others are beating their breasts about the mounting problem of juvenile delinquency, the title V program has essayed to support probing research programs into the causes and into practical measures of correcting this grave problem in the communities. Hopefully, a new approach, from a different direction, will provide some fruitful and constructive answers toward the prevention and control of juvenile delinquency than have been provided so far.

Another area in which new research is very much needed is in the area of alcoholism * * *. There is a growing recognition that alcoholism will be brought under control only when it is placed within a broader mental and public health framework. This is the emphasis governing the selection of research projects on alcoholism and it is our hope that this new approach will enable research science to break out of the many dead ends into which it has been led in its study of this problem.

We are very much impressed, too, by the fact that many of the projects under this title are concerned with matters such as emergency service in the community at time of crisis; immediate service, without waiting, in outpatient facilities; halfway houses to help the returned mental patient make an adequate readjustment to society, and society to him; psychiatric services in general hospitals; increased participation of general practitioners, nurses, social workers, and other skilled personnel in prevention, treatment, and rehabilitation programs.

Two or three projects which have caught our attention, and which are particularly worthy of note, are these: One which is attempting to learn how to bring mental health and psychiatric resources to out of the way areas; another—to determine whether mental illness is an insurable risk; and a third—which is making an on-the-spot study of would-be suicides.

The National Association for Mental Health enthusiastically endorses this research program, and recommends a $6,700,000 appropriation for this item.

In recapitulation then, we wish to express our most vigorous support of the research grants programs of the NIMH, and to recommend an appropriation of $36,890,000, for total research projects grants, an increase of $10,200,000 over the President's budget.

GRANTS FOR RESEARCH FELLOWSHIPS

New research projects hungrily consume all available trained research personnel, leaving a very serious gap unless there is a continuous flow of new, young research workers in the field. The research fellowship program of the NIMH assures such a flow—let us say, at this point it is a trickle, rather than a flow—but under any circumstances, the program assures the availability of a certain number of young, promising research scientists, who, coming in under fellowships, gain their experience through working with established and expert researchers. The competition for such young research fellows is very keen in the behavioral sciences, and programs must be made attractive and at least adequately remunerative to bring them into the relatively new field of mental health. We recommend therefore that the 1960 appropriation of $1,996,000 for the research fellowship grants be increased to $2,846,000.

GRANTS FOR TRAINING

As far back as the middle twenties, about 10 years or so after the establishment of our predecessor organization, the National Committee for Mental Hygiene, there was urgent recognition of the need for the training of a corps of specialists to work in the fields of psychiatry and mental health—the psychiatrists, psychiatric social workers, and psychologists. And so, with funds provided by the Commonwealth Fund and the Rockefeller Foundation, the national committee established training fellowships for graduate students in these three disciplines, and it was through this program that members of these three professions were siphoned into training positions in the mere handful of psychiatric clinics which just then came into being as a result of the national committee's work, and into those few hospitals that were willing and ready to accept psychiatrists in a training program.

Similarly, our predecessor organization, the National Committee for Mental Hygiene, set up in 1931, a Division of Psychiatric Training, in order to assure an increasing supply of psychiatrists and increase in the psychiatric orientation of all medical students.

Then—and some gentlemen present may remember this—for a number of years prior to 1956, our organization, represented in most instances by Dr. George S. Stevenson, came here to Congress to testify before you as to the need for a National Mental Health Act, precisely for the purpose of Government participation in a full-fledged training program, which, through training grants, would assure an adequate supply of professional people in this field.

This function, together with others, Congress willingly undertook in 1946, and the speed with which this program has developed is indicated in these figures: From 1952 through 1955, the training program remained relatively stable at about $4 million, rising to about $6 million in 1956. In 1957 there was a sharp rise in support to the $12 million level and then several sharp jumps in 1958–60 brought the level of support for the training program to a little over $22 million. Illustrative of the expanded program which this increase has permitted is the increase in trainee stipends from 850 in 1956 to about 2,650 in 1960.

Inside of 2, 3, 5 or 10 years, these trainees and the additional thousands that will come into the field as a result of grants made in the National Institute training program, will take their places in the mental hospitals and clinics, in the research laboratories, in teaching posts at medical schools, and postgraduate schools in social work and psychology, in the guidance and counseling services of schools, in the psychiatric and personnel departments of an increasing number of industrial and commercial concerns, in the courts and in the law enforcement departments, in the social welfare agencies and in the administrative and professional branches of local, State and Government agencies concerned with mental health, in the voluntary community organizations. And they will be swallowed up as quickly as they become available, and the available supply—according to the present capacity for production—will not satisfy the existing need.

Shortage of trained personnel continues to be the Achilles heel of the Nation's fight against mental illness, and according to Dr. George Albee, who has surveyed the situation for the Joint Commission on Mental Illness, the present crisis will be like the 7 fat years in Joseph's dream, in comparison to anticipated conditions 15 years from now, should present population trends continue, and should the need and the demand for psychiatric and mental health services continue at the present rate of growth.

Even today, when we are providing only one-tenth or even one-twentieth of the service which is required in treatment, prevention, rehabilitation, and education, we are already suffering from an acute shortage of professional personnel. According to minimum standards of the American Psychiatric Association for long-term care—not for intensive treatment—but for long-term care—there is only a 57-percent adequacy of physicians or a 43-percent shortage of physicians, in the Nation's mental hospitals. This means that the patients are getting a little more than half of the minimum psychiatric care required even for mere custodial care let alone intensive treatment. The estimated shortage for the other professions are as follows: psychologists, 24.3 percent; registered nurses, 76.8 percent; attendants and other nurses, 8.6 percent; psychiatric social workers, 59.7 percent. Certainly, not all the patients in the mental hospitals could profit from intensive treatment, but if intensive treatment were prescribed for all those patients who would be fairly good risks, then the statistics for inadequacy of professional staff would multiply threefold or even fourfold.

For many years, the central inspection board of the American Psychiatric Association has been conducting inspections and ratings of State mental hospitals, veterans mental hospitals and others. To date it has inspected 254 hospitals, and rated them according to certain criteria, one of the most important of which is personnel adequacy. Do you know what these inspection and rating teams have found to date? Of all the 254 hospitals inspected, only 48 merited total approval, and 72 merited conditional approval. The others were disapproved.

Again, let us take a look at the manpower situation with regard to psychiatric clinics. At the last count, there were some 1,300 psychiatric clinics in the United States. Of these, only about 650 were full-time clinics. The others gave part-time service, some as little as 1 day a month in some communities. Fifty percent of the States had fewer than 10 clinics, full or part time. We have checked with our State and local affiliates as to the reasons for the failure of clinic services to develop more rapidly, and everywhere we get the same answer: Manpower shortage. We can't get the psychiatrists. We can't get the psychologists. We can't get the social workers. State after State is adoping community mental health service acts to encourage, through financial and administrative aid, the development of local mental health services such as clinics, psychiatric services in general hospitals, and rehabilitation services. We would expect, as a result of this development that there would have been a mushrooming of such services in communities throughout the country. All that is mushrooming is the idea. The actual services themselves are coming into being at a painfully slow pace. The reason—manpower shortage. There are today, according to a recent count, 11,250 psychiatrists. It is essential that at least twice that number be available to provide needed service.

A recent report of the Joint Information Service informs us that there are now 2,723 doctors training in psychiatric residences. Considering the fact that the training period extends over 4 years, and, furthermore, not all of these actually enter the profession, these centers will actually turn out only about 500 psychiatrists a year. This, we know, will not be much more than enough to fill the vacancies left by death and other causes of departure. The existing grievous personnel shortages will continue to exist and new ones will come into being as research and services for prevention and treatment expand. Unless training is accelerated very sharply, we'll fall further and further behind. Another index which points to the critical personnel shortage is the ratio of medical specialists to population. In the medical specialty of psychiatry, there is 1 specialist to every 16,400 population. In the specialties of internal medicine and surgery, the respective ratios are 1 specialist to each 8,200 and 6,000 population.

Were this an academic question we would rest content with waiting and hoping that the condition could eventually right itself. But this is no academic matter. The clinics and psychiatric services in general hospitals and the counseling and guidance services and the rehabilitation services which are not coming into being as a result of this manpower shortage, are leaving without help the millions—and I mean that literally—the millions of children and adults who are in need of these services. According to one survey made at Columbia University a few years back, 1 schoolchild in every 10 is in the need of psychiatric treatment. And according to another survey made by the Commission on Chronic Illness, 10 percent of our urban population is suffering from some well-defined disorder severe enough to require psychiatric treatment. It is the Commission's opinion, as stated in its report that:

"Our findings that approximately one-tenth of an urban population have one or more of the relatively well-defined mental disorders is sufficiently alarming and one obviously calling for prompt, serious consideration. We doubt very much that a population having more than that rate of mental illness could function as a society."

As a result of this manpower shortage, tens of thousands of children are being deprived of help at a psychiatric clinic, or in counseling and guidance services in schools and family agencies. Many, many of these children will find an expression of their emotional problems in delinquency and later in crime. Many of them will develop serious psychosomatic illnesses. Many of them will end up in mental hospitals. Many of them will become the suicides, alcoholics, drug addicts of tomorrow.

The moral here is so much like that in the little jingle—"For Want of a Nail a Kingdom Was Lost." For want of a few psychiatrists and social workers and psychologists, hundreds of thousands of American lives are being lost to mental illness, waste, destruction—and this loss will continue to haunt all of us, not only in the human tragedy it represents but in the billions of tax dollars it will cost us—in our local tax expenditures, and in our State and Federal tax expenditures—money we will have to spend to undo the damage—not to save the human beings because they will already have been lost, but to repair the damage which will result from their failure to get psychiatric help when they needed it.

Research and training are two key answers in the fight against mental illness, and just as we have heartily endorsed the expansion of the National Institute's research grant program, so do we urgently recommend a continued expansion of the Institute's program for training grants.

In allocating training grants, the Institute is placing special emphasis in certain critical areas. A major area emphasis is the training of research workers, and a priority is being given to research workers in psychopharmacology. The shortage of qualified research workers in this area is extremely acute, and this shortage may threaten the quickly expanding research developments in this most extremely important field. An intensive effort is being made by the Institute to stimulate training of these research workers at the graduate level in universities and in cooperative ventures with medical schools.

GENERAL PRACTITIONER

Aside from the support of physicians for residency training—an important, standard program—the Institute is helping to open up a tremendous new reservoir of frontline fighters by encouraging and providing financial support for the psychiatric education of the general practitioner. It has been pointed out that more than 75 percent of all the cases of psychiatric illness treated in hospitals, clinics, and private psychiatric practice have their first professional contact with a general practitioner. It has also been repeatedly pointed out that at least 50 percent of all the cases seen by physicians have a substantial element of mental or emotional disorder. And we have overwhelming evidence from the field of psychosomatic medicine that many thousands of cases of physiological disorders stem from psychological causes. It seems eminent good sense, therefore, to equip the physician with training to handle emotional disorders on an emergency basis, preventing their further development where possible or making a meaningful referral when indicated.

This NIMH program encourages and supports training projects which may provide the physician with anything from a series of short-term lectures to longer courses involving seminars, to individualized intensive case study. Despite early skepticism about the willingness of the physician to undertake this kind of study, we are now informed that since the initial announcement of the availability of these grants, a very strong interest has been manifested, and there have been collaborative efforts on the part of national and local associations of psychiatrists and general practitioners, and that medical associations in general have given strong encouragement to this development.

A new and laudable undertaking initiated by NIMH in 1960 is one designed to develop teaching programs in medical schools, leading to the integration of the behavioral sciences—psychology, sociology, anthropology—and others into education of the physician-to-be, providing these young doctors with a scientific base for understanding human behavoir—an understanding which will enable them, later, to take a much more comprehensive approach to illness, and treat the patient as a human entirety rather than as a case of ulcers or high blood pressure.

The appropriation for the entire training grant program in 1960 was $22,356,000. It is urgently recommended that this be increased to $30,100,000 for 1961.

Under the heading of training grants, we come now to another very important item—the item for adjustment of project date periods.

ADJUSTMENT OF PROJECT PERIOD DATES

Because of administrative and legislative technicalities, training grantees (students and instructors) who should begin their work July 1 of any year—cannot be given final approcal of their grants—nor know the amounts of their grants until August or September of that year. Highly qualified candidates do not want to be kept in this position of indecision and consequently take more certain even if not more attractive proposals elsewhere. Some training centers try to cope with this situation by hiring personnel or appointing trainees as of July 1 in the expectation that the requested funds will be approved and in so doing, they place themselves in a precarious financial position.

This overall situation has seriously handicapped the mental health training program, and as a consequence, a remedy has been sought. The obvious answer to the problem is to appropriate funds in 1 year for grants which will be made the following year. To achieve this, the National Mental Health Advisory Council proposes an additional $5 million in 1961 and a similar amount in 1962 and 1963. It is the Council's recommendation, thus, to take 3 years to achieve a changeover, which will advance the entire program 1 full year. It is our recommendation, that in the interest of the urgency of this training program, the adjustment should be made in the course of 1 year, rather than 3. This will have the effect of smashing this hazardous bottleneck promptly and of facilitating the unhampered recruitment of the most highly qualified candidates for this vital training program. This, it is estimated, will require $16,150,000 to accomplish and we therefore recommend this item for the 1961 budget, pointing out, of course, that this will be a nonrecurrent item.

Combining our recommendation for total training grants and the item for adjustment of project period dates, we recommend a total of $46,250,000 for the total training program.

STATE CONTROL

One of the most encouraging aspects of the preventive phase in this field is the very quick development of State and local interest in community mental health services. Under this classification are included psychiatric clinics of all kinds—those attached to general hospitals, or to universities, or operating independently in the community; clinics giving only service to children; clinics serving only adults; clinics serving children and adults. Included also are counseling guidance and mental health education programs in grade schools, high schools, and colleges. Other community programs include social rehabilitation programs including halfway houses; vocational rehabilitation programs, including sheltered workshops; special employment referral services medical rehabilitation programs including followup centers for discharged mental patients.

Included also are special community programs to help curb juvenile delinquency, others to deal with the medical and social problems created by alcoholism; others to cope with the emotional and social problems of the aging.

Without question, the most important impetus for the development of these services in thousands of communities throughout the country has come from the State control program of the National Institute of Mental Health.

NIMH assistance, in the form of grants has operated primarily in a pump-priming capacity. Last year, Federal, State, and local funds budgeted by the States for community mental health services reached a new peak of $64.8 million—a 20-percent increase ($10.8 million) over the previous year. Federal grants in aid of $4 million made up only 6 percent of the total funds budgeted.

While community mental health services still appear today to have a patchwork character, and to represent in most cases only token services, we can look forward to the day when mental health services in the community will be considered as important as, or even more important than, the traditional institutional treatment programs. The bulk of financial support for these new services will come, as it does now, from the States and the communities.

But we may be fairly certain that local initiative will come to develop in direct proportion to the extent of Federal stimulation.

To help meet the growing need for community mental health services, it is important that the Federal Government increase its grant-in-aid program and we therefore recommend that this item in the NIMH budget be increased from $5 million in 1960 to $6 million in 1961.

Our recommendation for the total of grants is therefore as follows:

| | |
|---|---|
| Total research projects | $36, 890, 000 |
| Research fellowships | 2, 846, 000 |
| Total training | 46, 250, 000 |
| State control programs | 6, 000, 000 |
| Total | 91, 986, 000 |

DIRECT OPERATIONS

To meet the normal requirements for expansion and growth consistent with its rapidly expanding services, the Institute requires an increase in appropriations for direct operations.

Included under this item also, is the Institute's intramural research program, dealing primarily with basic rather than applied research. Expansion of this function, which last year was budgeted for $7,513,000, requires a commensurate increase. We are therefore recommending an appropriation of $12,871,000 for total direct operations, as against $11,281,000 for last year—an increase of about $1.5 million.

TOTAL PROGRAM

For the total program therefore, it is the recommendation of the National Association for Mental Health that $104,857,000 be appropriated for the budget of the National Institute of Mental Health in 1961.

This represents an increase of $36,892,000 over 1960 and an excess of $37,294,000 over the budget proposed by the President.

The recommendation of the President that the NIMH budget be held to last year's level—that, as a matter of fact it be reduced slightly below last year's level is puzzling.

I do not see how we can, on the one hand, give recognition to the mounting importance of the Nation's No. 1 health problem, and of the need for vastly expanded research, training, and services to combat this problem, and to reduce the terrible human and financial toll it takes, and then, on the other hand fail to appropriate funds to provide for the expansion of research, training, and services.

We, as a citizens' organization are certainly cognizant of what it means to the people of this Nation to be taxed, even though the taxation be for health and welfare services. However, we cannot as a nation ignore a health problem, which, according to the Commission on Chronic Illness threatens our existence as an organized society, and which takes such a terrible toll in millions of destroyed lives and billions of wasted dollars. We have learned from other health fields—and certainly from experience in the field of mental health, how a relatively small expenditure for research, training, and prevention today, can forestall a very large expenditure for treatment, custodial care, and rehabilitation later on.

So far as public intent is concerned, recent polls have shown that the public is willing to be taxed for programs to combat mental illness even more readily than to be taxed for such benefits as social security, unemployment insurance, police protection, recreation, parks, and other public services. There is no question in our minds that the Congress will have the overwhelming support of the people for a budgetary appropriation to meet the growing needs of a Government agency dealing with the Nation's No. 1 health problem, mental illness.

52692—60——9

We submit the following recommendation for this budget:

| Activities | President's budget | Recommended by National Association for Mental Health |
|---|---|---|
| Grants: | | |
| Research projects: | | |
| Regular programs | $14, 660, 000 | $18, 340, 000 |
| Psychopharmacology | 7, 200, 000 | 8, 500, 000 |
| Title V | 4, 300, 000 | 6, 700, 000 |
| Full indirect costs | 30, 000 | 2, 850, 000 |
| Clinical research units | 500, 000 | 500, 000 |
| Total research projects | 26, 690, 000 | 36, 890, 000 |
| Research fellowships: | | |
| Regular fellowships | 1, 034, 000 | 1, 584, 000 |
| Physiology fellowships | 962, 000 | 1, 262, 000 |
| Total research fellowships | 1, 996, 000 | 2, 846, 000 |
| Training: | | |
| Regular programs | 18, 832, 000 | 23, 600, 000 |
| General practitioner | 2, 300, 000 | 4, 000, 000 |
| Psychopharmacology | 300, 000 | 1, 000. 000 |
| Biological and social sciences | 924, 000 | 1, 500, 000 |
| Subtotal training | 22, 356, 000 | 30, 100, 000 |
| Adjustment of project period dates | 0 | 16, 150, 000 |
| Total Training | 22, 356, 000 | 46, 250, 000 |
| State-control programs | 5, 000, 000 | 6, 000, 000 |
| Total grants | 56, 042, 000 | 91, 986, 000 |
| Direct operations: | | |
| Research | 7, 697, 000 | 8, 297, 000 |
| Review and approval of grants | 1, 293, 000 | 1, 493, 000 |
| Training activities | 100, 000 | 200, 000 |
| Professional and technical assistance | 1, 926, 000 | 2, 226, 000 |
| Administration | 505, 000 | 655, 000 |
| Total direct operations | 11, 521, 000 | 12, 871, 000 |
| Total program | 67, 563, 000 | 104, 857, 000 |

Mr. JUDD. In the interest of time, I would like to present personally only a portion of some of these statements.

Mr. FOGARTY. Go right ahead.

Mr. JUDD. We have watched with great pride and satisfaction the development of the program carried on by the NIMH, and we credit it directly with many of the great strides which have been made in the past 10 years. Each year we have endorsed the appropriations of the agency. We now recommend that the National Institute for Mental Health be granted an appropriation of $104,857,000 for its program requirement for 1961. We make this proposal after a review of the 1961 budget recommendations of the National Advisory Mental Health Council. Their recommendations were $90 million. The principal difference between our figure and the figure of the Council is in the adjustment of the project period dates. The Council takes $5 million a year for 3 years. We believe in view of the urgency of the training program that this should be done in 1 year.

I would like to speak very briefly about research because there will be most of the important factors in our eventual conquest of mental illness. In fact, it is already that. The money that has already been spent is being shown in the figures which Dr. Braceland has spoken about earlier. Today patients suffering from some of the psychoses

have a 60- to 75-percent chance of partial or total recovery; 20 years ago the chances were 35 percent to 45 percent. That is an amazing payoff from research effort, and it has meant literally hundreds of millions of dollars saved in future and present hospitalization costs.

Mr. JUDD. I believe you asked Dr. Braceland about what it costs to keep a person in a mental institution. It has been estimated that a person who does not recover will eventually cost his State between $16,000 and $20,000 for the time he is staying in the hospital. So the research work that has already been done is now paying off in saving many, many States from building additional mental institutions at a cost of hundreds of millions of dollars.

As Dr. Ewalt has pointed out, out of the research already completed you will now have promising leads which puts a heavy number of applications on NIMH for financial support. We recommend that $18,340,000 be appropriated for grants in the regular research program. That compares with $14,660,000 proposed in the President's budget.

The NIMH program in psychopharmacology has been in existence only 3 years, but it is already beginning to provide some positive answers concerning the effectiveness of the tranquilizing and the antidepressant drugs.

We are all mindful of the sweeping changes which have developed in the treatment of the hospitalized mentally ill as a result of the introduction of chemotherapy, and we are mindful, too, of the extent to which chemotherapy is a factor in the treatment of less severe mental and emotional upsets and disorders in the general population. Dr. Braceland has already brought out how effective the drugs are in the treatment of patients in the mental hospitals. We believe that a substantial increase in the funds appropriated for this program is thoroughly justified and we would therefore strongly recommend an increase in this item from $6.5 million to $8.5 million.

Under title V we are especially interested in the emphasis being given in this program to the critical social problem areas of the aging, alcoholism, and delinquency.

It is one thing to express grave concern about the problems of the aging, and it is another to give support to projects which are attempting to find out how something can be done about it. The mental health projects program, the title V program, is to be applauded for supporting this line of exploration.

In the same vein, I might comment that while others are beating their breasts about the mounting problem of juvenile delinquency, the title V program has essayed to support probing research programs into the causes and into practical measures of correcting this grave problem.

Another area in which new research is very much needed is in the area of alcoholism. There is a growing recognition that alcoholism will be brought under control only when it is placed within a broader mental and public health framework. This is the emphasis in the title V projects.

We enthusiastically endorse this research program and recommend a $6,700,000 appropriation for this item.

In addition, we would like to also put in a strong plea that the indirect costs be raised to 25 percent from the present 15 percent. We feel that at least 25 percent should be provided over and above the

grants to cover the overhead in the research facilities and laboratories. They are finding it very difficult to get along and subsidize the difference between the 15 percent and what their actual costs are.

In recapitulation, then, we wish to express our most vigorous support of the research grants programs of the NIMH, and to recommend an appropriation of $36,890,000 for total research projects grants, an increase of $10,200,000 over the 1960 level.

I would like to speak now of training.

The shortage of trained personnel continues to be the Achilles heel of the Nation's fight against mental illness, and according to Dr. George Albee, who has surveyed the situation for the Joint Commission on Mental Illness, the present crisis will be like the 7 fat years in Joseph's dream, in comparison to anticipated conditions 15 years from now.

According to minimum standards of the American Psychiatric Association for long-term care—not for intensive treatment but for long-term care—there is only a 57-percent adequacy of physicians or a 43-percent shortage of physicians in the Nation's mental hospitals.

The estimated shortages for the other professions are as follows: Psychologists, 24.3 percent; registered nurses, 76.8 percent; psychiatric social workers, 59.7 percent.

At the last count, there were some 1,300 psychiatric clinics in the United States. We as a citizens' group are tremendously interested in the psychiatric clinics which are so active in the communities. Only about 650 of these 1,300 psychiatric clinics were full-time clinics. Fifty percent of the States had fewer than 10 clinics, full or part time. We have checked with our State and local affiliates as to the reasons for the failure of these clinics developing more rapidly, and the universal answer is shortage of manpower. We we not have the psychiatrists. We do not have the psychologists. We do not have the social workers.

There are today, as has already been brought out, 11,250 psychiatrists in this country. We could stand at least twice that number.

Only a few hundred physicians complete their residency in psychiatry each year and enter the profession. This number is barely enough to fill the vacancies left by death and other causes of departure from the profession for other reasons. Unless this training is accelerated, and accelerated very sharply, we will fall further behind. If this were just an academic question, we would rest content with waiting and hoping that the condition could eventually right itself. But this is no academic matter. The clinics and psychiatric services and the rehabilitation services which are not coming into being as a result of this manpower shortage, are leaving without help the millions—and I mean that literally—the millions of children and adults who are in need of these services. Many, many of these children and adults will find an expression of their emotional problems in delinquency and later in crime. Many of them will develop serious psychosomatic illnesses. Many of them will end up in mental hospitals. Many of them will become the suicides, alcoholics, and drug addicts of tomorrow.

Research and training are two key answers in the fight against mental illness, and just as we have heartily endorsed the expansion of the National Institute's research grant program, so do we urgently recommend a continued expansion of the Institute's program for training grants.

Dr. Braceland has already spoken of the general practitioner. It has been estimated that more than 75 percent of all the cases of psychiatric illness treated in hospitals, clinics, and private psychiatric practice, have their first professional contact with a general practitioner. It seems eminent good sense, therefore, to equip the physician with training to handle emotional disorders on an emergency basis, preventing their further development, where possible, or making a meaningful referral when indicated.

The appropriation for the entire training grant program in 1960 was $22,356,000. We very strongly recommend that this be increased to $30,100,000 for 1961.

I should like to speak now of the adjustment of project-period dates.

Because of administrative and legislative technicalities, training grantees who should begin their work July 1 of any year, cannot be given final approval of their grants until August or September of that year. This means that highly qualified candidates do not want to be kept in this position of indecision and consequently take more certain, even if not more attractive, proposals elsewhere, as they do not want to be kept in this position of indecision.

This overall situation has seriously handicapped the mental health training program. The obvious answer to the problem is to appropriate funds in one year for grants which will be made the following year. To achieve this, the National Mental Health Advisory Council proposes an additional $5 million in 1961, and a similar amount in 1962 and 1963. It is the Council's recommendation, thus, to take 3 years to achieve a changeover which will advance the entire program 1 full year. It is our recommendation that in the interest of the urgency of this training program the adjustment should be made in the course of 1 year rather than 3. This, it is estimated, will require $16,150,000 to accomplish, and we therefore recommend this item for the 1961 budget, pointing out, of course, that this will be a nonrecurring item.

Combining our recommendation for total training grants and the item for adjustment of project period dates, we recommend a total of $46,250,000 for the total training program.

For the total program, therefore, it is the recommendation of the National Association for Mental Health that $104,857,000 be appropriated for the budget of the National Institute of Mental Health in 1961. This represents an increase of $36,892,000 over 1960, and an excess of $37,294,000 over the budget proposed by the President.

We, as a citizens organization, are certainly cognizant of what it means to the people of this Nation to be taxed, even though the taxation be for health and welfare services. However, we cannot, as a nation, ignore a health problem which, according to the Commission on Chronic Illness, threatens our existence as an organized society, and which takes such a terrible toll in millions of destroyed lives and billions of wasted dollars. We have learned from other health fields—and certainly from experience in the field of mental health—how a relatively small expenditure for research, training, and prevention today can forestall a very large expenditure for treatment, custodial care, and rehabilitation in the future.

Mr. Fogarty. Thank you, Mr. Judd. That is a very fine statement.

The majority of this committee happens to be friendly to these pro-

grams, but we have many Members of Congress who do not believe in spending money for research, period. You are a successful businessman. I wish you would tell us briefly how can we argue against that point of view on the floor when we try to get more funds in a bill like this. What kind of an aswer can we give, strictly from a business point of view?

Mr. JUDD. I think we could point out that the Government itself expends large amounts of money in research in the defense industry, and has come up with the atom bomb and developments in defense missiles purely and simply from expending money for research.

I think we can point out that research in the field of tuberculosis has come a long way toward licking that health problem.

We can point to polio where the problem has been licked practically 100 percent by the research activities of Dr. Salk and the others.

And we can point to the research in the heart field, prolonging the lives of the President among others.

And we can point to the research being done in the field of cancer.

And I think the next one is the research to be done in mental illness. The others are succumbing.

Mr. FOGARTY. You people in business spend a lot of money for research in order to stay in business, do you not?

Mr. JUDD. I think you can say that no business today can stay in business without spending a certain amount in research to develop ways and means for new products and new ways to solve things.

Mr. FOGARTY. And you think this is a worthwhile expenditure regardless of the budget?

Mr. JUDD. I think it is an absolutely essential expenditure, because I think it can be proved that the expenditure of this relatively small amount of money for research will be paid back in a matter of a relatively few number of years in emptying mental institutions.

Mr. FOGARTY. Do you think you have asked for enough?

Mr. JUDD. We feel that whatever is necessary to do the job, the people of this country will pay if it is put up to them in just so many words. They put money on the line in the NIMH, and out of that comes hundredfold in actual dollars but in addition to that in thousands—millions, as a matter of fact—of better lives of the citizenry.

Mr. FOGARTY. You still did not answer my question. Do you think you have asked for enough?

Mr. JUDD. I think we have asked for what we feel the NIMH can effectively spend in 1961.

Mr. FOGARTY. What do you think of the NIMH?

Mr. JUDD. We think the NIMH is doing an outstanding job, and it seems to reach into every State and provide this seed money that is so necessary. I can see it in my own State of Connecticut. They are putting money into a seminar for ministers to help them in their ministerial counseling and marriage counseling and so forth. The object is that we in the State, after a project like that is done, will go ahead and create other similar projects with our own money.

Mr. FOGARTY. Any questions?

Mr. DENTON. No questions.

Mr. FOGARTY. Thank you very much.

Dr. Braceland, did the Surgean General or the Secretary ask you for any advice in the making up of the 1961 budget?

Dr. Braceland. We were not asked, no, sir; not to my knowledge. We were not asked directly about the budget at all. They did not ask us, but we suggested to them our recommendations.

Mr. Fogarty. Thank you very much.

---

Tuesday, March 1, 1960.

## Neurology and Blindness Activities

### WITNESSES

**DR. C. J. VAN SLYKE, CONSULTANT TO RESEARCH TO PREVENT BLINDNESS, INC.**
**DR. JULES STEIN, FORMER FELLOW OF THE AMERICAN BOARD OF OPHTHALMOLOGY**
**ROBERT E. McCORMICK, CORPORATE VICE PRESIDENT OF OLIN MATHIESON CHEMICAL CORP.**
**DR. FRANK W. NEWELL, PROFESSOR AND HEAD OF THE DIVISION OF OPHTHALMOLOGY, UNIVERSITY OF CHICAGO**
**DR. A. EDWARD MAUMENEE, DIRECTOR, DEPARTMENT OF OPHTHALMOLOGY, JOHNS HOPKINS UNIVERSITY AND HOSPITAL**

Mr. Fogarty. The committee will come to order.

This morning, we are pleased to honor Dr. Van Slyke in another role. He is still serving humanity, might I say. You were paid a very high compliment by Dr. Shannon a couple of weeks ago.

Dr. Van Slyke. Thank you, sir.

Mr. Fogarty. We all concurred in it and said that we were sorry to see you leaving the Institutes, but we were pleased to hear that you were going to be employed on a consulting basis and would still maintain your ties there. We are very pleased that you are following up what you have been doing all your life. In the capacity in which you appear before us today you are doing something in behalf of the people who are blind. This is one of the areas we think a little more emphasis could have been put on in the National Institutes of Health. As you know, this committee had encouraged Dr. Bailey to put a little more emphasis on the problems of the blind, and we finally got a program started out there.

Dr. Van Slyke, are you going to introduce your witnesses?

Dr. Van Slyke. With your permission, I think they can well introduce themselves.

I would like to say, though, sir, that I have just made a trip around the country to all the important ophthalmological research centers. The time is just right for expanded activity in this field. It is a beautiful opportunity that now faces us.

I want to thank you, sir, and the committee members, for the privilege of our group's appearing before you this morning.

Thank you, sir.

Mr. Fogarty. If you do as good a job as you have done for the Institutes of Health, they are in pretty good hands.

Dr. Van Slyke. You are very kind, sir.

Mr. Fogarty. Dr. Stein, we are also very pleased to have you with us. Senator Javits called me this morning and told me of his interest in this problem and about his association with you in New York, and

I told him that we would take good care of you. So you go right ahead.

Dr. STEIN. Thank you, sir.

STATEMENT OF DR. JULES STEIN

My name is Jules Stein. I am founder and chairman of the board of the Music Corp. of America, sometimes known as MCA. I was born in Indiana. I studied medicine and became a physician, specializing in ophthalmology. I graduated at the University of Chicago—Rush Medical College, which is now the University of Chicago—as well as at the University of Vienna.

I gave up active practice in 1925 to found MCA, but now I have the opportunity to return, if only indirectly, to medicine, in the field of ophthalmology; and particularly to assist in research for the prevention of blindness.

In association with others, we have formed a voluntary organization under the laws of the State of New York, called Research to Prevent Blindness. This title clearly sets forth our premise.

I have agreed to become chairman of this volunteer organization and to do everything within my ability to raise private funds for this purpose.

We shall further do everything possible to make the public aware of the problems involved and the necessity for assistance and financial help.

We recognize the wonderful work which is being done to alleviate the plight of persons to whom the awful curse of blindness has come, and we will cooperate fully with all groups whose main objectives are these fine humanitarian efforts.

However, in looking over the field of research into prevention, we are appalled at the small amount of work being undertaken to find the causes of the diseases which result in blindness, so as to be able to prevent this tragedy from striking.

I would like to tell you briefly the plans we have and why we believe that the appropriation to the U.S. Public Health Service Institute of Neurological Diseases and Blindness should be substantially increased for work in the blindness area.

First, as to the magnitude of the problem. No reliable figures on the total incidence of potentially blinding eye diseases have ever been available. However, it is estimated that 70 million people in the United States today, or 40 percent of our population, have eye defects and need glasses. I personally believe there are many more that are not fully counted; 350,000 are legally blind, equal to the population of Atlanta or St. Paul; 1.5 million are blind in one eye, and an estimated 9 million children require eye care, and a large number of them should be wearing glasses.

The costs of care for the blind are most interesting. For the fiscal year 1959, the total amount of public funds, that is, Federal, State, and local, appropriated for aid to the blind is estimated at over $90 million, with an additional $60 million coming from private sources, or a total of $150 million.

In addition, there is an estimated economic loss exceeding $200 million. Yet only $4 million from both public and private funds have

gone for research to prevent blindness. This represents about 1 percent of the minimum costs, the $4 million does.

I was taught as a medical student that an ounce of prevention is worth a pound of cure. It is my opinion that if public and private funds become sufficiently available for research into the causes that create blindness, that if they do, we can reduce the incidence of blindness about 25 percent or more.

I am told that there are over 40,000 people that become blind annually in the United States.

If we could only save 10,000 of those, the cold calculations would save many, many millions devoted to the care of the blind by spending a few more million in research to prevent that blindness.

I read yesterday that $6 million is annually spent for eye washes. They are nothing but boric acid with a little colored water. Still, only $4 million is spent for research to prevent blinding conditions.

Yet, with these limited funds, I would like to review for a moment the interesting, dramatic, and spectacular accomplishments in the treatment, surgery, and prevention of eye blindness which has happened in the 35 years since I gave up practice.

When I was in ophthalmology, there was a cataract operation, during which we had to put the patient between sandbags and hold them there some 2 or 3 days, in order to avoid any damage to the tissues, as the incision was healing.

Today, by newer methods, they are able to operate on cataracts, take the conjunctiva, cover the wound, and take the patient off the operating table and let him walk to his room.

For 2,000 years doctors have tried to find a way to replace scar tissues of the Cornea—that is the little window. During these 35 years, and, as a matter of fact, only in the last 15 or 20, they now are able to do corneal transplants by the use of the eyebank. In other words, they can replace the scar tissues, either small ones or large ones, and bring sight back to people who have been blinded.

We now see tremendous developments in contact lenses and the day may come when you will be able to eliminate your glasses entirely and just wear these small contacts. As a matter of fact, vision is tremendously improved by contacts over the ones that are so far away from the eyeball.

One of the greatest things that has been done in recent years is the virtual elimination of retrolental fibroplasia, which happens in little babies that have been put in oxygen tents. For this particular elimination, total credit must be given to your appropriation to the U.S. Public Health Service, to the Institute of Neurological Diseases and Blindness, since this Institute financed the complete study, and they found out that the oxygen that they used on children had been given in too large quantities, which was causing this blindness. The savings in this one thing alone, which was causing around 7,000 blind children a year, would run into astronomical figures, if you realized that these are babies that have some 50 or 60 or 70 years to go.

Where the blindness happens in the later years of life, the economic loss would be substantially less.

Dr. Van Slyke has arranged for a symposium of some 25 to 30 of the outstanding ophthalmologists of the country in New York on

March 20. At that time, the representatives of all the medical schools with active research departments of ophthalmology will be there, as well as Dr. Masland of the National Institute of Neurological Diseases and Blindness.

Dr. Van Slyke toured the country discussing our plan and objectives with the leading specialists. He reports tremendous enthusiasm. They will enlarge their present efforts substantially if financial support can be assured. We hope very much to help in giving them that assurance. We expect the symposium to present forums with problems, and possibilities of research, to prevent blindness, so that this subject can be fully explored.

The results of the meeting will be presented to this committee in written form as soon as possible, and to the Senate appropriations hearings at a later date.

Private efforts have been significant, and they must be continued and enlarged.

We plan to cooperate with all existing agencies caring for the blind or helping in its prevention.

They have been greatly helped and directed in the past few years by the programs of the National Institute of Neurological Diseases and Blindness.

We strongly urge that the appropriations for the Institute be increased to a level of $12 million for 1960–61, from the present $6 to $6.5 million. We advocate this within the total appropriation to the Institute of $61 million.

I know that medical witnesses who follow me this morning will demonstrate the urgency of this recommendation.

For myself, and my associates in Research To Prevent Blindness, Inc., I can say that we look forward to the challenge of this work and deeply appreciate the opportunity of appearing before you, and trust that the same opportunity is given next year, so that we will be able to report some solid, important achievements.

Thank you very much.

Mr. Fogarty. Thank you, Dr. Stein. That is a very fine statement.

One of the problems we have, you know, is convincing some people that research pays off. You have been in this profession, and you are in business now, so I think you can see it from both sides. We have people who think that we ought to curtail spending in this area, that the rate at which we have been going should be slowed down, that we should level off at the current level or a little below so that we can balance the budget.

What do you say to such people?

Dr. Stein. I think anything that is done to prevent disease is an economic benefit to a nation. You create greater productive possibilities and capacity, and if I were making an investment myself, this is where I would put my money almost first.

Mr. Fogarty. Even though it might exceed the budget?

Dr. Stein. Yes, because I don't hardly consider it an expense. I consider that if these moneys are spent wisely, there would be tremendous moneys saved in the future by not having to care for the blind, which is presently being done.

Mr. Fogarty. Well, I agree with you, and the majority of this committee agrees with you, but there are some who do not believe in research, period.

Dr. STEIN. They don't know, if they don't believe in it.

Mr. FOGARTY. Some of them have been around here a long time. They were here long before I came here, and are still here.

Dr. STEIN. If they were stricken with some unfortunate malady, they might think otherwise.

Mr. FOGARTY. I agree. I remember when Dr. Bailey was head of the Neurological Institute, that we were pressing him to tell us what was needed in this particular field. We have to press some of these Government witnesses, as Dr. van Slyke well knows, to get them to tell us what they really think, because they are under wraps when they come here; they are under orders to come down and justify the President's budget.

After pressing Dr. Bailey for his professional opinion, he said there was one area in which he could use more money, and this was in the area of retrolental fibroplasia. We gave him additional funds over the President's request at that time, and we were told that it did help to find the cause.

Dr. STEIN. No question about it.

Mr. FOGARTY. And, as a result, with only $50,000 we——

Dr. STEIN. Saved many millions.

Mr. FOGARTY. Many millions. That is a good example, is it not?

Dr. STEIN. Certainly is.

Mr. FOGARTY. That could be multiplied many times over, not only in blindness but in other disease areas.

Do you go along with the idea, then, that a few million more spent in research in some of these disease areas would be economically sound investments?

Dr. STEIN. I do.

Mr. FOGARTY. As far as the Government is concerned, regardless of the Bureau of the Budget's feelings?

Dr. STEIN. I happen to believe it very strongly.

Mr. FOGARTY. Usually the people in the Public Health Service and the Institutes of Health are not to blame, because they believe in the same thing, but then they go to the Bureau of the Budget, and someone who has no professional knowledge at all of the problem just says: "Well, we have an overall figure to meet, and we have to cut down 10 or 20 or 30 percent." As a result, they are cut off by the Bureau of the Budget.

I happen to be one of those who thinks that the Bureau of the Budget exceeds their authority once in a while in getting into policy-making, and they were never set up for that purpose.

Now, are you going to introduce Mr. McCormick?

Dr. STEIN. May I have the permission of the committee to have my statement put into the record?

Mr. FOGARTY. Oh, yes. We will include it.

(The prepared statement of Dr. Stein follows:)

STATEMENT OF DR. JULES STEIN

I am founder and chairman of the board of the Music Corp. of America. Previously, I studied medicine, became a doctor, did postgraduate work in ophthalmology at the eye clinic of the University of Vienna and was a fellow of the America Board of Ophthalmology.

My early interest in problems of the eye has continued and my concern about the growing problem of blindness has increased with the passing of time. I have

determined to do what I can personally to promote research in this field. In association with interested friends of mine in New York including Mr. Robert McCormick who is here this morning, we have very recently formed a voluntary organization under the laws of the State of New York called Research to Prevent Blindness, Inc.

The objects of our organization are clearly set forth in its name. We recognize the wonderful work which is being done to alleviate the plight of persons to whom the awful curse of blindness has come and we will cooperate fully with all groups whose main objectives are these fine humanitarian efforts. However, in looking over the field of research into prevention, we are appalled at the small amount of work being undertaken to find the causes of the diseases which result in blindness, so as to be able to prevent this tragedy from striking.

I speak to you as a layman and I will not impose upon your time to do more than touch on the facts which have caused us to form the organization I have just described.

I would like to tell you briefly the plans we have and of why we believe that the appropriation to the U.S. Public Health Service Institute of Neurological Diseases and Blindness should be substantially increased for work in the blindness area.

First, as to the magnitude of the problem. No reliable figures on the total incidence of potentially blinding eye diseases has ever been available. However, it is estimated that 70 million people in the United States today—40 percent of our population—have eye defects and need glasses 350,000 are legally blind—equal to the population of Atlanta or St. Paul; 1,500,000 are blind in one eye, and an estimated 9 million children require eye care and a large number of them should be wearing glasses.

For the fiscal year 1959 the total amount of public funds that is, Federal, State, and local, appropriated for aid to the blind is estimated at over $90 million with an additional $60 million coming from private sources—a total of $150 million.

And a further $200 million represents a minimum cost to industry of the partially and completely blind.

And the human suffering cannot be evaluated in mere dollars.

Yet it is estimated that only slightly over $4 million is available from public and private sources combined for research in the blinding eye diseases—about 1 percent of the minimum costs of blindness.

Looking at the experiences of research in other diseases such as cancer, heart disease, mental health, polio, and so on, it has been clearly demonstrated that when there are funds available to support continuing programs in these specific areas, assuring the manpower to carry out the research, and providing adequate facilities in which the work may be performed, there will be corresponding interest and effort among medical scientists in that particular field and conversely that without such funds little vigor and enthusiasm can be anticipated. Money will not necessarily solve a tough medical problem—but lack of it will almost certainly contribute to failure.

We believe that the supply of all of these essentials—money, trained manpower, and facilities—must be enlarged and enlarged promptly if we are to get at the problems of blindness with the vigor which is required.

Our organization expects to contribute importantly and increasingly to that end. We emphatically do not advocate transferring the responsibility entirely to the Government.

We do, however, strongly advocate that the level of appropriations for the excellent programs of training and of project support in disorders of vision which have been undertaken in the past few years by the National Institute of Neurological Diseases and Blindness be substantially increased and without delay. We urge that the current level of some $6 to $6½ million devoted to problems of blindness by the Institute be increased to $12 million for 1960–61. We advocate this within a total appropriation to the Institute of $61 million. This allocation would increase the percentage of the Institute's total resources devoted to blindness from a current level of about 15 percent to approximately 20 percent. The witnesses who follow me this morning will demonstrate the urgency of this increase in the blindness allocation and on Wednesday I understand witnesses will speak in support of work in the neurological diseases.

One of the first activities of the organization I represent is the sponsorship of a 1-day symposium to be held in New York City on March 20 at which representatives of virtually all of the medical schools with active departments of ophthalmology will attend to discuss in rather specific detail, manpower, facili-

ties, and financial support which they need in order to get on with the blindness problem without delay. Dr. Masland from the National Institute of Neurological Diseases and Blindness will attend.

The organization has arranged for expert advice in setting up its operation and its program. Its medical consultant, Dr. C. J. van Slyke, a former Deputy Director of the National Institutes of Health, has just returned from a nationwide tour visiting leading ophthalmologists in most of our medical centers. He reports widespread interest in research in these institutions and a readiness to substantially enlarge the present efforts if financial support is assured, adequate both in amount and in certainty of continuity. The results of this trip and of the symposium, unfortunately, cannot be presented to this committee here today but I trust that a summary will be available for the Senate appropriations hearings which will be held later and information made available to them will be supplied to this committee at that time in written form.

Promising work has been started. What is needed now is increasing its tempo and stimulating interest in the many excellent people in our fine medical schools in pursuing the attack on blindness vigorously until we have found the cause of such things as cataracts, glaucoma, uveitis, and other blinding diseases.

I am glad to pledge to you the firm cooperation of Research To Prevent Blindness, Inc., and I am certain that by next year we will be able to tell you of concrete accomplishments rather than merely of what we plan to do.

Dr. STEIN. I would like to introduce Mr. Robert E. McCormick, of the Olin Mathieson Chemical Corp., who happens to be one person prodding me for the last few years to go forward with this project.

Mr. FOGARTY. Mr. McCormick.

## STATEMENT OF ROBERT E. McCORMICK

Mr. MCCORMICK. Mr. Chairman and committee members, I am Robert E. McCormick, a member of the New York bar and a corporate vice president of Olin Mathieson Chemical Corp.

Yes, I did prod Mr. Stein about a year and a half ago to give his tremendous energies, to unleash his tremendous energies and direct them in the direction of eye research. I had a selfish reason for it, because, rather abruptly, in November of 1955, I first suffered a detached retina in my right eye, followed in June of 1958 by the same occurrence in my other eye. I was faced, as are thousands of others, with the possibility of blindness, and all of the mental anguish such an outlook holds.

Before that time, I had never given any real thought to eye research.

Well, during that period, from 1955 to 1958, I spent a great deal of time, thought, discussion, with members of the ophthalmological fraternity, and I was inquiring primarily about the causes of retinal detachment. I was shocked then to learn how little they knew as to the causes and the incidence. The more I inquired into the overall subject of blinding eye diseases, the more I learned that relatively little was being done.

I was given the figures which Mr. Stein has quoted to you gentlemen.

Continuing my inquiries, I became acquainted with certain representatives of the Retina Foundation of Boston, an independent medical research institute, academically affiliated with the Massachusetts Eye and Ear Infirmary; and, thanks to the skillful treatment I received there, I am still able to see and read and carry on my work, even though I have suffered a substantial impairment of vision.

I found that to be an organization that seemed to be dedicated to basic and clinical research. In my opiinon, it was doing an excellent job.

This same foundation was also training the young doctors, the young scientists, in the field of ophthalmology.

I continued my attentions and devotions to the neurological, or to the Retina Foundation, and they are now, as you perhaps know, engaged in a much larger operation and have a rather ambitious building program, part of which is being supported, in part, by your Public Health Institute here.

Now, I did not come here to make a plea for the Retina Foundation, but I merely cite that foundation's fine work and what is being done and what can be done in the field of research.

Of course, there are other centers throughout the United States doing perhaps similar work. This is the one that I happen to know, what it is doing and what it can do. It is a rather new organization, which Mr. Stein is now chairing, the RPB we call it, Research to Prevent Blindness. It has, I think, an admirable opportunity of working closely with your Institute of Neurological Diseases and Blindness, in order to try to find out answers to some of these baffling questions in the field of blindness.

I think I can speak for the organization, RPB, that its primary function, one of its primary functions, is to work at all times closely with the Institute of Neurological Diseases and Blindness, in order to do what they can to get or attempt to get rid of some of these frightful cases of blindness.

Thank you, gentlemen.

Mr. FOGARTY. Now, I will ask you the same question. You heard me put it to Dr. Stein. This concerns the problem that we are faced with. There is a great campaign going on to balance the budget. Those of us on Appropriations Committees are sometimes deluged with that kind of mail. We were last year.

The chambers of commerce and the manufacturers association, and groups like that, spearhead these drives, and, as a result, we get many hundreds of letters.

Last year, for instance, Congress cut every appropriation bill with this one exception, and I guess the figure that was being used was that the Congress cut the President's budget by a billion and a half last year, but we increased this budget by $259 million. They cut back several programs a year ago, and the administration is doing the same thing this year.

We have the problem of providing additional funds for needed research that you people are interested in, but we also have a large number of cuts in other worthwhile programs that many of us feel must be restored. The President this year has cut back on vocational education, which is one of the most popular programs in the country. The majority of us, anyway, think that we have got to restore that cut.

He has cut back aid to schools in federally impacted areas. There is a deficit we have to make up, if we can. He has cut back construction of waste-treatment works, to help clean up the streams of our country from $45 million to $20 million. So there is another $25 million that we hope to make up.

There are other groups like yourself who are going to appear before us this week, and I guess the total figure that they would want is a little over $200 million more than the $400 million that is in the President's budget.

So these are the problems that we have to face as a committee.

We have had four appropriation bills pass the House so far. Every one of them has been cut, and quite severely.

When they cut the Post Office appropriation bill, which is generally a popular bill, you can see the tenor of the feeling in Congress.

You are chairman of the building-fund committee for this institute in Boston.

Mr. McCormick. This foundation; yes, sir.

Mr. Fogarty. And you have received a $300,000 grant from the medical research facilities program? But here is another area that the President cut back from the authorized amount of $30 million to $25 million; and we have to correct that by putting $5 million back.

So, when you say you have assurances that this amount will be very substantially increased—I don't know how you could get such assurances, when the President has cut back this fund by $5 million, unless the Congress does something about it and puts that $5 million back.

So, you see, we have a lot of deficits to make up before we even get to the point of increasing some of these appropriations that you are here seeking.

I am not criticizing you. I think you should be complimented. I think we ought to be spending more in this field. It doesn't bother me to go before my constituency and say that I have sponsored such increases in these areas, and tell them why; or to go to Congress, either. But I don't know how we are going to make out this year.

I just give you that for overall background. Now, will you, as a businessman, a member of the bar, tell us what you think about it?

Mr. McCormick. Mr. Chairman, I reduce it to one of simple economics. Take the expense to the State, the Federal Government, what, through research, we may be able to accomplish—in some instances have accomplished: retrolental fibroplasia is a good example. I think Dr. Maumenee and Dr. Newell will give you more of a detail as to what has been accomplished there; and projecting those figures—they run into millions and millions of dollars in saving to the national economy, let alone the great humanitarian aspect that we have been able to perform for the poor devil that was born or might have been born blind.

So, to me, it is like an investment in a new project built on a very sound foundation. As sure as God made green apples, it is going to pay dividends—given time.

Mr. Fogarty. I am sure it will, too.

Mr. McCormick. The dividends will be in the saving to the national economy.

Mr. Fogarty. We have a problem of convincing Members of Congress—and also the general public—that this would happen.

Mr. McCormick. Of course.

Mr. Fogarty. We may need your help.

Mr. McCormick. I think that these arguments, placed on an economic level or basis, are irrefutable.

Mr. Fogarty. I think they are, too, but there are some Members of Congress whom those figures don't affect at all.

Mr. McCormick. That is what makes horseraces.

Mr. FOGARTY. Putting it that way, we have had many a horserace on this in Congress.

Mr. MCCORMICK. May I offer into the record my statement?

Mr. FOGARTY. Yes, sir.

(Prepared statement of Mr. McCormick follows:)

I am Robert E. McCormick, a member of the New York bar and a corporate vice president of Olin Mathieson Chemical Corp.

My own interest in eye disorders dates from November 1955, when I first suffered a detached retina in my right eye, followed, in June of 1958, by the same occurrence in my other eye. I was faced, as are thousands of others, with the possibility of blindness and all of the mental anguish such an outlook holds.

In searching for the best treatment available, I talked with many medical experts in the field of ophthalmology and was amazed to learn how little was known about this disease from which I suffered—as to its causes and incidence—and also to learn that very little research was being performed to answer those questions which to me, and others suffering from the same disease, had suddenly assumed such vital importance.

Fortunately, I found out about the Retina Foundation of Boston, an independent medical research institute academically affiliated with the Massachusetts Eye & Ear Infirmary, and thanks to the skillful treatment I received there, I am still able to see and read and carry on my work—even though I have suffered a substantial impairment of vision.

I have maintained an active interest in the affairs of this foundation which is doing effective basic and clinical research into eye disorders. Additionally, this foundation is training selected basic scientists and young doctors from all parts of the world in special methods of examination and treatment of blinding eye diseases. Already, 40 young doctors and scientists have been trained in this institution from 1951 to 1959, and are carrying on their work in this country and 13 foreign countries.

The foundation urgently needs $1,350,000 for a new research building so that its work in basic eye research can be enlarged. I have accepted the chairmanship of the building-fund campaign committee and I am glad to report that we have already received an allocation of $300,000 from the medical research facilities fund of the Public Health Service, with assurances that this amount will be very substantially increased.

I mention the Retina Foundation as an example only because it is the research operation with which I am most familiar. I am certain that there are opportunities for similar productive work existing in many of our medical schools and centers. What is needed is encouragement to the young scientists and doctors—both financial and moral encouragement—and it is for that reason that I am devoting so much of my own time and effort to spurring on an enlarged research program. Research to Prevent Blindness, Inc., which organization Mr. Stein just referred to, can, and in my opinion will, become a strong influence here.

I also regard it as all important that private organizations, such as Research to Prevent Blindness, Inc., should work closely with the Institute of Neurological Diseases and Blindness. Here we have the golden opportunity of promptly finding the answers to many of the questions concerning blindness, thus saving the country a large part of hundreds of millions of dollars now being spent each year in the care of the blind and, more important, conserving the economic output of these people and eliminating the misery and loneliness which only those deprived of the blessings of sight can really understand.

Mr. FOGARTY. Dr. Newell, we will be pleased to hear from you at this time.

STATEMENT OF DR. FRANK W. NEWELL

Dr. NEWELL. Mr. Chairman and members of the committee, first of all, I wish to thank you for the privilege of appearing before you to present the importance of research in ophthalmology.

I am Frank Newell. I am a graduate of Loyola University School of Medicine in Chicago, Ill. I am now professor and head of the Division of Ophthalmology at the University of Chicago.

I trained in ophthalmology at the University of Minnesota.

During the past year, as a member of the Board of Scientific Counselors of the National Institute of Neurological Diseases and Blindness, I have had a unique opportunity to become intimately acquainted with the intramural program of the Institute, especially as it is related to problems of the eye.

And I would like to bring out some of the main points of this program, because it is within a group such as at the National Institutes of Health that the advances in basic research can be most quickly applied to the diseases in patients.

This has been a great fault in medicine in years past. There have been many, many years elapse, on occasion, between a medical finding and its application to disease. It was some 14 years between Fleming's discovery of penicillin and its application to disease. The same with the sulfonamides.

It is within such tightly knit working units that the greatest power can be generated to solve the pressing problems of blindness and new discoveries in the laboratories can be applied most quickly and usefully to blinding diseases. The basic scientists are working shoulder to shoulder with clinicians.

Now, last year, at the Clinical Center, within the ophthalmology group, there were 250 carefully selected patients treated, and some 800 patients seen in consultation. These patients served as a focal point for a broad research program. Four of these areas, I think, are of particular interest to this group.

One of the most serious causes of blindness in adult life is inflammation of the delicate tissue of the back of the eye, uveitis. At the Institute, they have been correlating a sensitive skin test for diagnosis of toxoplasmosis, a widely spread disease, which is the cause of a great deal of inflammation of the eye.

With this correlation they have found that nearly 50 percent of the patients who have a positive skin test and are treated with specific medication for toxoplasmosis improved, and a significant group of patients have improved.

I think it is worth pointing out that toxoplasmosis is a cause of acquired inflammation of the eye, has been described only since 1953, and it is the work within the National Institute for Neurologic Diseases and Blindness that has delineated its importance.

Now, in 1958, an important development occurred in the surgery of cataract. By the injection of an enzyme, the supporting structures of the lens were dissolved, and the lens could be more easily removed. This has permitted removal of the complete lens in many patients in whom it was not possible before, particularly patients between the ages of 20 and 40. After the age of 40, this enzyme is not quite as important as it is before that.

The investigators at the Institute attached a very important problem concerning this: Does this enzyme have any effect in other structures of the eye, and the supporting ligaments? Fortunately, the effects are very minor, and the enzymes do have a definite application. One would, of course, rather prevent cataract from forming, than to have to remove them.

The group at the National Institute have been studying nutritional deficiencies, particularly in the development of cataracts, and experimental animals; and studying the deficiency of the amino acid

52692—60——10

tryptophane in guinea pigs, and have been producing cataracts in guinea pigs by eliminating this amino acid from the diet.

This has suggested possibly a nutritional factor plays a role in the cataracts in man.

Another cause of blindness is glaucoma, in which the pressure in the eye becomes so elevated that damage occurs in the optic nerve, and blindness may ensue.

In the past few years, a large number of new drugs have been developed for the treatment of glaucoma, so many new drugs, in fact, that medicine has become so effective both in improving the flow of fluid from the eye or reducing the flow of fluid into it that surgery is being used less and less to relieve some types of glaucoma.

Here, again, it is important to diagnose a disease before it develops, or in its early stages; and the investigators at the Institute have been using a sensitive index of the amount of fluid flowing from the eye, and the amount of fluid flowing into it, as an early diagnostic step in glaucoma. It is a very effective one.

Now, the investigators at the Institute also have been studying the flow of fluid within the animal eye. They have found, rather importantly, that there is a considerable difference between the way fluid is formed in a cat, the guinea pig, rabbit, and man; and these are of great importance, since we use these animals so commonly in our experimental studies.

Additionally, they have demonstrated a control center in the central nervous system that has something to do with the maintenance of a normal interocular pressure.

Another area in which they have been working is in inborn errors of metabolism, so-called molecular diseases, in which there is a deficiency of an enzyme, so the tissues do not form normally. The retina is a very important tissue for this type of study, because its function is so highly maintained and can be so easily tested with the eye being right available for testing.

Within this area, they have brought Dr. Rushton from England, who, I think, is probably the most outstanding scientist in this area in the world, to work at the National Institutes of Health during the past year. Using the facilities at the National Institute, which are truly unique, he has studied color blindness and studied the mechanism of vision in certain patients, and he has correlated some of the studies that were only done in animals, and brought them right to the mechanism of vision in humans.

In the same line, in the Tay Sach's disease, a tragic inherited form of blindness, and which causes death, the investigation at the National Institutes of Health has developed a test which permits a differentiation between the congenital early disease which occurs between the 15th and 24th month, and the disease that occurs later in life.

I would think that up to now we had already considered these diseases as being the same thing, but the tests at the National Institutes of Health indicate that these are two different conditions, at least as far as the tracings that they get electrically from the retina.

Now, these advances at the National Institutes of Health have been carried out within a very brief span, only since 1953 has this program been going on, since ophthalmology was one of the last programs to develop at the National Institutes of Health. It has suffered very

much from the shortage of space. There is a new facility being erected at the National Institutes of Health, and I should hope that there should be adequate space for basic research in ophthalmology within this new facility.

Most importantly, I think, the National Institutes of Health has pointed the way with a pattern for basic scientists working shoulder to shoulder with clinicians, so that basic discoveries can be applied early to patients.

And I should like to urge your consideration that the Congress consider appropriating funds to supplement local philanthropic funds, foundation funds, for the establishment of research centers throughout the country similar to those at the National Institutes of Health.

With 250 patients hospitalized last year within the eye section at the NIH, it should be evident that there is just a limited amount of research that can be carried out within this single facility, and yet the development of research centers throughout the country would permit a large number of basic scientists to work closely with clinicians in the prosecution of eye disease.

Thank you for your attention.

Mr. FOGARTY. Thank you very much, Doctor.

(The prepared statement of Dr. Newell follows:)

Mr. Chairman and members of the committee, I am Dr. Frank W. Newell, of Chicago, Ill., and am a graduate from Loyola University School of Medicine in that city. I am now professor and head of the division of ophthalmology at the University of Chicago. I am most appreciative of this opportunity to appear before this committee and discuss problems relating to research in the field of ophthalmology. I should like to mention that the travel expenses incurred in the journey from Chicago to Washington have been paid by Research to Prevent Blindness, Inc.

During the past year as a member of the board of scientific counselors of the National Institute of Neurological Diseases and Blindness, I have had a unique opportunity to become intimately acquainted with the intramural program of the institute, especially as it is related to problems of the eye. I would like to take a few minutes to describe this program and give some picture of its breadth. I believe that it is extremely important for the members of this committee to understand the tremendous advantages which accrue in the understanding of disease when a broad program of this type is available, a program in which scientists working on fundamental problems in the laboratories are brought into close cooperation with a clinical group responsible for patient care. It is within such tightly knit working units that the greatest power can be generated to solve the pressing problems of blindness and new discoveries in the laboratories can be applied most quickly and usefully to blinding diseases.

Last year this unit had under investigation more than 250 carefully selected patients and was called on to see more than 800 other patients within the clinical center on consultation. These carefully selected patients serve as a focal point for a broad research program. Four parts of this program may be of particular interest to this group.

One of the most serious causes of blindness in adult life is inflammation of the light sensitive membrane in the back of the eye. Within the past few years it has been found that in many instances this condition, known as uveitis, may be caused by infection from a widely spread small organism called toxoplasma. This protozoa is found throughout the entire animal and bird kingdom and has been found to account for many cases of uveitis. Within the past year this disease has been under constant investigation at the institute and the applicability of a sensitive skin test has been under study. It has been found that this skin test is completely reliable in indicating past infection with this organism and that 50 percent of those patients with a positive skin test have shown improvement when treated with newly developed drugs which are effective against the toxoplasma. This study is being continued and broadened in an effort to determine other factors which may cause and influence this devastating inflammation of the eye.

An important development in 1958 involved an improved technique for the removal of cataracts. The injection of an enzyme into the eye leads to a softening and dissolution of the delicate fibers which hold the cataractous lens in position immediately behind the pupil. With dissolution of these fibers the lens may be more easily removed and the enzyme has greatly facilitated the removal of cataracts in the age group between 20 and 50 years in which surgery is difficult. Investigators at the institute have been evaluating the possible harmful effects of this enzyme with particular reference to its action upon parts of the eye other than the supporting lens fibers. It has been most reassuring to find that the disturbances are relatively minor and do not contraindicate the use of this enzyme.

Of course one would much rather prevent the formation of a cataract than be forced to remove the lens surgically. Investigators at the institute have been carrying out a large number of studies relating to factors involved in cataract. They have discovered that certain dietary deficiencies in experimental animals will product cataracts. Cataracts produced in this manner have been studied with the electron microscope and other sensitive instruments to determine whether these experimental cataracts in animals are comparable to those which occur spontaneously in man. It may be that disturbances in diet or metabolism in man in some instances are related to cataract formation.

Another cause of blindness in the adult is glaucoma, a condition in which the pressure within the eyeball becomes elevated, causing damage to the optic nerve and ultimate interference with vision. Over the past few years our methods of treating this condition medically have improved markedly. A number of new drugs have been developed which allow the fluids to drain from the eye more freely and other compounds have been developed which decrease the amount of fluid being formed. This has led to many fewer operations for this condition and treatment now is more generally medical than surgical.

Effective medical treatment, however, requires early diagnosis before irreversible changes have occurred in the eye. The development of a reliable diagnostic test is thus of the utmost importance. Scientists at the institute are discovering the sensitive indices of the volume of fluid flowing into and out of the eye may offer the best hope for early diagnosis.

Clinical studies of glaucoma are receiving strong support from animal experimentation to determine the mechanism of fluid transfer within the eye. This transfer apparently depends to some extent upon the anatomy of the small blood vessels within the eye itself. In addition, there seems to be some regulatory system within the nervous system which operates independent of the vascular system to control the pressure within the eye.

Among the most tragic causes of blindness are those associated with congenital defects. Hereditary diseases are "inborn errors of metabolism"—peculiarities of body chemistry which lead to degeneration of the light sensitive membrane at the back of the eye, and understanding of these conditions rests upon accurate knowledge of the anatomic structure, chemistry, and function of the retina.

During the past year one of the world's outstanding investigators of the physiology of the eye has been a visiting scientist at the National Institute of Neurological Diseases and Blindness. The unique facilities of the Institute are making it possible for him to study for the first time in humans the response of the eye in normal as well as color-blind individuals to various forms of light stimulation. Working at his side are basic scientists who are studying the response of the eye of the horseshoe crab, which was selected because of the simplicity of this eye in contrast to the complex structure of the human eye.

Also under investigation has been a group of children suffering from Tay Sach's disease, a tragic inherited form of blindness. Investigators have developed a highly sensitive technique of measuring electrical changes in the retina occurring with light stimulation. These techniques promise to become one of the most sensitive indexes of progression of this tragic condition.

All of us should take great pride in the accomplishments which I have briefly outlined of this dedicated, competent group of investigators. These accomplishments and development of this Institute have been carried out over the brief span of but 7 years. However, I believe that this work should now be broadened and strengthened. I should like to point out that because of the fact that the program in ophthalmology has been one of the most recent to develop within the Institutes, the program from the start has been handicapped by serious shortages of space. I am pleased to note that increase in the basic laboratory space for the program of the National Institute of Neurological Diseases and Blindness is being planned for the near future. I should like to urge that

adequate space be allocated within any new facility to assure that this tremendously important program of eye research be permitted to go vigorously forward.

I think that the pattern of the National Institutes of Health in having basic scientists work shoulder-to-shoulder with clinicians is one most likely to yield significant returns in all medical research in the future. The number of studies, however, that can be carried out within the National Institutes of Health is, of course, limited. I should like to recommend, therefore, that Federal funds be used to augment existing local and philanthropic funds for the establishment and the maintenance of a series of adequate eye research centers throughout the country. This is a topic about which Dr. Maumenee is going to speak in much greater detail, but I wish to indicate how tremendously important and rewarding eye research in this area can be.

STATEMENT OF DR. A. EDWARD MAUMENEE

Dr. MAUMENEE. I am A. Edward Maumenee, William Holland Wilmer professor of ophthalmology, and director, Department of Ophthalmology, Johns Hopkins University & Hospital. I am also the chairman of the collaborative glaucoma detection study, and a members of the National Institute of Neurological Diseases and Blindness Uveitis Committee.

Mr. FOGARTY. You have a patient who is a Member of Congress from New Jersey, Mr. Rodino. He has been very complimentary of your efforts to help him since last summer. I have been talking with him just this morning. He said he would be here, but he is on the Judiciary Committee, and they have a very controversial problem up this morning, and he has to be there.

Dr. MAUMENEE. Thank you. I wish we knew a little bit more about glaucoma, so I could do a better job for him.

Dr. Newell has already spoken to you of the unusual opportunities available to us through the intramural program of the Institute. But I think we must realize that this program can really tap only a very small percentage of the potential research team and material that is available in this country for programs of this type.

I would also like to urge that several centers of this type be set up in large institutions, large teaching institutions throughout the country, to carry out the correlation of basic laboratory research with clinical research. That can be done only in such an institution.

The National Institute of Neurological Diseases and Blindness has just recently started a collaborative study for the detection of glaucoma. In a survey of glaucoma, we have found that approximately 2 percent of the population over 40 have manifestations of this disease. We are not exactly sure what percentage of these people will eventually go blind from glaucoma, but certainly, if left untreated, a high percentage, we feel, will lose vision from this disease.

Very interestingly, in this study it has already been found that if one member of a family has glaucoma, approximately 15 percent of the other members of the family will have glaucoma. We think we can detect this at a very early age—that is, in the twenties or so—evidence of this.

Now, this is all new work that is being supported by the Neurological Diseases and Blindness Institute.

Our methods of detection of glaucoma are still completely inadequate, because we really don't just know where the disease begins. In order to carry out adequate therapy, it is necessary that we get

these cases early; for once vision has been lost from glaucoma, we cannot bring this vision back by any known medical means, once the optic nerve has degenerated.

Another field of very great importance, as far as blindness is concerned, is the field of uveitis. It is an inflammation in the eye, of the uveal tract, the retina, and probably in the vitreous.

I am sure that this is not a single disease entity that is caused by one micro-organism or bacteria, but probably has multiple causes bacterial and viral and allergen type of responses. This disease has been known for hundreds of years, really, in ophthalmology, but we are still just about as far from the basic cause of this disease as we were 100 years ago.

Except for the few isolated instances of toxoplasmosis, as Dr. Newell has mentioned, and a few other specific causes, there still remains to be a great deal of work done in the field of uveitis.

One of the great problems we have in ophthalmology is lack of trained investigators in basic science, the basic science aspects of medical research, and the training program which was begun in January of 1958 has done a great deal to stimulate young men who have some basic training in research to stay in the field of ophthalmology.

This fund, as it creeps from approximately $800,000 to $1.5 million in the last few years, I think it could be expanded still further. It is one of our greatest needs in research in ophthalmology to attract more people who are capable of doing this work at a very basic level of investigation.

Now, when we discussed blindness, we might look back over the past 10 years and point with pride to some of the things that have been accomplished. Retrolental fibroplasia has been mentioned on several occasions, and I might point out, from the economic point of view, this: In 1953, when I was active in California with the rehabilitation program, it was pointed out to me at that time that approximately 5 percent of blinded individuals were completely self-supporting; others were receiving aid for their support. So that if you have a person who has become blinded, then this person has to receive support—at least in the past they have. They haven't been able to earn their living.

We know a great deal more about glaucoma than we did 10 years ago, but I think this is a field that still needs considerable investigative work.

Removal of cataracts has also been mentioned by Mr. Stein, and improvements that have occurred with newer techniques of suturing the wound and removing the lens and the capsule and recently the development of an enzyme which has allowed the zonules to be broken, so the lens can be removed more easily. The field of corneal transplantation is a very important one in ophthalmology for persons who had cloudy corneas, can now be made to see by transplanting a clear window or cornea from another person.

This goes beyond the field of opthalmology, really, because if we can find out why corneal grafts turn cloudy, because of the graft from another person, or the allergy—someone else's tissue—this can be applied to research in transplanting kidneys, heart, and many other tissues in the body.

Likewise, ophthalmology in the field of research has other factors that bear on disease in general.

For instance, uveitis. We know that uveitis is frequently related with rheumatoid arthritis. If we can find out through research in the field of uveitis, the cause of this, I feel sure that some of these contributions can be applied to the rheumatoid arthritis diseases and the problem of various vascular diseases of the eye, and our search for the causes of diabetic retinotherapy, changes in blood vessels in the back of it.

This is the best place in the eye to look at the changes in the vessels, and to pick up these early changes, so that research in this field will also be applied to medicine in general.

Another field that has made great advances in recent years is the surgical treatment of retina detachment work. Our percentage of cures, even as late as 10 years ago, even as recently as 10 years ago, was only about 50 percent of the reattachments of retinas, and now this percentage has increased to around 80 percent, with the saving of vision of many, many people.

These are just a few example of some of the things that are being done in research in ophthalmology. There are many others that need to be done.

I feel that with sufficient support, our advances in the next 10 years will be very much greater than they were in the past 10 years.

Mr. FOGARTY. Thank you very much, Doctor.

(Prepared statement of Dr. Maumenee follows:)

Mr. Chairman and members of the committee, I am A. Edward Maumenee, M.D., William Holland Wilmer professor of ophthalmology, and director, department of ophthalmology, Johns Hopkins University and Hospital. I am also the chairman of the collaborative glaucoma detection study and a member of the National Institute of Neurological Diseases and Blindness Uveitis Committee.

Dr. Newell has spoken to you of the unusual opportunities available to us through the intramural program of the institute. We must recognize, however, that this will continue to be a relatively small program and cannot possibly fill the tremendous need which exists for eye research. During 1959, almost $4 million was spent by the National Institute of Neurological Diseases and Blindness for eye research. Only about 1 million or 25 percent was used for intramural research. This, of course, is only a small fraction of the Nation's potential for research in this important area.

Supported by the National Institute of Neurological Diseases and Blindness, and in cooperation with the Bureau of State Services, four large centers are now cooperating in a study to determine an effective means of glaucoma detection. As pointed out by Dr. Newell, early detection is essential if the present drug therapy is to save vision in individuals developing glaucome. We know that our present detection techniques are quite inadequate. Through this cooperative study it is anticipated that newly developed methods can be rapidly brought to test, and the most effective program for glaucoma detection developed.

The study of eye inflammation is another area which requires the cooperative effort of clinics scattered throughout the country. Uveitis is not a single disease, but probably is an inflammation of the eye which may result from many different factors. It is important that the manifestations of this disorder in various parts of the country and under different geographic and climatic conditions be compared. Through the concerted effort of a large number of investigators, the various causative factors beyond toxoplasmosis, discussed by Dr. Newell, can be uncovered. I am presently working with an active group of investigators attempting to formulate a protocal for a large-scale attack on this significant cause of blindness.

One of our most difficult problems in the development of a broad national research program in blinding diseases is the lack of trained investigators in this vital field. Training programs for scientists who can study the blinding diseases must be the cornerstone of our future research and should have first priority in any long-range program. From 1958 until January of this year, the amount of money spent for training programs in ophthalmology has almost doubled from approximately $800,000 to 1½ million. This, of course, is only a small

fraction of the country's need. At the present time, most of the training programs within our university centers are manned by men who must devote much of their time to other responsibilities. The training of our future scientists is not a part-time matter, but demands the full-time attention of top-level leaders. It is essential that a way be found as quickly as possible for the leaders in this field to concentrate on the development of teaching and research programs in each of our university centers.

Dr. Newell has referred to the value of the Institute's intramural program and its broad multidisciplinary attack on problems relating to the eye. Why should the National Institutes of Health at Bethesda be the only place in the country where such a broad program is being developed? I should like to urge that Congress give serious consideration to the establishment of similar units of various sizes located within university centers. These organizations should be provided with the facilities and staff necessary to mount a large-scale attack on all disorders of vision.

In considering the problem of blinding diseases, we can view with pride the accomplishments of the last 10 years. Retrolental fibroplasia has been eliminated as a cause of blindness. Scientific advances now make it possible for a large proportion of glaucoma patients to retain useful vision if treatment is started in time. The removal of cataracts through surgical means has been simplified through improvements in surgical technique. Individuals previously doomed to a life of total blindness by reason of opacity of the eyeball are now being restored to sight through corneal transplantation. In spite of these advances, however, many thousands of our citizens lose their sight each year. Therefore, we should think of the advances of the last 10 years as evidence of the potential of research, research which can improve the outlook for millions of citizens who now have serious eye disorders and for other millions who will be blind unless we find many long-sought-for answers.

Mr. FOGARTY. What do you doctors think about our problem in appropriating these funds? We have other demands on us to cut down Federal spending in all areas.

I was just adding up these deficits I was telling Dr. Stein about a while ago, and I added up here about $180 million we are short now, before we start increasing any of these funds for research.

So, before we get to this part of the budget, we feel that we are about $180 million short now, that we have to make up these actual cuts below the current level in these other important programs.

Then we have the responsibility of providing the health services for the Indians now. Mr. Marshall has been handling that problem for us in committee, and has been doing a real good job. That used to be in the Department of the Interior, but now the Public Health Service is charged with it. We are trying to get better sanitation facilities, doctors out on the reservations, hospitals built, and things like that. Any increase for that would add to the $180 million, which represents just cuts below the current level.

Dr. MAUMENEE. I might say to you the problem of trachoma in the American Indians—in some areas the incidents is as high as 18 percent of the Indian population—had severe trachoma, causing practical blindness.

With the advent of the sulfonamides, and with the use of this drug to prevent trachoma, I think the figure that I quote was in about a period of 3 years; this percentage dropped from 18 percent to less than 1 percent of the Indians having active cases of trachoma.

So, from purely an economic point of view of supporting and caring for these patients in hospitals, with proper sulfate treatment,

they had to come back, had to hire physicians to take care of them, people to take care of their blindness—you have already saved money, and the blindness you have prevented in trachoma.

Mr. FOGARTY. What do you think of our problem? What are some of the best answers to give to the House, if we are lucky enough to get these increases some of us think we ought to have, through the appropriations committee? What are some of the best answers we can give the Members of Congress?

Dr. NEWELL. Mr. Fogarty, if the economic argument is not accepted, it is hard to get any argument except at an emotional level. We teach student nurses, in the nursing of surgical cases, by blindfolding their eyes for an hour, and they appreciate some of the problems the patients go through with their eyes tied up and unable to see.

But we have already within this area, I think, even retrolental fibroplasia, and with glaucoma, have also kept a huge number of people as taxpayers and supporters of the Government, and prevented them from becoming wards of the Government.

Nearly 50 percent of the blind are not self-supporting, and receive either State aid or Federal aid of some type.

Mr. FOGARTY. We have the same problem in mental health, you know. But sometimes those arguments don't seem to go very far, as far as some of these Members of Congress are concerned.

Dr. MAUMENEE. Certainly, the population, the average age of the population, is growing older, as we have more people who live to a longer age. And many of these diseases that we have spoken of, such as glaucoma and retinal detachments, occur in a higher percentage in older age groups. So that at least to keep up with the progress of the aging population, we have to learn a little bit more about this, or the blindness, our percentage of blindness in the country, will not stay still, but will continue to increase.

Mr. FOGARTY. The Secretary of Health, Education, and Welfare, when this budget was announced, held a press conference announcing that this was a progressive, forwardlooking budget that would allow expansion and advancement in the field of medical research.

You mentioned a while ago that one of the areas that needs increased emphasis is the area of training personnel. But there are no increases in the budget allowed this year for research fellowships or training of personnel.

So this budget is not one that will allow advancement in the field of medical research, but is one of retrenchment.

Mr. DENTON. I was interested in this comment that if we spent money on this program now it would save us a great deal of money in the future. Of course, Mr. Fogarty spoke about the deficits we have here. That is where there have been cuts in the budget by the administration, and I expect in most all of those it would save us money in the long run if the cuts are restored, but the big point is we have some people who are not so much concerned with the future and our children and our grandchildren as they are with balancing this budget today. That is a problem we have.

What would you say to that argument?

Dr. STEIN. Well, it is a difficult one to argue, because no doubt there is a great desire to protect the value of the dollar, and to avoid inflation, avoid these expenditures.

We keep coming back—I do—keep coming back to the point that the greatest investment is investment in our health, and we can increase the economic usefulness of anyone whose health we can improve or preserve.

Mr. DENTON. I think they will all agree with you on that.

Dr. STEIN. One thing with relation to it, unfortunately, perhaps, it hasn't been presented by a group that has been particularly interested, such as we are. The amount that has been allocated for prevention of blindness has been rather nominal in relation to many other diseases which are not as staggering numerically.

Perhaps it is like the story of the man who said he was doing very good business this year, in a year of the depression. Somebody said, "What business are you in?" He said he was in the automobile business. Last year he only sold one car, and this year he sold five.

We are coming in from a basic level that no one has made any approach on.

Mr. DENTON. I don't think we have any argument about that, but I would like to have some answer to this argument that we want to balance the budget today; the future is a different question.

We just had this water pollution bill vetoed. Most everybody agrees, in the long run, that would be good money to spend, but it is money this year.

I would like to have somebody give me an answer to that argument.

Dr. STEIN. I think great economists have tried to answer this. There is only one, and that is increased taxation, and I for one would be in favor of it, if it could be used for medical benefits, because I think it would be repaid many times over.

Mr. DENTON. You think that is the only way we could do that? Do you think it would be possible to cut down money in other places where there is great waste?

Dr. STEIN. I wouldn't like to come before this committee and cut out moneys being given to other organizations.

Mr. DENTON. The increasing interest on the debt for the last 7 or 8 years would take care of this whole budget for the Department of Health, Education, and Welfare.

Dr. STEIN. The increase——

Mr. DENTON. The increase in the interest on the debt would take care of this whole budget before us. Of course, a great deal of waste is in foreign aid. I am talking about the waste in it—much more than would take care of medical research. Building roads through the jungle that start no place and end no place, for water buffaloes to walk over—expenditures like that. Let me ask one other thing: Why do we get farsighted as we get older?

Dr. STEIN. I can answer that, with my background, but I would rather have the doctors do it. It is a fixation of lens.

Dr. MAUMENEE. The lens in your eye changes its shape as you look at something close, and as you get older, this lens, the nucleus, the center of the lens, gets hardened so that you can't change the shape of this lens as easily. Thus, a small child likes to put his funny paper

about 2 or 3 inches in front of his face. As you get older, you can't change the shape of the lens and therefore you get less accommodation, which makes you presbyoptic.

Mr. DENTON. Off the record.

(Discussion off the record.)

Mr. MCCORMACK. Has any thought been given to tying the overall medical programs together? This involves research—tie it together with social security benefits?

I read recently that they are contemplating raising a half point in benefits, to be charged the employer or employee or both, for geriatrics and for their medical treatment.

Mr. DENTON. A great deal of legislation was introduced on the subject.

Dr. STEIN. Many of these conditions start in childhood. As contrasted to some other medical conditions, such as cancer, while it is very important to do, as a rule the cancer patient won't live too long; but here you may have a charge on the economy for 50 or 60 or 70 years.

Mr. DENTON. Since I have been on this committee I have seen great savings to the public generally—on tuberculosis, venereal disease, infectious diseases, typhoid, pneumonia, and malaria—a great saving to the public. Research has paid off. That money was spent years ago, and we are getting dividends on it now.

Mr. FOGARTY. Then, on control of venereal disease, for a while the incidence was going down, then it leveled off, and it is now starting to go up again. The administration is asking less funds this year than last.

So we have about $700,000 cut there this year that we think is unjustified, in view of the incidence going up. Another $700,000 I forgot which I think we ought to restore.

Dr. STEIN. We will be lucky to get out with the same money we had this year.

Mr. FOGARTY. We are going to appropriate more, somehow, some way.

Mr. DENTON. Before we get through.

Mr. FOGARTY. Do you gentlemen have anything more you want to say?

Dr. STEIN. We want, on behalf of our committee, Mr. Chairman, to thank you.

Mr. FOGARTY. I think you have given us a real good insight into the problem. This is the first time in my knowledge in 14 years that we have had so much said about the problem of blindness, before this Committee. I think you have done a real good job, and we thank you for coming.

(The following was subsequently submitted for the record:)

LETTER FROM THE HONORABLE PETER W. RODINO, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY; AND STATEMENT OF DR. HUMBERT M. GAMBACORTA

HOUSE OF REPRESENTATIVES,
*Washington, D.C., March 3, 1960.*

Hon. JOHN E. FOGARTY,
*Chairman, Subcommittee on Departments of Labor and Health, Education, and Welfare Agencies Appropriations, House of Representatives.*

DEAR JOHN: In accordance with our telephone conversation I am attaching herewith statement of Dr. Humbert M. Gambacorta.

For your information Dr. Gambacorta has, along with Dr. Maumenee, who appeared before your subcommittee Tuesday, been attending to my glaucoma disorder.

Regards.

Sincerely yours,

PETER W. RODINO, Jr.,
*Member of Congress.*

STATEMENT OF DR. HUMBERT M. GAMBACORTA BEFORE THE SUBCOMMITTEE ON DEPARTMENT OF LABOR AND HEALTH, EDUCATION, AND WELFARE AGENCIES APPROPRIATIONS

Mr. Chairman, it is my privilege to submit to your committee a statement concerning the problems of visual disorders and diseases of the eye prepared by Dr. Humbert M. Gambacorta of Newark, N.J.

Dr. Gambacorta, whom I have come to know well as a friend and neighbor and physician is a dedicated member of that noble profession and a person with a great heart for service.

Although a relatively young man in his chosen specialty, I believe that his searching mind, his ability and his scholarly devotion to his profession together with an inspiring desire to give comfort and aid to those stricken with the diseases which rob one's treasured sight will drive him on to help find answers to the yet unknown causes to some of these dreadful diseases, so that one day mankind will benefit.

May I also include at this point a brief sketch of Dr. Gambacorta's professional background and experience.

Humbert M. Gambacorta, M.D. was born in Boston, Mass., on August 12, 1926. He received his B.S. at Seton Hall College, South Orange, N.J., in 1946, and his M.D. at the University of Pennsylvania School of Medicine in 1950. He served his internship at St. Michael's Hospital, Newark, N.J. in 1950 and 1951. He took a basic science course in ophthalmology at Postgraduate School of Medicine of New York University, 1951–52, and was a resident in ophthalmology at the New York Eye and Ear Infirmary from 1951 to 1954. From 1955–56, he served as ophthalmologist for the Second General Hospital, USAREUR.

Staff appointments: Assistant attending in ophthalmology, Newark Eye and Ear Infirmary, Newark, N.J.; St. Michael's Hospital, Newark, N.J.; and Columbus Hospital, Newark, N.J.; associate attending in ophthalmology, Clara Maas Hospital, Belleville, N.J.; courtesy staff, New York Ear and Eye Infirmary, New York City.

As a practicing ophthalmologist for the past 6 years, I have had occasion to note the more or less secondary role that ophthalmology plays in the makeup of the average general hospital. It is for this reason, perhaps, that the specialty hospital arose many years ago, so that adequate and complete diagnostic and therapeutic facilities could be made available to the public in the specific area of visual disorders.

In recent years, the concept of the "large medical center" has arisen both in medical, hospital, and business thinking. In other words, it is becoming desirable to have a large center capable of handling any medical or surgical problem whatsoever, whether it be diagnostic, therapeutic, preventative, or rehabilitative.

Tremendous emphasis is being placed on cancer, cardiac, and rehabilitative facilities with little if any, on disorders of vision. It goes without saying, that the diagnosis and the treatment of cardiac disease, cancer, and orpthopedic

anomalies, are of paramount importance in the restoration of disabled individuals to useful productive lives. By the same token, should not one's eyes be given the same importance?

Our eyes are extremely important in the execution of our daily tasks whether we be in Government life, the military, the professions, business or trades. The loss, partial or total, of this sense, which we take so much for granted, brings about a sudden inability to earn a salary or wages; creates dependencies and emotional disturbances of a grave nature on the psyche of the individual afflicted, to the same extent, if not more so, as the aforementioned maladies.

In the United States, 250,000 people are classified as being blind. Seven of every hundred of these are teenagers or younger. One-third of the blind are of middle age. One-half of the blind are senior citizens of 65 or older. Glaucoma accounts for 15 percent of all blindness.

These people are blinded by various diseases of the eye such as glaucoma, uveitis, and retinitis pigmentosa. Others are blinded by systematic disorders which bring about alterations in the visual apparatus, such as diabetes and hypertension. Others are blinded by traumatism, and still others, following unsuccessful ophthalmic surgery.

For the most part, people are going blind from conditions about which we know very little. It is true that a great deal is known about these diseases but much remains to be discovered and this can only be brought about by an unrelenting effort on the part of physicians, legislators, and leaders in the community to afford a broader base of research in this sphere.

Throughout the Nation, a tremendous expansion in our existing hospital facilities is now taking place. Funds which are now available, and funds which are being raised, are being used primarily for research and rehabilitation in the area of cancer, cardiac disease, and orthopedics. Some of these funds originate from a Federal level.

It is at this time that I strongly urge this committee to seriously consider raising the level of assistance to worthy projects directed towards better diagnostic, therapeutic, research, and rehabilitative facilities in the area of visual disorders, whether they originate from ophthalmic specialty hospitals or from projected medical centers.

---

TUESDAY, MARCH 1, 1960.

## COOPERATIVE RESEARCH IN WELFARE AND SOCIAL SECURITY

### WITNESS

### RUDOLPH T. DANSTEDT, DIRECTOR OF THE WASHINGTON BRANCH OFFICE OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS

Mr. FOGARTY. We are glad to have Rudolph T. Danstedt, director of the Washington branch office of the National Association of Social Workers with us. We will hear from you now. Your statement will be included in full.

(The statement referred to follows:)

Mr. Chairman and members of the committee, our association represents somewhere in the order of 27,000 social workers employed in governmental and voluntary health and welfare agencies.

I am pleased to note that the administration is asking for $700,000 for cooperative research in welfare and social security. We are certain that the case for these funds has been ably laid before this subcommittee by both Secretary of Health, Education, and Welfare Arthur Flemming and Commissioner of Social Security William Mitchell, for we know that both Mr. Flemming and Mr. Mitchell have placed the need for these funds at the top of their priority list for the social security and public welfare fields.

The members of this subcommittee undoubtedly are aware of the fact that the Advisory Council on Public Assistance and the Advisory Council on Child Welfare, authorized in the 1958 amendments to the Social Security Act, have also underlined the urgency of research in the fields of public assistance and

child welfare, stressing particularly the need for examining factors that bring about family disorganization and child dependency. Both of the Advisory Councils have urged the importance of Federal leadership and funds for such research, following, therefore, a pattern that has proved so successful in the health field. Federal stimulus to social welfare research should and would stimulate emphasis and interest in problems of dependency on the part of States, communities, universities, and other research groups, and encourage the growth of voluntary and non-Federal public funds for needed research.

The urgency of getting started in welfare research cannot be overstressed. This subcommittee last year asked the Department of Health, Education, and Welfare for a study of what is being done and should be done in the area of prevention and control of juvenile delinquency. The Senate Subcommittee on Appropriations asked the Department for a study of illegitimacy and its relationship to ADC. In both instances the Department had to turn to State welfare departments, juvenile courts, voluntary agencies, and other groups for data bearing upon these two requests and has found, in the main, a rather discouraging lack of such data.

I believe a good case could be made for an appropriation for cooperative research in welfare and social security in the order of $1.5 million rather than the $700,000 requested by the administration in order to truly encourage the sort of demonstrations and research that are needed, first to help people constructively, and secondly to point out better directions for the use of the $2 billion of Federal funds and the $1 billion State and local funds now being expended through public assistance for the needy.

I want to register our support also for a $17 million appropriation for child welfare services instead of the $13.6 million requested by the administration. The elimination of the rurality feature in the child welfare section of the maternal and child welfare title in 1958 has appropriately placed larger burdens on public welfare departments with respect to the care of dependent and neglected children. These burdens are not now being adequately discharged and will not be even if the $17 million is made available. But, of course, this $17 million figure would at least come substantially closer to putting into effect the intent of the Congress when it eliminated the rurality feature.

We are disappointed that the administration did not ask for any money for training of public welfare personnel. We welcome the efforts currently in process for inservice training of field representatives of State public welfare departments and the plans that are projected for further inservice activities in 1960. We appreciate that State welfare departments can now, on a 50–50 matching basis, provide training out of their administrative grants, but this is so far below the formula available for training in health and vocational rehabilitation we can understand why little advantage has been taken of this 50–50 matching program.

Again, I would like to note that the Advisory Councils on Public Assistance and Child Welfare laid urgent emphasis on the need for training of personnel and recommended that such grants be 100 percent federally financed, following the pattern now in effect in the public health and vocational rehabilitation areas.

It is my understanding that a number of States are in a legislative position to take advantage of the 1956 training amendment with its 80 percent Federal funds and 20 percent State and local funds. We think they should have and they need this opportunity and respectfully suggest that $1 million be made available for training under this 1956 authorization.

The deteriorating personnel situation in many States and areas needs an offset that recognizes that a high degree of skill and ability is required to constructively administer services to our most disadvantaged group—the recipients of public assistance. I think I can assure that the kind of recognition to public welfare staff that would be represented in appropriating $1 million for training would contribute a great deal to building morale among a group of devoted public servants who are bedeviled on the one hand by the economizers and hostile community attitudes toward recipients of public assistance, and on the other by their inability, in terms of both lack of time and skill, to render constructive help to at least some of the families they serve who want such help.

In speaking for my association, I want to express our appreciation for the fact that the Congress in 1958 recognized some of the urgencies in the areas of public assistance and child welfare sufficiently to authorize the creation of the two Advisory Councils to which I earlier referred. I hope that the Congress will, in this next fiscal year, put in effect through appropriations some of the recommendations of these Councils for which authority in law already exists.

Thank you, Mr. Chairman.

Mr. FOGARTY. You may proceed, Mr. Danstedt.

Mr. DANSTEDT. Mr. Chairman, if I may, I want to talk just briefly about three items, in review or summary, as it were. One is research in welfare and social security. The other is training of public welfare personnel; and the third is child welfare funds.

On the first one, on research and welfare security, I don't think I need to say much more on that, because, I gather that both Mr. Flemming and Mr. Mitchell have set the course, set the case forth very strongly.

I do want to refer, however, to a speech that Mr. Flemming gave here in Washington yesterday, and he said that we are rightfully investing hundreds of millions of dollars for medical research; why shouldn't we be willing to invest a relatively small amount of money for curing social ills. He was referring to $700,000 for cooperative research in welfare and social security. He said before that he criticized the Congress for failing to appropriate $700,000 for research into the causes of poverty and neglect.

Well, social illnesses are costing us billions, including $3 billion last year, for public assistance alone. I want to challenge him a little bit on that.

In the first place, I don't think the $700,000 that the Department is asking for is really enough to do this job adequately. I can make a case for a million and a half.

Mr. FOGARTY. Just to keep the record straight, and keep Mr. Flemming straight, I will say that this committee allowed this initial request 3 years ago.

Mr. DANSTEDT. I know they did.

Mr. FOGARTY. It was more than $700,000 that we allowed, but it was cut out in the full committee, and the amendment was offered by a member of the Secretary's party.

Mr. DANSTEDT. I appreciate that lead, because that gives me the opportunity to say——

Mr. FOGARTY. You may tell Mr. Flemming, if we can get his party's support for it, we will have no difficulty getting the appropriation through Congress.

Mr. DANSTEDT. Exactly the criticism I was going to make.

Mr. FOGARTY. That completes the record as far as that is concerned.

Mr. DANSTEDT. I am glad to endorse your statement.

I do want to point out, also, that there are strong urgings that there be some funds for research in both the two Advisory Council reports. Some of you remember that in 1958 the amendment to the Social Security Act created an Advisory Council on Public Assistance, and the same on child welfare. I don't think those reports have been printed yet. I know there is a request which has been made by the Senate Finance Committee for the printing of those reports, but in both of them they urge very strongly that money be made available for research into family disorganization and child dependency. I think this is the first time that a committee, authorized by Congress, has made such a strong urging with respect to research in this particular field.

They didn't specify any amount of money; but they indicated that advantage should be taken of the 1956 amendments to the Social Security Act, which authorizes $5 million into welfare and social security.

I think it is rather significant that both of these groups urge funds in this area.

Now, I just want to take a few minutes on the question of training of public welfare personnel. I know the administration is not asking for anything this year, against the argument that has been advanced several times, they have had no luck. I do know, historically, that at least in one session or maybe two sessions they didn't ask for any money. So, actually, I think they have tried only once to get money in this particular field. I know that the welfare departments can train personnel right now under the administrative grants, some 50–50 matching; but if I were a State welfare administrator, I wouldn't use that approach, either, because they look over at the health field, and they look at the vocational rehabilitation field, and note that it is 100 percent financing of personnel being trained in those areas.

I know that the 1956 amendment to the Social Security Act provided 80–20: 80 Federal and 20 percent State and local.

But, again, I think if I were a welfare administrator, I would have some problems.

But I think it is important to note that a number of States have now changed their legislation so they could participate in this 80–20 matching, and I just sort of feel that there ought to be an opportunity for those States that want to go ahead to train public welfare personnel. I think it would be a real boost, because I cannot think of any tougher job that a governmental servant can have in this day and age than administering public assistance in a State. They are caught by economizers and people hostile toward public assistance on one hand. Then the difficult loads that they have to carry, ABC loads, persons who are disabled, the individual with special problems. They have too big caseloads, not qualified, many of them, to do the job adequately. Yet they want to help. But they are not getting assistance or leadership from the Federal Government in this area.

I know it can be demonstrated time and time again, unless there is leadership and good leadership and financing and training, most of the States are not going to get off and moving on this.

We have seen this happen in the health field, that the Federal Government has to move in and provide leadership. Then it is surprising the way in which States will move forward on that particular front.

On the child welfare appropriations, the only thing I want to say on that is that the administration asked for $13.6 million, and the authorization is $17 million. In 1958 the administration asked to have the child welfare section amended to make child welfare funds available to children, not only in rural areas, but also metropolitan areas, and the Congress approved that legislation, and there is not enough money to put that legislation into effect now in the States.

So that, summarizing, what I am saying, in a sense, is that there exists now authorization both with respect to cooperative research, with respect to training, with respect to child welfare; and what we need is appropriations.

And all these authorizations are closely related to the recommendations made by these two very able advisory councils, the one on public assistance, and the one on child welfare.

Thank you, Mr. Chairman, for this opportunity. I will gladly answer any questions that anyone has.

Mr. MARSHALL. Are any States carrying on a training program at the present time?

Mr. DANSTEDT. Very limited, sir. There are a few that are doing a little, a limited amount, under the 50 percent matching, as far as public assistance personnel is concerned.

Of course, with respect to child welfare personnel, they can do a certain amount there because of the fact that the child welfare appropriation, or the authorization for the child welfare section permits them to use some of those funds for the training of personnel, but most of them being trained in child welfare field, and that is a limited number—maybe a couple of hundred people a year—in contrast to what is happening in some of the areas like the National Institutes of Mental Health—what they are doing is training something on the order of maybe a thousand or more, maybe 1,500 persons in psychiatric social work. Fortunately some of those are being made available to the public welfare departments.

But, as I say, this is only a drop in the bucket in relation to what needs to be done.

Mr. FOGARTY. Thank you very much.

Mr. DANSTEDT. Thank you.

Mr. FOGARTY. We will place this additional material that you have presented to the committee in the record at this point.

(The material referred to follows:)

RECOMMENDATIONS WITH RESPECT TO RESEARCH AND TRAINING OF ADVISORY COUNCILS ON PUBLIC ASSISTANCE AND CHILD WELFARE AS PRESENTED TO THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE AND THE CONGRESS ON JANUARY 1, 1960

RESEARCH

*Advertising Council on Public Assistance, recommendation 18*
*Strengthening family life*

(*a*) The Congress should appropriate funds authorized under the Social Security Amendments of 1956 for grants for research and demonstration projects such as those relating to the prevention and reduction of dependency, coordination between private and public agencies, and improvement in social security and related programs, and research leading to strengthening family life.

(*b*) We recommend the establishment of a national institute which would have the responsibility for studies and demonstration programs leading to strengthening of family life.

Although the people coming to the assistance agencies need more than money, and the agency staffs often lack proper training for their complex responsibilities, large sums of tax revenue are continually spent and intimate details of many people's lives are involved. The cost of carrying on the daily job and the pressures on overloaded staff to deal with applicants and recipients make virtually impossible any research or experimentation in improved ways to prevent or meet need.

We regret that the Congress has never appropriated the money to implement the authority, enacted in 1956, for research and demonstration activity, and we recommend that it do so now. Numerous Federal grants are made to States and to voluntary agencies for research and demonstration projects in the fields of biology, mental health, psychology, education, and others. We believe that similar investment in exploration of the problems brought to public assistance agencies would likewise pay dividends both in human and fiscal terms. Research and demonstration related to the causes and prevention of dependency are especially necessary because public assistance functions in an ever-changing setting.

A national institute dedicated to discovering the best means possible of solving social problems like family breakup and chronic dependency is as appropriate and desirable in a democracy as the existing National Institutes of Health.

*Advisory Council on Child Welfare Services, recommendation 4*
*Grants for demonstration and research projects in child welfare*

In other programs (e.g., vocational rehabilitation, mental health) special projects that discover and develop new or improved methods and facilities or evaluate present methods and facilities, have proven to be sound and effective ways of stimulating and encouraging better services. The grants under these present laws are available to both agencies and institutions of higher learning. Payments are made on the basis of an approved project, without an apportionment of funds on the basis of a formula. In addition to review by the administering agency, these laws usually provide for review and recommendation by specialists competent to evaluate specific projects or by an advisory group chosen for this purpose. The Council recommends that: "Federal legislation provide for grants to research organizations, institutions of higher learning, public and voluntary social agencies for demonstration and research projects in child welfare."

The Council believes that this legislative provision will give specific encouragement and incentive to experimentation and research directed toward new or improved methods for child welfare programs as a whole. It will stimulate use of resources of both public and voluntary agencies, as well as those of institutions of higher learning and research organizations. It will encourage testing new ideas and evaluate effectiveness of present methods. It will make it possible to vary the amounts of grants in relation to the size and potentialities of the particular project, thereby, making possible the financing of a larger scale project if it holds sufficient promise.

In administering such a program, the Children's Bureau should seek the judgment of technical experts. This expert judgment, combined with the discretionary powers of the Children's Bureau, would provide reasonable safeguards in granting Federal funds for such projects and also would help in developing criteria and guidelines for selecting individual projects. Among the guidelines considered could be: regional and national significance of the proposed project; demonstration of a new method or service in the child welfare field.

### TRAINING OF PERSONNEL

*Advisory Council on Public Assistance, recommendation 17*

(*a*) In order to improve administration, promote social rehabilitation, and help prevent dependency, States should increase the numbers and raise the qualifications of personnel administering the public assistance programs.

(*b*) To assist States in increasing the number of their qualified staff, the existing Federal matching provisions for educational leave programs should be amended to provide 100 percent Federal funds for training of public welfare personnel, as is provided in other specialized fields.

(*c*) As an aid to increasing generally the present short supply of social workers, it is recommended that, in addition to grants for other groups, 100 percent Federal funds be made available to accredited graduate schools of social work for the training of persons in such fields as strengthening family life and caring for the needs of the aging.

(*d*) States should take such action as is necessary to assure that the salaries of public welfare personnel are established and maintained at levels required to obtain and retain competent personnel, in order to provide the services required by public welfare recipients.

Most public assistance agencies are understaffed. Some limit services to determining and checking on need. Only a few State public assistance agencies provide directly such special services as homemakers, volunteer aids, or foster homes for the aged. Some persons are accepted and remain on public assistance for want of intensive effort directed toward solving their employment, family housing, emotional or physical health problems.

In demonstration projects, groups of typical assistance recipients whose workers carried small caseloads were compared with equally typical groups whose workers carried large caseloads. Consistently, the activities of the public assistance workers concerned with relatively few individuals and families paid off in terms of reducing assistance payments.

The quantity of visitors, however, is only one element in the staff deficiencies of current public assistance programs. Their quality is another. Although hospitals do not attempt to treat patients without having qualified doctors on their staffs, latest available figures show that public assistance agencies must make out with only 2 percent of qualified social workers among their caseworkers, and about 15 percent in addition with partial social work training. We deplore the fact that even some of these have their skills and energies drained off in nonprofessional activities, and urge the States to take steps to insure that all professional staff be productively used for the strictly professional service they alone can give.

Social work is so young among the "helping" professions that many people do not really know that it is a profession nor what is encompasses. A qualified social worker has had at least 2 years of postgraduate study at an approved school of social work and of supervised experience. He is schooled in why human beings behave as they do and has the skills to help them make the most of themselves. Also, he learns about community organization, and how to use community resources.

The widespread lack of social work training among public assistance workers compels agency supervisory staffs to give more or less satisfactory inservice training. Increasingly, agencies are giving educational leave under the 50–50 provision for Federal participation in administrative costs, so that staff members can get real professional training. As against 1954, when only 118 individuals from 19 State welfare agencies went to schools of social work, 40 agencies sent 392 to school in 1958. We heartily approve this trend, and recommend that to accelerate it, there be not 50 percent Federal participation as now, but 100 percent Federal funds for the professional training of public welfare personnel. Similar Federal training grants exist in fields like medicine, vocational rehabilitation, mental health, and the physical sciences. Surely it is equally appropriate and vital to the Nation to support a profession that contributes to efficiency and economy of administration, and at the same time furthers the happiness, well-being, and independence of individuals.

There is a nationwide shortage of social workers. But there is an even more acute shortage of social workers in public assistance. One reason is that scholarships are available in other fields of social work. We therefore recommend that 100 percent Federal funds be made available to accredited schools of social work for professional training in fields of social work needed in public assistance agencies as well as voluntary agencies, such as work with the aging and strengthening family life. Another reason for the shortage of both qualified social workers and others in public assistance agencies is that the caseload required and the salaries paid cannot compete with working conditions and pay in other governmental or in voluntary agencies. In 1958, the turnover of public assistance employees, professional and nonprofessional combined, was very heavy. Separations were at the rate of 22 per 100 jobs; the accession rate was 27 per 100 jobs.

*Advisory Council on Child Welfare Services, recommendation 5, grants for training of personnel in child welfare*

The personnel shortage in child welfare programs is acute and will become more so. The expansion of these programs through training grants to enlarge the number of trained personnel would greatly benefit the child welfare field as a whole and contribute to improved programs, both public and voluntary. It is estimated that at the present time 3,000 additional public child welfare employees in positions requiring professional training are needed to provide minimum geographical coverage for the entire Nation. By 1970, 4,300 more will be required. The current turnover in public child welfare personnel is annually about one-fourth of the total employed. These facts make it vital to increase the number of trained professional workers. The Council therefore recommends that:

"Federal legislation provide grants for training of personnel (*a*) to State departments of public welfare which may be used for scholarships to individuals; (*b*) to accredited schools of social work which may be used for scholarships to individuals and for expanding and improving training resources for the child welfare field; and (*c*) to public and voluntary social agencies to conduct training projects in child welfare of regional or national significance."

The Council believes that expansion of educational facilities is essential to guarntee a constant stream of professionally trained personnel entering the child welfare field. In the academic year of 1958, only 1,744 students were

graduated from accredited schools of social work in the United States. These schools are the source for professional personnel in the entire field of social work. The provision recommended by the Council would encourage more people to enter the child welfare field, especially those with special interest and capacity for work with children—people who might otherwise go into other fields where more opportunities for training already exist. Training opportunities for houseparents, volunteers, and others in positions not requiring professional training also should be broadened. These latter opportunities would stimulate and encourage improved services to children, particularly in groupcare facilities where practice has frequently not kept pace with current thinking and research findings on child care.

Mr. FOGARTY. My mail indicates that there is a real interest in the research and training program throughout the country. I will include a few of the letters I have received in the record.

(The letters referred to follow:)

THE UNIVERSITY OF CONNECTICUT,
SCHOOL OF SOCIAL WORK,
*Hartford, Conn., February 27, 1960.*

Hon. JOHN E. FOGARTY,
*Chairman, Subcommittee on Appropriations for LHEW,*
*House Office Building, Washington, D.C.*

DEAR CONGRESSMAN FOGARTY: It is my understanding that your subcommittee has before it proposals for appropriations in the amount of $17 million for child welfare services, $700,000 for cooperative research in child welfare, and $1 million for the training of child welfare personnel.

As one professionally engaged in research and training in this field I find it difficult to give sufficient emphasis to the importance of these proposals to countless children. Because the legislation concerns children delays have the effect of denying to them the meeting of their childhood needs, hence the urgency of these appropriations.

I think that no one can be familiar with the character of services generally available to children who have been deprived of parental care and not feel the gravest concern for the discrepancy between what we know these children need and what official services provide for them. Many agencies provide excellent services, but I think it indisputably true that throughout the country thousands of these children should be placed in adoption homes or, preferably, their own parents helped so that their own homes could be rehabilitated. Instead, for lack of qualified staff, these children are shifted from foster home to institution and back until they are disturbed perhaps beyond repair. Here in Connecticut I recently analyzed data concerning children who required hospitalization for serious mental illness over a 5-year period and discovered that the incidence was 25 times greater among neglected children (public wards) than among uncommitted children of the same age. The inadequacies of available service place the severest kind of handicap on children already suffering the loss of parental care.

There are tens of thousands of children who are not receiving the benefit of present knowledge and this is largely because of the grossly insufficient number of qualified child welfare workers. Again, to refer to the situation in Connecticut: caseloads average 8 to 90, far greater than any accepted standard, and hardly a handful of the State's child welfare workers have had the basic training needed for such work. Actually, few even of the people employed to supervise these untrained workers have themselves had the advantage of professional education in social work.

The proposal before your subcommittee for an appropriation for training will make a direct contribution in the most immediate possible way to the solution of this problem. Certainly, also, the nature of the problems in this field amply justifies the proposed appropriation for cooperative research. We are far from being able to apply on behalf of underprivileged children all the knowledge we now have, but there are many areas in which available knowledge falls far short of what we need to know.

Your support for these appropriations and favorable early action by the committee will make an important contribution to the improvement and extension of urgently needed services.

Sincerely yours,

VERL S. LEWIS, *Associate Professor.*

DELAWARE CHAPTER,
NATIONAL ASSOCIATION OF SOCIAL WORKERS,
*February 23, 1960.*

Hon. JOHN E. FOGARTY,
*Chairman, House Subcommittee on Appropriations for Labor, Health, Education, and Welfare, House Office Building, Washington, D.C.*

DEAR MR. FOGARTY: The Delaware Chapter, National Association of Social Workers, strongly supports the administration's request of $700,000 for cooperative research and demonstration projects in social security, and urges the appropriation of $100 million for the training of public welfare staff and of $17 million, the full authorization, for child welfare services.

We respectfully urge that the House Subcommittee on Appropriations for Labor, Health, Education, and Welfare take appropriate action toward this end.

Sincerely yours,

JAMES B. TAYLOR II, *President.*

---

NATIONAL ASSOCIATION OF SOCIAL WORKERS,
*Harrisburg, Pa., February 24, 1960.*

Hon. JOHN E. FOGARTY,
*Chairman, Subcommittee on Appropriations for Labor, Health, Education, and Welfare, House Office Building, Washington, D.C.*

DEAR CONGRESSMAN FOGARTY: The Central Pennsylvania Chapter of the National Association of Social Workers strongly urge the support of your committee for the following appropriation items:

For cooperative research and demonstration projects in social security, $700,000 requested by the administration. This is for demonstration community projects to explore the causes and ways of eliminating financial need. Today, millions of dollars of State, local, and Federal funds are spent for persons in financial need. Few public welfare agencies have the staffs or skills to help many of these persons to become financially independent. Clearly, these demonstration projects are needed to determine what can be done and could lead to the savings of millions of dollars through greater efforts to eliminate financial dependency.

For training of public welfare staffs, $1 million. The 1956 amendments to the Social Security Act authorized $5 million for training, but no funds were requested in the administration budget. There are a great many problem families receiving financial assistance who need help in order to give adequate care to their children and to become self-sufficient.

For child welfare services of the U.S. Children's Bureau, $17,000,000 instead of the $13,600,000 requested by the administration. Under the administration request, Pennsylvania would only receive $60,054 in additional funds for child welfare services. Through State and Federal funds, Pennsylvania is only able to help counties with 20 percent of their child welfare expenditures. Because of the financial problems faced by many of our counties, additional State and Federal funds are badly needed to help counties with these costs.

These items are extremely small amounts in the overall Federal budget, but their approval will do much to provide better social services to both families and children in need.

Sincerely yours,

ARCHIBALD STUART,
*Chairman, Committee on Social Policy and Action.*

---

JUVENILE COURT FOR THE COUNTY OF OAKLAND,
*Pontiac, Mich., February 23, 1960.*

Congressman JOHN E. FOGARTY,
*Chairman, House Subcommittee on Appropriations for Labor, Health, Education, and Welfare, House Office Building, Washington, D.C.*

DEAR MR. FOGARTY: The Oakland County Chapter of the National Association of Social Workers is pertinently interested in the considerations of the Senate and Congress regarding child welfare services and social welfare programs.

A current proposal to use $700,000 of the social security appropriation to set up cooperative research and demonstration projects is excellent. Such efforts demonstrate how the needy can become more self-sufficient. Research can ex-

plore causes of dependency and lead to suggested methods for its elimination. A review of existing knowledge and present ongoing research would be helpful throughout the social security program. It would be beneficial to the many cooperating voluntary social agencies as well.

As a profession, we feel that a better service can be granted by trained personnel in the social services field. Along with the Advisory Council on Public Assistance, we urge Federal financing for training of personnel involved in social welfare programs. We endorse the proposal of $1 million for such training.

We recommend the full appropriation for child welfare services in order to provide the type of program needed in our country to keep pace with current developing needs. We appreciate the thoughtful attention given to a major problem of child life—delinquency—and urge aggressive consideration of H.R. 7335.

We appreciate the attention you may give to our letter.

Sincerely,

WILLIAM R. McCARTHY,
*Chairman, Social Action and Policy Committee, Oakland County Chapter, NASW.*

---

CONNECTICUT CHAPTER,
NATIONAL ASSOCIATION OF SOCIAL WORKERS,
*February 22, 1960.*

Hon. JOHN E. FOGARTY,
*Chairman, House Subcommittee on Appropriations for Labor, Health, Education, and Welfare, House Office Building, Washington, D.C.*

DEAR CONGRESSMAN FOGARTY: The Connecticut Chapter of the National Association of Social Workers strongly urges that your committee approve $700,000 for cooperative research, $1 million for training, and $17 million, the full authorization, for child welfare services. We especially wish to urge the $1 million for the training of child welfare workers. This is not a large sum of money in view of the shortage of trained workers in this vital field.

Sincerely yours,

HERBERT H. HYMAN,
*Chairman, Commission of Social Action and Policy, Connecticut Chapter.*

---

UNIVERSITY OF MINNESOTA,
COLLEGE OF SCIENCE, LITERATURE, AND THE ARTS,
*Minneapolis, February 15, 1960.*

Mr. JOHN E. FOGARTY,
*Chairman, House Subcommittee on Appropriations for Labor, Health, Education, and Welfare, House Office Building, Washington, D.C.*

DEAR MR. FOGARTY: I would like to urge that your committee approve the administrative request for $700,000 for cooperative research for social security and welfare. I cannot express too strongly my deep belief that this appropriation is one of the most important and essential ones which you will consider. Beyond this item, however, I have strong feelings that the $1 million for training which was not requested by the administration should also be appropriated and in addition the $17 million for the full authorization for child welfare services should be appropriated.

I do hope that you will use the influence of your good offices in securing these ends. With warmest best regards and continuing admiration for your fine work.

Sincerely yours,

JOHN C. KIDNEIGH, *Director.*

---

UNIVERSITY OF DENVER SCHOOL OF SOCIAL WORK,
*Denver, Colo., February 12, 1960.*

Hon. JOHN E. FOGARTY,
*Chairman, House Subcommittee on Appropriations for Labor, Health, Education, and Welfare, House Office Building, Washington, D.C.*

DEAR CONGRESSMAN FOGARTY: Just a note to let you know that I hope sincerely it will be possible for you to support the administration's request of $700,000 for cooperative research in public welfare, as well as $1 million for the

education of public welfare personnel. The latter was not requested by the President but it is a most urgent need.

We simply must do more intensive research pertaining to the causes for public assistance in this country; especially must we examine some of the psychological problems which make for economic need. Furthermore, as we move in the direction of more and more emphasis on the rehabilitation of public welfare clients, we must have people with professional education and experience to carry out such programs. If a million dollars were made available to the schools of social work and these moneys were for faculty, as well as stipends for students, it would not take us very long to get "tooled up" for the production of a larger number of well-equipped men and women to man these services. In this connection, it would be helpful if you could get H.R. 7335—introduced by Congressman Carl Elliott—amended, and provision made for education of social work personnel. It has to get out of the House Education and Labor Committee where it has been since last summer.

Thanks greatly for your help.

Yours most sincerely,

E. M. SUNLEY, *Director.*

---

NATIONAL ASSOCIATION OF SOCIAL WORKERS,
SANTA CLARA CHAPTER,
*Menlo Park, Calif., February 16, 1960.*

Hon. JOHN E. FOGARTY,
*Chairman, House Subcommittee on Appropriations for Labor, Health, Education, and Welfare, House Office Building, Washington, D.C.*

DEAR MR. FOGARTY: The majority of our 160 members are presently employed as professional social workers in public and private institutions and agencies. All of them are concerned with good administration of, and adequate appropriations for, public welfare.

We support the administration's request for funds to begin cooperative research in public welfare and social security and we further recommend that the appropriation bill for HEW for the fiscal year 1961 include an adequate appropriation to start the program of grants to the States for the training of public welfare personnel, which was authoried in the 1956 amendments to the Social Security Act. It is important that some basic research be undertaken to see what can be done to prevent and reduce dependency, to determine ways of effecting greater coordination between public and private welfare agencies, and to find ways of improving the administration and effectiveness of public assistance programs.

We urge your support in making available funds for training social workers in public welfare. Experiments in California as well as in other States have demonstrated that skilled casework services are needed in order to prevent long-time dependency, and to help persons to be self-sustaining, just as in the health field the prevention and treatment of disease depend on the knowledge and skill of the physician. There is a great shortage of professionally trained personnel in California as in the other States. We are sure that an appropriation by HEW for training and research will eventually result in significant savings to the taxpayers.

We also urge your support for the full authorization for child welfare services. In California, with the increasing number of children, the amount of Federal money available is constantly decreasing on a per child basis. We believe it is false economy to save on children's services. If we have specialized services for children who are not developing normally, we can often help them grow into normal and self-supporting adults. Many children now in foster homes could be placed for adoption if funds for sufficient trained staff are made available. Many in foster homes could have remained in their own homes if proper protective services had been given and many older children are in training schools for delinquents for lack of early preventive services. We believe that adequate child welfare services are the best preventive of juvenile delinquency which has been so costly in our State in dollars as well as in human misery. For this reason we should like to suggest that some of the $3.4 million (the difference between the President's request and the full authorization) be directed toward training and grants-in-aid for the prevention and control of juvenile delinquency.

We know, Chairman Fogarty, that your committee has been interested in a joint National Institute of Mental Health-Children's Bureau study on juvenile delinquency, and we are hopeful that you will consider also recommending some additional funds in the budget of the National Institute of Mental Health to be directed toward research and demonstration in the prevention of juvenile delinquency.

We shall be grateful if you will see fit to bring our views to the attention of your committee.

Respectfully,

LEAH LACHENBRUCH, *Legislative Chairman.*

---

COUNCIL OF SOCIAL AGENCIES OF ROCHESTER
AND MONROE COUNTY, INC.,
*Rochester, N.Y., February 10, 1960.*

Hon. JOHN E. FOGARTY,
*House Office Building, Washington, D.C.*

DEAR MR. FOGARTY: The Rochester area chapter of the National Association of Social Workers urges your support of the request of $700,000 for cooperative research in public assistance, and also urges that you use your good office to secure an adequate sum for personnel training grants.

It is a sad commentary that in our own State of New York we face the peculiar dilemma of being besieged on all sides to improve public welfare administration; while our own legislature is asking to pass a bill to lower qualifications for public welfare staffs. Therefore, we are particularly interested in any Federal leadership that can be provided to improve staff training.

Sincerely,

KENNETH M. STORANDT, *Executive Director.*

---

TUESDAY, MARCH 1, 1960.

## VENEREAL DISEASE CONTRAL

### WITNESSES

**PHILIP R. MATHER, CHAIRMAN OF THE BOARD, AMERICAN SOCIAL HEALTH ASSOCIATION**
**DR. WILLIAM L. FLEMING, MEMBER, BOARD OF DIRECTORS**
**T. LEFOY RICHMAN, ASSOCIATE EXECUTIVE DIRECTOR**

Mr. FOGARTY. We have with us now Mr. Philip R. Mather, formerly of Cleveland and now of Boston, who appeared before this committee as president of the American Social Hygiene Association, which has changed its name to the American Social Health Association.

With him is Dr. William L. Fleming and Mr. T. Lefoy Richman, associate executive director.

Mr. MATHER. Thank you, Mr. Chairman. I might say that I have moved up to chairman of the board, or moved on the way out—I don't know which—instead of president. We have a new president.

I have with me, as you pointed out, Dr. William Fleming, of the University of North Carolina, a member of our board.

Mr. FOGARTY. He has been here before.

Mr. MATHER. He has been here before.

And Mr. T. L. Richman of our staff, associate executive director.

They will have something to say, also.

I see a copy of this joint statement right in front of you, sir. I gather from what you were saying to the blindness people that you have already looked through it?

Mr. FOGARTY. Yes, we have asked a few questions about the problem.

Mr. MATHER. We are here to request—it will not surprise you, I guess—a modest increase in Federal appropriations to the Public Health Service for venereal disease control. Venereal disease is not licked, and it is not decreasing, but it is increasing. I am sure you gentlemen will recall that you probably felt as we did when Dr. Mahoney discovered that penicillin could effect almost miraculous cures in both these diseases, both syphilis and gonorrhea.

Many people thought the problem was over, that it was solved, but that is not the case. Penicillin does not prevent venereal disease. As long as men continue to act with women the way men always have acted, there will continue to be venereal disease. Venereal disease is cured only when the patient is treated. Most of the people who are infected—I won't say most of them, but a great number of them, are not being treated because they are not being found. The private physicians who treat some of them do not report the way they should to State and local public health departments, so the followups, to find out where the people who are infected are, where they contracted it, who the people are that they got it from, so they can be found and treated; those followups are not being made. That is the basic situation today.

Now, this statement which only came out a week ago contains the full support of the rough outline of what I have given to you.

This is, I think, our seventh annual report. It began 7 years ago, and it is sponsored by our association and by two other bodies: The Association of State and Territorial Health Officers, a professional body, and the American Venereal Disease Association, which is a professional body of private physicians who specialize in treating these diseases.

The report was developed from information provided by the health departments of all 50 States, from three important counties, and from 91 cities with populations of over 100,000, and the District of Columbia. I think we have never had such complete and detailed response to the questionnaires we sent out, as we had this past year.

We have, as you see on page 3 of this report, a very high grade, helpful committee, members and consultants, that helped work out the questionnaire, so that it would be easier to answer and would supply the necessary information that we wanted to get, on which this statement is based.

I will give you some of the high spots. More States and cities reported increases in early infectious syphilis in fiscal 1959 than for any previous year since 1953. Those are the reported cases. Yet, not even one-sixth of the early infectious syphilis or one-quarter of the gonorrhea that is estimated to have occurred each year, is being found and treated. That is the great trouble with any figures based on reported cases. We have to improve the reporting.

The number of early infectious syphilis cases increased from 6,600 in 1958 to 8,200 in 1959, or 23 percent. Gonorrhea rose from 220,000 in 1958 to 237,000 in 1959, or almost 8 percent.

There is every evidence that these trends will continue. First quarter reports for fiscal 1960 show 42 percent of early infectious syphilis, 42 percent more than for the same period last year. Data we have

received from the British Isles indicates significant rise in VD over there also.

Their reports, which are very accurate, show increases in all ages for males, up through 59, and in all ages except 35 to 49 years old for females.

The most disturbing thing is that during the past year in this country venereal disease continued to increase in the teenage population. It is up 14 percent in kids from 10 to 14 years old, that much up over 1958; and up 11.5 percent in the 15- to 19-year-old group. But these figures, as I say, do not show the complete picture, because of the lack of adequate reporting.

Over half of the venereal disease caseloads in public clinics are teenagers and young adults. The indications are that only about one out of four teenage cases are brought in for diagnosis and treatment.

At the same time, it also brings out that greatest concentration. Reported veneral disease cases in all groups is in cities with populations over 100,000. In New York City, for example, where early infectious syphilis is up 59.6 percent in all ages, it is up 78.3 percent in the 15-to 19-year-old group.

Los Angeles County and San Francisco reported rises in all stages of syphilis and gonorrhea; as do Philadelphia, Pittsburgh, Atlanta, Chicago.

Syphilis kills a minimum of about 4,000 persons a year. It costs $12 million a year to maintain the syphilitic blind, and $46 million a year for hospitalization of syphilitic psychotics. That is tax money.

Now, the statement indicates three major blocks to proper control of venereal disease. These three blocks are: One, lack of private physical participation in case finding and reporting, and in a few moments Dr. Fleming is going to address himself particularly to how that situation can be improved.

The second major block is the lack of knowledge about venereal disease, coupled with talks among parents, teachers, administrators, health workers, PTA's, and so on, to support and participate in educational efforts. That part of the program is what our association is trying to deal with. We are carrying on a broad educational program with the general public, working with PTA groups in schools, and doing everything we can, first to alert the public to the fact that it is still a problem, and increasing; and, second, to do our best to alert the younger people, in particular, as to what they should do to avoid infection and so on.

We figure that is the part of the private agency. That is our phase of it.

The third thing is insufficient funds. That is where we ask Congress to increase by $1 million over what was granted last year. That is, we were asking, instead of cutting from $5.4 million to $4.7 million, an increase to $6.4 million. That figure is based on the estimated needs of the various parts of the country which are summarized in here.

I think at the present time it is something like $20 million being spent in this effort, of which about three and a quarter is State and local funds, and about one and a quarter, or about $5.5 million is Federal funds.

I am not a physician myself, I am just a layman; so I am not very well prepared to answer any medical questions that you may have, but Dr. Fleming can do that. If you have any general questions of me or Mr. Richman, I will try to answer them.

Mr. FOGARTY. Dr. Fleming, you may proceed now.

Mr. MATHER. Dr. Fleming is a member of our board of directors, and is on the faculty of the University of North Carolina. Are you not also president of the American Venereal Disease Association?

Mr. FOGARTY. Go right ahead, Doctor.

STATEMENT OF DR. WILLIAM L. FLEMING

Dr. FLEMING. I am primarily in medical education. That may not appear from my title. But I certainly retain a very strong interest in this field, even though primarily in an investigative way.

Mr. Mather has brought you up to date on what is in this joint statement on today's venereal disease controls, so I won't cover the same ground.

I certainly strongly favor the recommendation made in that report, and I certainly think that the administration's budget proposal of a cut is certainly very untimely in view of the demonstrated crisis that exists both with regard to syphilis and gonorrhea.

Mr. FOGARTY. Doctor, that word "untimely" wouldn't mean anything if I used it upstairs, trying to get this cut restored. Can you put it another way that would mean something?

Dr. FLEMING. I will say, not only untimely but also unwarranted.

Mr. FOGARTY. That wouldn't ring a bell, either. What would happen? What are some of the results that might come with this cut?

Dr. FLEMING. Further increase in both of these problems in which we have been able to accomplish a good deal up to date; further regression in our control both of syphilis and gonorrhea.

As I say, I do feel that certainly no one was more surprised than I to see that the recommendation was made. As you know, it was based on the premise that if the Federal Government cuts its appropriation, that the State and local governments will have to increase theirs. As far as we are concerned, we think that the State and local governments ought to increase their appropriations, but we think the Federal Government ought to increase their appropriation also.

Mr. FOGARTY. You know, they did the same thing a year ago. They cut this program back. But we restored the cut.

Mr. MATHER. We remember that.

Dr. FLEMING. I think we undoubtedly would be in a worse position today had that not been restored last year.

Mr. FOGARTY. Proceed.

Dr. FLEMING. As far as the crisis goes, Mr. Mather has mentioned the situation. As far as actual increase in the attack rate in syphilis and in the reported number of cases of gonorrhea, I would like to mention still another factor in the crisis and that is that there is good evidence now that penicillin-resistant strains of gonorrhea are appearing in the United States. What that is going to mean in the way of increased disability from the late complications of gonorrhea that our treatment might not prevent remains to be seen; but certainly it seems a very serious situation indeed, in which, certainly,

further research as well as control efforts are needed for that particular disease.

But my main thesis this morning is that whereas we have cut the attack rate of syphilis to one-fifteenth what it was at its peak, just after World War II, the trend is now being reversed. The thing that some of us have been dreading for the last 5 years may be really occurring.

For the last 5 years, you know, there has been no substantial change in the syphilis attack rate, and now the attack rate seems to be definitely up, and very clearly we need not only an augmented program, but we need some different control efforts than we have had.

Mr. Mather mentioned the fact that we feel that part of the answer to this, aside from the new knowledge that might come from research, is building the private physician more realistically into the venereal disease control program.

I would like to say that I don't think it is the private physician's fault that he has not been in the control program. We feel that several States, perhaps most notably the State of Georgia, has demonstrated that if the health department has the trained, skilled personnel to work with private physicians they are able to convince them that cases of infectious venereal disease can be reported to health departments with no violation of the privacy and confidence of the patient. Furthermore, if trained personnel are made available for the job, private physicians will actually request health departments to have the skilled personnel interview these infectious cases for their sex contacts, and thereby bring infectious cases under treatment and prevent the spread of disease. We feel that one of the things that is clearly needed is a considerable increase in this pilot project program of having the private physician team up with the health department in order to achieve more in the way of control.

I might say that I personally feel that this has significance, even beyond the field of venereal disease control. Many problems, such as the group that was here in connection with blindness were mentioning, are going to increase in this country with the aging of the population. Chronic disease control is certainly going to become much more necessary. With our present state of knowledge, we largely have to control chronic disease by treating disability.

So, if this liaison with the physician and health department is really brought into the picture, I think it will have significance in many other fields.

In the States in which this has been begun, it has been very evident that this has the wholehearted support of the organized medical societies. So we feel that this is one positive thing that could be done. It is still, admittedly, somewhat in the early stages. We feel that the Federal Government can accomplish a great deal by not only demonstrating that these efforts can be paid off to the States and localities, so that they will increase their programs for these activities, but also to make the skilled personnel available for them. That is neded.

We have estimated that as a minimum in order to do this, we feel that a million dollars more than last year's appropriation would be needed to bring VD control efforts generally up to minimal strength and to strengthen gonorrhea control in the light of emerging penicillin-resistant strains, and in order to increase the research that is needed in both of these diseases.

Then we must set about enlisting of the private physician in venereal disease control in order to reverse this adverse trend that both Mr. Mather and I have referred to.

Actually, what was—or it was estimated, as we mentioned last year, that if this private physician demonstration were done on a 10-State basis, that this perhaps would cost itself something on the order of a million dollars additional. So, hopefully, while a minimum over the present budget might be regarded as perhaps the minimum essential for the present control operation, if this trend were really going to be reversed any time soon with real help from the private physician it would perhaps mean $2 million over the present program.

So I will be glad to try to answer any questions.

There are a few other points that you may wish to read if you care to in my statement.

Mr. FOGARTY. We will see that your prepared statement is put into the record at this point.

(The prepared statement of Dr. Fleming follows:)

STATEMENT BY WILLIAM L. FLEMING, M.D., MEMBER OF THE EXECUTIVE COMMITTEE AND BOARD OF DIRECTORS, AMERICAN SOCIAL HEALTH ASSOCIATION; CHAIRMAN, DEPARTMENT OF PREVENTIVE MEDICINE, SCHOOL OF MEDICINE, UNIVERSITY OF NORTH CAROLINA

I strongly support the recommendations for increased Federal appropriations for venereal disease control contained in the joint statement on today's VD control problem by the Association of State and Territorial Health Officers, the American Venereal Disease Association, and the American Social Health Association. Increased Federal appropriations are essential to help meet the need for increased appropriations at all levels required to meet the current crisis (see below) in VD control in the United States. The administration's budget allocation which suggests a decrease in the Federal VD appropriation seems most untimely in view of the crisis and the Federal Government's responsibilities in VD control because of the military organizations and other employees, national and international factors, interstate travel and migration, etc. There seems no adequate evidence to indicate that decrease in the Federal appropriation will induce States and municipalities to increase their appropriations sufficiently to cover not only the need for increases on their part but also to compensate for the decrease in the Federal appropriation.

Consequently, I support the joint statement's recommendation that the Federal appropriation be increased to a minimum of $6.4 million with preferably another million dollars being made available for a large-scale demonstration of involvement of the private physician in the VD control program.

The crisis in the control program derives from the impressive evidence that the attack rate of syphilis has recently increased in this country and that gonorrhea strains resistant to penicillin are appearing in the United States. The number of reported primary and secondary syphilis cases as an indication of the attack rate showed that a reduction to less than one-fifteenth of the 1947 rate had been accomplished by 1954–55. After little change for 4 to 5 years, the number of reported infectious syphilis cases in fiscal 1959 increased more than 20 percent over fiscal 1958 and the number for the first quarter of fiscal 1960 more than 40 percent over the corresponding period of the previous year, partly due to increases in cases among teenagers. It seems evident that new programs will be necessary to achieve new progress in syphilis control. Pilot projects have been carried out in such States as Georgia on the provision of sufficient workers in health departments to permit adequate visiting and instruction of private physicians to encourage prompt reporting of primary and secondary syphilis cases, and on the provision of sufficient health workers to do casefinding on the sex contacts of these cases. Results in these private physician projects suggest that expansion and increased effectiveness of these projects

might well result in reversing the recent unfavorable trend in the attack rate of syphilis. States and localities will need help in supplying the increased skilled personnel needed for those projects. Demonstration of the effectiveness and significance of this sort of teamwork between health department and private physicians should show the possibilities in community chronic disease disability control as well as VD control which should result in more general application and greatly increased local support for this and similar programs.

It is estimated that $1 million would permit the establishment of a 10-State demonstration project in promoting private physician participation in VD control.

The appearance of penicillin-resistant strains of gonorrhea puts a premium on immediate efforts to develop alternative treatment methods to avoid increase in the disabling complications of gonorrhea and hopefully to make possible more effective control efforts that might even reduce the attack rate. Funds are needed to set up adequate surveillance facilities to watch the penicillin-resistance situation in gonorrhea.

Greatly increased subidization of research on the Federal level is also needed to meet the crisis in VD control by the development of new tools and methods.

In summary, an increase of $1 million over the present Federal appropriation is needed to provide some increase in research support and some increase in private physician control projects; another million would be needed to set up the 10-State private physician project which might in the near future reverse the trend in the syphilis attack rate.

Mr. DENTON. Can you use any other kind of antibiotic for venereal disease, if the germ develops resistance to penicillin?

Dr. FLEMING. Yes, sir; there are a number of other drugs that can be used against the gonococcus. Unfortunately, we have none that is as good, at least in the overall, as penicillin is. So we feel that further investigation is needed, as well as perhaps the shift to other drugs. We don't really know completely what the penicillin-resistant situation is with gonorrhea in this country, because we do not have any surveillance laboratory in this country, in the way that you perhaps know we have on staphylococcus, the hospital infection program.

This is a problem we are certainly going to have to watch.

Mr. DENTON. I think that's all.

Mr. MARSHALL. No questions.

Mr. FOGARTY. Thank you very much, Doctor.

Have you anything else you would like to say?

Mr. MATHER. Mr. Richman may have a word.

STATEMENT OF MR. T. LEFAY RICHMAN

Mr. RICHMAN. I would like to call your attention to the cover of this report. There is pictured a little epidemic in Alabama. It involves 211 people in 2 adjoining counties. Fifty-four of them had early infectious syphilis. All of them have been treated; 144 contacts with these people were also treated.

An interesting thing in this chart, and in others which are being developed now, is the appearance more and more often of the homosexual. In the one county pictured here, the group was almost entirely homosexual. In the other county, it was heterosexual. We see this often in big cities. We don't so often see it in rural counties.

One other thing I would like to call your attention to is this exhibit, a map of the United States, showing primary and secondary syphilis cases per 100,000, and where the concentrations are.

The reason I think this is important—on page 36—the reason that this is important is that it shows real concentration of early infectious syphilis in Northern and Far Western States as well as in the Southern States. We have come to feel that traditionally concentrations would be greatest in Southern States. More and more, as we study these details, we find concentrations of syphilis up the Atlantic seaboard, and also up the west coast.

That's all I have to say.

Mr. FOGARTY. Thank you very much.

Mr. RICHMAN. I would like to have this booklet made a part of the record.

Mr. MATHER. An interesting new sidelight—I might take a moment—with the opening of the St. Lawrence Seaway, more foreign ships are getting into various Great Lakes ports, and our association has arranged to call a conference of health commissioners with those Great Lakes cities because they are going to be confronted with infections and epidemics of various kinds that they have never had before, with these foreign ships coming in.

That is not your problem——

Mr. FOGARTY. It is a problem, though.

Thank you very much.

(The booklet referred to above follows:)

# TODAY'S VD CONTROL PROBLEM

***A Joint Statement by***

The Association of State and Territorial Health Officers
The American Venereal Disease Association
The American Social Health Association

February 1960

52692 O—60——12

## ACKNOWLEDGMENT

The Association of State and Territorial Health Officers, the American Venereal Disease Association and the American Social Health Association, in releasing this 7th annual Joint Statement on today's venereal disease control problems, express their sincere thanks to the health officers and their staffs who, by their courteous co-operation and candid appraisal of their own program progress and deficiencies, have made the Statement a valuable public health document.

The Statement this year was compiled from questionnaire replies from all of the 50 state health departments, the health departments of Puerto Rico and the Virgin Islands, and from 94 major cities in the United States, including Los Angeles County, Calif., Fulton County, Ga., and the District of Columbia. It represents a thorough and authoritative canvassing of the country's venereal disease problems and program needs.

## MEMBERS AND CONSULTANTS
## COMMITTEE ON THE JOINT-STATEMENT

**WILLIAM J. BROWN, M.D.**
Chief, Venereal Disease Branch
Communicable Disease Center, Atlanta, Georgia

**C. S. BUCHANAN**
Director, Division of Venereal Disease Control
Georgia Department of Public Health

**E. GURNEY CLARK, M.D., DR. P.H.**
Professor of Epidemiology,
Columbia Univ., School of Public Health

**LT. COL. JOSEPH W. COOCH, M.C.,**
Chief, Communicable Disease Branch
U. S. Army

**NICHOLAS J. FIUMARA, M.D., M.P.H.**
President,
American Venereal Disease Association

**WILLIAM L. FLEMING, M.D.**
Chairman, Department of Preventive Medicine,
University of North Carolina

**SIDNEY OLANSKY, M.D.**
Former President
American Venereal Disease Association

**MAJOR GEORGE W. POWELL**
U. S. Air Force, M.C.

**T. LEFOY RICHMAN**
Associate Executive Director,
American Social Health Association

**T. F. SELLERS, M.D.**
Former Director, Georgia Dept. of P. H.

**CAPT. LLOYD B. SHONE**
U. S. Navy, M.C.

**S. ROSS TAGGART, M.D.,** Former Secretary,
American Venereal Disease Association

**BRUCE WEBSTER, M.D.,** Chairman,
Exec. Comm., American Social Health
Association

**E. EILEEN HENDY**
Secretary to the
Committee and Statistical Editor

# FOREWORD

For nearly a decade now many of us have been wishing that the spirochete and the gonococcus would take penicillin and die. That they haven't is a frustrating experience to everyone — especially since many of us have made special efforts to be helpful, at least in getting the penicillin to them. Accompanying this helpfulness has been a running debate on the cost of achieving control and who should pay for it.

For the most part during this extended debate, the spirochete and gonococcus have simply gone right on traveling unrecognized and/or unsuspected and proliferating their kind. At present, one suspects that a couple of well-trained VD investigators could uncover a VD epidemic in most any city in the country where investigation service is not now available. Last year, 8,178 cases of early infectious syphilis were reported out of an estimated 60,000 that occurred. How many were treated without being reported, we don't know; but even if it were another 8,178 the gap between the number of cases reported and those occurring is much too wide to permit any notion that "control" is just ahead. The same is true of gonorrhea: 237,000 cases reported; an estimated 1,000,000 occurring.

Surgeon General Leroy E. Burney, in a message to Venereal Disease workers in Memphis, Tennessee, February 2, 1960, stressed the idea that control will not be easy. "I have been aware . . . of the general increase in early syphilis morbidity over the past four years. And I know that you have accepted these increases not as signs of defeat but as symbols of challenge. . . . These increases in morbidity serve also as an important reminder that the communicable diseases — and the venereal diseases in particular — are by no means eliminated. . . .

"I know that the work you have cut out for yourselves will not be easy. You will need patience and perseverance. You cannot expect everyone, regardless of occupation or status, to share your enthusiasm immediately. . . . Gradually, you will approach total epidemiology and eventually you will eliminate syphilis."

In the British Isles the spirochete and the gonococcus have also been demonstrating their staying qualities; and there is evidence at hand, although not so carefully documented as are the British data, to

indicate that in other countries, too, the venereal diseases are increasing. Our frustration in the control of these diseases in the United States is obviously shared.

One thing we all know to our sorrow: the gonococcus and the spirochete are not inclined to take penicillin and die. We are, therefore, confronted with the prospect either of building our attack on the venereal diseases to a realistically effective effort with co-operation from all responsible community leadership, or of continuing to support for years to come inadequately staffed and implemented VD control programs.

T. Lefoy Richman
*Author of the Report for the*
*Committee on the Joint Statement*

## SUMMARY

Substantial increase in venereal disease is apparent in the United States with parallel increases in the British Isles. Accordingly, the *7th Annual Joint Statement* of the Association of State and Territorial Health Officers, the American Venereal Disease Association and the American Social Heath Association strongly recommends:

1. increased venereal disease control appropriations at all levels for fiscal year 1961;
2. a multi-state demonstration effort to bring the private physician into the control effort more effectively;
3. an education effort that will involve parents and teachers;
4. an increased research effort in behavioral science, immunology and diagnosis of gonorrhea.

Back of these recommendations are the following data from the Joint Statement:

Twenty-nine states and 49 major cities reported increases in early infectious syphilis in 1959. Only 6 states and 14 cities reported decline. The others reported no change.

For the country as a whole, the number of early infectious cases of syphilis increased from 6,661 in 1958 to 8,178 in 1959, an increase of 22.8 percent. There were 237,318 cases of gonorrhea reported in 1959, an increase of 7.8 percent.

These upward trends are likely to continue. During July-September 1959 (first quarter fiscal year 1960) states and cities reported 42 percent more cases of early infectious syphilis than they did July-September 1958.

Greatest change in number of health departments reporting increase in early infectious syphilis and gonorrhea is among major cities—49 in 1959; only 26 in 1958.

Data from British Isles indicate similar rise in VD. British Co-operative Clinical Group (147 VD clinics in England, Scotland and Wales) reports increases at all ages through age 59 for males and in all ages except 35-49 for females.

Reported cases of VD in the United States are on the increase among teenagers and younger children. Infectious VD among 10-14 age group increased from 2,443 to 2,793, up 14.3 percent; in the 15-19 age group, from 44,864 to 49,909, up 5,045 cases or 11.4 percent.

Military personnel and migrant workers create special demands on VD program staffs in two-thirds of the states. Indians, merchant seamen and tourists were also noted as creating special demands.

VD investigative network is growing. In the past year, 38 states received 9,905 notices from other states reporting contacts of known VD patients for investigation. Fifteen states reported receiving contact referral notices from other countries.

Over 23¼ million people live in areas which are judged by their health departments to have inadequate control coverage.

After over two decades of intensive VD control activity in the United States, there are still 21 states that do not have diagnostic and treatment facilities sufficient to meet the needs of VD control.

Thirty-six states find their VD programs will need an additional $760,410 in the coming fiscal year, but only 8 of them anticipate any increase in state funds — and that for a total of only $59,487.

Major blocks to control:

1. Lack of private physician participation. Private physicians may treat as much as 50 percent of the venereal disease in the United States. They probably report not more than 25 percent of what they treat. For the most part, their patients are not interviewed; the sexual contacts of their patients are not brought to diagnosis.
2. Lack of knowledge among the public about the venereal diseases and a reluctance among parents, teachers, school administrators, and health workers generally to support and participate in educational efforts.
3. Funds to bring full force of control resources to bear on the problem. Present Federal appropriation of $5.4 million is not commensurate with problem or with federal responsibility in control of VD.

On the credit side, the Statement indicates: Reporting of venereal disease may be improving. Thirty states and 56 cities believe reporting is sufficiently complete to provide reliable indication of the size of the problem. Nevertheless, 21 states and 30 cities do not rate their reporting so highly.

States and cities are beginning to check up on reporting. In 23 states and 30 major cities, surveys were undertaken during the past year to determine the completeness of VD reporting among private physicians.

More states and cities are plotting their epidemic outbreaks and are thus able to personalize their analysis of the control effort. Outbreaks were observed in 24 states and 16 cities in the past year.

# Venereal Disease Profile - 1959

## VD Attack Rate

More states (29) and more cities (49) reported increases in early infectious (primary-secondary) syphilis in fiscal year 1959 (ending June 30) than in any previous year since 1953. Only 6 states and 14 cities reported decline, while 15 states and 24 cities reported no change. Thirty states and 49 cities reported increases in gonorrhea and 6 states and 13 cities reported decline. (See *Appendix,* Question 1 for tabulation.)

These increases in states and cities, widespread as they are, would account for the higher number of cases reported for the country as a whole: from 6,661 cases of early infectious syphilis reported in 1958 to 8,178 in 1959; and from 220,191 cases of gonorrhea in 1958 to 237,318 in 1959. The percentage incerases were: early infectious syphilis, 22.8 percent; gonorrhea, 7.8 percent. (See *Appendix,* Table I.)

States and cities reported 42 percent more cases of early infectious syphilis in the 1959 July-September quarter than they did in the same quarter of 1958.

Significantly, the greatest number of health departments reporting increase in early infectious syphilis and gonorrhea is among cities over 100,000 population. The 49 cities reporting increases in early infectious syphilis this year compare with 26 last year. This is consistent with the general consensus that problem behavior tends to concentrate in urban areas. While VD is not solely a big city problem, it becomes increasingly so as the big city itself becomes less a responsible corporate entity and more a sprawling nexus of ill-defined service and shopping centers strung along roads and highways.

In California, where VD control has been consistently a quality effort for a number of years and where urban populations have been exploding wildly since the war, there have been four consecutive years of rise in early infectious syphilis — from a rate of 2.96 per 100,000 in 1955 to 6.32 in 1959.

In the city of Los Angeles, there was a rise in all stages of syphilis in 1959; and in Los Angeles County and San Francisco, there were rises in all stages of syphilis and gonorrhea.

In Pennsylvania, there has been continuous rise in all stages of syphilis since 1957; and in Philadelphia and Pittsburgh there were rises in all stages of syphilis and gonorrhea in 1959.

In the past year, 6 states and 8 cities report rises in all stages of syphilis and in gonorrhea; 9 states and 13 cities, in all stages of syphilis.

More states (21) and more cities (31) reported increases in total syphilis during 1959; and more states (19) and more cities (34) reported increases in early latent syphilis.

Although not so menacing as now, these danger signs have been appearing with regularity in states and cities for a number of years. In each of the past five years, 16 or more states and 20 or more cities have reported increases in the number of cases of early infectious syphilis brought to treatment. In fact, only 8 of the 50 states have not reported an increase in infectious syphilis at least one year out of the last five. And only one state has not reported increase in gonorrhea at least once in the past five years.

## Reporting — Reliable or Not

There is reason to believe that reporting of venereal disease may be improving in many of the states and cities. Thirty states and 56 cities think that reporting of syphilis is sufficiently complete to provide a reliable indication of the size of the problem. They point to checks on laboratory tests and surveys of private physicians reporting to justify their faith in the data they report. (*See Appendix, Questions 2 and 5.*)

This growing tendency among health officers to survey periodically reporting practices of physicians and institutions is altogether commendable. Nevertheless 21 states and 30 cities do not consider the reporting of syphilis sufficiently complete to provide a reliable indication of incidence or prevalence. They state their reasons in comments like the following:

Colorado: Under-reporting by private physicians and hospitals has been proven by recent survey.

Illinois: Reporting is not sufficient in primary syphilis and gonorrhea. Physicians miss the former and do not report the latter.

Kansas: Surveys indicate that cases treated are not reported.

Ohio: Physicians seldom volunteer a case report. Reporting from private laboratories is incomplete. Therefore, no follow-up is accomplished on most private physicians' patients.

Oregon: During the year of 1958 when private physicians reported only 453 cases of syphilis and 330 cases of gonorrhea, private laboratories reported 4,682 reactive and 2,808 weakly reactive serologies for syphilis, plus 725 positive smears and 484 cultures for gonorrhea.

South Dakota: Survey of physician reporting in South Dakota in November 1958 revealed that only 49 percent of the total syphilis, 56 percent of the late and late latent syphilis, and 28 percent of the early

syphilis that was diagnosed by physicians was reported to the South Dakota Department of Health.

Vermont: Several large hospitals do serologic tests for syphilis and do not report results to the State Health Department. Too many cases are called biologic false positives.

### Reporting — Physician

Of special importance in the control of the veneral diseases is reporting by physicians to the local VD control program services. The physician treats a sizeable percentage of syphilis cases in the United States. Whether he treats few or many depends on how alert he is to the clinical recognition of symptoms and to the need for routine serologic tests. How effectively he enters into the control program depends, for the most part, on the extent to which the health department makes a consistent effort to work with him.

Reporting of VD patients by physicians varies from 0 percent of the total number of cases reported from all sources, as occurs in Puerto Rico, to 100 percent in North Dakota and Vermont. Between these extremes, if we range the percentages into 5 groups and consider only early infectious syphilis, we find that 8 states fall in the 0-19 percent range, 11 states in 20-39 percent range, 17 states in the 40-59 percent range, 4 states in the 60-79 percent range, and 7 states in the 80-100 percent range. Five states did not answer the question. (See *Appendix,* Question 4.)

Thus, in over half of the states (28), physicians account for between 20 and 59 percent of the early infectious syphilis reported from all sources.

In the cities the picture is less encouraging. Here the largest number (24) of the 62 cities answering the question give the proportion of early infectious syphilis reported by the physician as 0-19 percent of cases reported from all sources. In well over half (39) of the cities answering the question, private physicians report less than 40 percent of the early infectious syphilis cases.

These findings underscore a problem of growing concern to signers of this Statement: in the cities, *where VD is growing most rapidly as a health problem,* private physicians report much the lowest percentage of early infectious syphilis cases from all sources.

Physicians in the cities tend to report a higher percentage of their late syphilis cases. The greatest number of cities place their physician-reporting of late latent syphilis in the 40-59 percent bracket.

In the latent stages of syphilis, both states and cities show most physicians reporting in the 40-79 percent bracket.

## Reporting — Checks and Surveys

In considering the reasons for the greater number of health departments showing increases in early infectious syphilis in the past year, one may not overlook the very substantial effort many health departments are making to check on reporting from physicians, laboratories and hospitals.

In 23 states and 30 major cities, surveys were undertaken during the past year to determine the completeness of VD reporting among private physicians. In 14 states and 18 cities surveys were directed at reporting by private laboratories, and in 17 states and 34 cities, surveys were directed at reporting by hospitals. (See *Appendix*, Question 5.)

Fifteen of the states reporting increases in early infectious syphilis did surveys to check on physician reporting; 6 states did surveys on laboratory reporting; and 7 states did surveys on hospital reporting.

In Dayton, Ohio, health officials and the societies of local physicians did a joint survey. A questionnaire was sent to all physicians on stationery of the Montgomery County Medical Society and signed by its President. The same questionnaire was sent to all osteopaths on the stationery of the Dayton District Academy of Osteopathic Medicine. It was signed by the Academy's Executive Secretary.

There was only one question, a request for the approximate number of gonorrhea and syphilis cases (or suspects) treated by the physician in 1958. No signature was required. Goals were three: to determine number of cases treated; nature and volume of response; possibility of working out program.

Having decided on the basis of the response that a program with physicians was possible, the Dayton Health Commissioner proceeded to mail to each physician a postal reply card which is in effect a monthly report on VD seen and a request for services — diagnostic or investigative.

In October 270 cards were mailed; by November 10, 123 cards had been mailed back, reporting 27 cases of syphilis and 65 cases of gonorrhea. Requests were received for interviewing, investigative and diagnostic services.

Comments from other health departments accent the need for this type of survey and resulting action program.

Kentucky: "By regulation of the State Board of Health, private laboratories are required to report all reactive serologies to the State Department of Health. While this does not constitute a survey, it gives a reliable index to the number of syphilis cases being seen by private physicians. This program has shown that approximately 20 percent of all reactive serologies on private physician cases are reported to us as not infected.

We feel this percentage is too high when compared with results obtained from health department clinics and we plan to do further study in this area."

North Carolina: "As we have further emphasized the private physician program, we have demonstrated an increase in syphilis morbidity. Our first year of use of a private physician follow-up form resulted in a 51.72 percent increase of reporting from private physicians over the average of the three previous years." In North Carolina, private physicians account for 27.38 percent of total veneral disease reported from all sources.

Chattanooga: "Reporting by private physicians is incomplete, especially of early lesion cases. These are often missed altogether and penicillin administered."

Chicago: "Since June, 1959, 15 cases of primary and secondary syphilis have been reported from 4 to 8 months after the positive serologic test was recorded; and then the report was made only after a written request was sent to the attending physician asking for his disposition of the case."

In Chicago a carefully detailed private physician plan is in operation, complete with simplified pre-coded reporting card and continuous epidemiologic service on request.

Houston: "Twenty percent of all syphilis cases were reported by private physicians. After a recent drive to improve reporting, this figure increased to 40 percent for several months and then returned to the usual 20 percent."

## Rates May Be Misleading

Respondents were asked to provide VD rates for areas within their respective jurisdictions demonstrating the tendency of rates for large areas to conceal high prevalence rates of smaller areas within them. Twenty-two states and 17 cities were able to comply with the request and gave specific illustrations. The demonstrations were conclusive, and individuals reporting morbidity by state, region or nation, would do well to qualify any large area rates with some indication of the range of rates within the area.

In Arkansas, for instance, the statewide rate for early infectious syphilis was 12.1 per 100,000 population. Area 1 in the state had a rate of 55.8; Area 2, a rate of 279.6; and area 3, a rate of 8.14. With rate variations ranging so widely, the statewide rate has little value either for defining the problem or for planning program.

Similarly wide variations in rates show up in the much narrower confines of town and city. In Cincinnati, for instance, the citywide rate

per 100,000 for early infectious syphilis is 15.26. In the three areas reported, rates were from 2 to 5 times the city rate: Area 1, 65.8; Area 2, 28.0; Area 3, 78.15.

Colorado reports an interesting variation in range of rates for gonorrhea. The state-wide rate is 65.4 per 100,000 population. Area 1 shows a rate of 154.75; Area 2, a rate of 142.4; Area 3, a rate of 23.53.

In Los Angeles, the early infectious syphilis rate is 11.0. One area in the city shows a rate of 50.4; a second, 37.6; and a third, 5.7.

## Epidemic Outbreaks

Both states (24) and cities (16) had observed, and in many cases carefully diagramed, VD outbreaks occurring since the last questionnaire. Outbreak was defined as "any significant rise in reported cases or chain of cases which are demonstrated to have been spread from a common source or sources." (See *Appendix*, Question 7.)

The cover design shows an actual outbreak which was charted in two Alabama counties between February 16 and June 12. The two-county epidemic involved 211 people. The County A group were homosexuals for the most part, and described as "from a higher social and economic level" than the essentially heterosexual group in County B. The average age of the group was just under 22 years. There were 54 persons found to have early infectious syphilis in the group. All were treated. The 144 named contacts were treated prophylactically.

Alabama reported two other outbreaks, both beginning with patients of private physicians. The first, in January-February, 1959, resulted in finding 20 persons with syphilis (13 early infectious cases); and the second in August, 1959, found 21 persons diagnosed as having syphilis, 16 of them in the early infectious stages.

In a large northern city, a single person with secondary syphilis was referred by a practicing physician to the County Health Department for diagnostic tests and treatment. Investigation of this case disclosed the following: a chain of infection involving 269 persons. Of these, 33 (or 12 percent) were found to have syphilis; 20 of these were brought to treatment for the first time; 7 (with previous *inadequate* treatment) were returned to treatment, and 6 revealed previous *adequate* treatment. Of the 33 persons with syphilis, 20 named each other, 13 (or 42 percent) were found through cluster testing. Of the 17 persons with "early" syphilis, 9 (or 53 percent) were found through cluster testing.

In Pennsylvania, an outbreak occurred involving 144 individuals. Thirty-four were infected with syphilis (13 early infectious). Fourteen of the infected individuals were teenagers. In all there were 72 teenagers involved (28 boys, 44 girls). In most instances, they met at a dance, were exposed to VD in an automobile.

Investigation of an outbreak of early syphilis in Vega Alta, Puerto Rico, in May, 1959, discovered 18 persons with syphilis (10 early infectious). There were 27 persons in the group; ages ranged from 16 to 66. Sex relations were both homosexual and heterosexual.

Complete data are now available on an outbreak in Memphis, Tennessee (see *Appendix,* Cluster Test Chart, Tennessee), involving in all 1,446 persons. Investigation of this group resulted in the discovery of 111 persons with syphilis — 101 in the early stages. An *additional* 111 persons had gonorrhea.

In South Carolina (see *Appendix,* Epi Chart South Carolina) a 20 year old male, patient of a private physician, led health department investigators into an outbreak involving 97 individuals both adult and teenage. Twelve were syphilitic.

An outbreak in Richmond, Virginia, during the past year is notable for the variety of epidemiologic techniques utilized in finding and treating the 124 persons involved. "The success of the epidemiology was a combination of private physician consultation, jail blood-testing, street blood-testing, and cluster interviewing," using standard investigative techniques. Sixteen cases of syphilis were found and treated (6 early infectious), and 17 persons were given prophylactic treatment.

The concern of the true "VD-ologist," as well as the precarious nature of the entire VD control process, comes through in this summary statement of the Richmond outbreak: "Even by co-ordinating all agencies and persons who may help . . . there is always that chance that an infected person may slip by undetected . . . only to start the entire process over again."

# Problem Groups

## VD Under 24 — United States

Reported cases of veneral disease are on the increase among teenagers and children. From 1957 to 1958, the number of children with infectious veneral disease in the 10-14 age group increased from 2,443 to 2,793, up 14.3 percent; in the 15-19 age group, the increase was from 44,864 to 49,909, up 5,045 cases or 11.4 percent. (See below.)

| AGE | YEAR | INFECTIOUS SYPHILIS | GONORRHEA | TOTAL INFECTIOUS VD |
|---|---|---|---|---|
| 0-9 | 1956 | 11 | 1,221 | 1,232 |
| | 1957 | 33 | 1,624 | 1,657 |
| | 1958 | 23 | 1,556 | 1,579 |
| 10-14 | 1956 | 75 | 2,424 | 2,499 |
| | 1957 | 80 | 2,363 | 2,443 |
| | 1958 | 90 | 2,703 | 2,793 |

| AGE | YEAR | SYPHILIS | GONORRHEA | TOTAL INFECTIOUS VD |
|---|---|---|---|---|
| 15-19 | 1956 | 1,093 | 44,233 | 45,326 |
| | 1957 | 1,192 | 43,672 | 44,864 |
| | 1958 | 1,228 | 48,681 | 49,909 |
| 20-24 | 1956 | 1,778 | 74,667 | 76,445 |
| | 1957 | 1,856 | 70,679 | 72,535 |
| | 1958 | 2,005 | 76,867 | 78,867 |

In 1959, more states and more cities reported incerases in teenage VD than reported such increases in 1958. VD morbidity by age is not yet available nationally for 1959, but 29 states and 21 cities report increase in early infectious syphilis among the 15-19 age group; and, in the same age group, 25 states and 43 cities report increases in gonorrhea. (See *Appendix*, question 8.)

Among the 10-14 age group, 10 states and 8 cities report increase in early infectious syphilis for 1959; and 19 states and 21 cities show increase in gonorrhea.

In New York City, early infectious syphilis increased from 911 cases reported in 1958 to 1,454 cases reported in 1959 — up 59.6 percent.

In the 15-19 age group, early infectious syphilis increased from 83 cases reported in 1958 to 148 cases reported in 1959 — up 78.3 percent.

## VD Under 24 — British Isles

The number of states (3) and cities (5) showing decline in the three age groups and for both early infectious syphilis and gonorrhea is discouragingly low. A sizeable number, however, show no change; and this, although small, is some comfort, plus the fact that Rise in teenage VD is not confined to the United States. The British Isles reports significant increases in 1958 over 1957 among both boys and girls. In the 15-19 age group, the total increase was from 1,846 to 2,233 and in the 14 or under, from 30 to 60. (See Table III.)

Greatest increase in numbers of persons infected was in the 20-24 age group — from 5,768 to 6,719. There were increases at all ages through age 59 for males and in all ages except 35-49 for females. In both years, over 96 percent of all persons treated for VD in the clinics were treated for gonorrhea. The British data were from 147 VD clinics in England, Scotland and Wales. They were made available especially for the *Joint Statement* through the good offices of Dr. R. R. Willcox, Secretary of the British Co-operative Clinical Group, and they are one of a number of BCCG studies.

Thirty-eight British towns and cities with populations over 100,000 reported on change in VD morbidity by age in 1957 and 1958. In the 15-19 age group, 22 cities reported increase, 4 stationary, 12 decrease. In the 20-24 age group, 25 reported incerase, 1 stationary, and 12 decrease. Not until age 50 does the number of cities reporting stationary or decrease total more than those reporting increase. (See Table IV.)

## Special Demands

Military personnel and migrant workers create special demands on VD Programs in a significant number of states and cities.

Thirty-four states and 21 cities report that military personnel create special demands on their program; 24 states and 9 cities report special demands because of migrant labor. Seventeen states and 4 cities report special demands because of both. Thirteen states and 8 cities report Indians as creating special demands. (See *Appendix*, Question 9.)

In the case of the military, this simply means that where there are military bases or where there are cities that are recreation areas for military bases, health departments give special staff attention to VD among military personnel and their contacts.

Nine states and 4 cities say special demands are made on their VD program by merchant seamen; and 3 states and 6 cities say tourists create special demands.

Arizona notes that among its 80,000 Indians, syphilis is "4 or 5

times" that of the general population; among its 30,000 migrant workers, syphilis is 6 times that in the general population; and that its 20,000 military personnel are within easy distance of Mexican brothels. Latest (1958) prostitution studies in Arizona failed to disclose any brothels within the state.

In California there is a special serologic testing program for Mexican migrant laborers.

Florida notes migrant labor camps, tourists, military installations and personnel from foreign ships as special problems.

Hawaii notes military personnel and tourists.

In Kentucky, about 10 percent of all VD investigations are of sexual contacts of military personnel.

Testing of agricultural migrants in Maryland resulted in bringing to treatment 200 persons with untreated syphilis.

In Massachusetts, military personnel require about 20 percent of VD staff time.

Michigan notes that the increase of military personnel from 2,500 to 15,000 will require reinforcement of "existing VD machinery in this area."

New Jersey has a statutory requirement for testing migrant workers.

In North Carolina, blood testing among migrant laborers in 1959 produced 432 (13.25 percent) positive reactors among 3,260 blood tests. Military personnel accounted for 1,407 cases of VD.

In South Dakota, 51 percent of syphilis cases and 77 percent of gonorrhea cases were among Indians. These represent only 5 percent of the State's population.

Texas notes seaports, migrant workers, military and tourist centers as creating special demands on the VD program.

Virgin Islands reports special migrant labor problem.

Wisconsin anticipates merchant seaman problems as Great Lake Ports become used more by ocean ships.

52692 O—60——13

# Control Problems

## Exchange of Contact Information

Although VD ranges around the world, the investigative network to control it is less widespread. Nevertheless, the network is growing.

In the past fiscal year, 38 states received 9,905 forms from other states reporting VD contacts for investigation. Fourteen states either failed to provide information or said they had no data.

Illinois received contact referral forms from 38 states, Connecticut from 36, Pennsylvania from 34, Kentucky from 29, Michigan from 28, West Virginia from 27.

Fifteen states reported receiving forms from other countries. Massachusetts received forms from 7 countries, Kansas and Texas from 3 each, Georgia and Arkansas from 2 each.

Forty-one states sent 8,552 contact referral forms out to other states and countries. Again, 11 states either failed to answer or said they had no data.

Georgia and North Carolina sent contact referrals out to 30 states each, and North Carolina sent referrals to 15 countries.

Maryland sent referrals to 10 countries, Massachusetts to 7, Georgia to 5, New York and North Dakota to 4 each, and Michigan to 3.

## Inadequate VD Control Coverage

Over 23¼ million people in territories, states, cities and counties live in areas which are judged by their state health departments to have inadequate VD control coverage.

States report 49 cities, 34 counties and 14 other areas with a total population of 23,270,667 as having inadequate VD control coverage; and cities report 89 census tracts, 9 health districts, 4 wards and 2 other areas with a total population of 3,300,754 without adequate VD control coverage. (See *Appendix*, Question 12.)

Many of these inadequately covered areas have no VD control service at all; others have partial service. Kentucky, for instance, reports 15 cities, only one of which has adequate gonorrhea control. The remaining 14 have a combined population of 815,600. Also in Kentucky, a total of 48 counties with a combined population of 1,385,000, lack adequate control facilities for either gonorrhea or syphilis.

Wisconsin acknowledges inadequate "contact and source investigation by physicians and health workers" and suggests it is "questionable whether or not the program is adequate to maintain or slowly reduce

prevailing rate levels."

Wichita observes that to cover all areas adequately "our public health ecologist works many hours overtime."

## Personnel Needs

In 33 states the reason for inadequate VD control coverage was lack of personnel — for the most part, physicians and VD investigators. In 12 states the reason was lack of travel funds for investigative personnel; and in 13 states, it was lack of facilities, lack of well-trained personnel, lack of funds, lack of leadership. Three states frankly admitted it was lack of interest on the part of local health officers.

States list their personnel needs above present staff as 42 physicians, 35 nurses, 76 investigators, 6 laboratory technicians, 5 health educators, 2 record analysts and 16 administrative and clerical personnel.

In 13 cities, there is a need for 10 physicians, 9 nurses, 28 investigators, 5 laboratory technicians, 4 record analysts, 4 health educators and 14 clerks.

The total additional personnel need is higher than last year in all categories except health educators and nurses. In all states and cities answering the question on personnel, there is a need for 52 additional physicians, 44 additional nurses, 104 additional investigators, 11 laboratory technicians, and 45 others. (See *Appendix*, Questions 13, 14.)

## Interview Service to Physicians

Only one state and two cities say they do not provide epidemiologic services to private physicians who report infectious syphilis. Four cities did not reply.

Forty-one states and 61 cities were able to report interviewing of physicians' patients by health department personnel. Alabama, among the states, and New York among the cities, reported the highest number of physicians' patients interviewed by health department personnel: 246 and 221 respectively. Paterson, N.J., reported 120, El Paso 100, San Francisco 73, Chicago 71; New York State reported 94, Tennessee 74, Virginia 49 syphilis and 57 gonorrhea. Several states and cities reported by percentage.

Although, for the most part, the numbers of patients interviewed for physicians is small, it is most encouraging to note that a beginning has been made in so many states and cities.

California observes that "only a minority of the local health departments provide this service."

Mississippi points out a need for repeat calls on the physician, "in-

cluding effective briefing regarding the local veneral disease problem."

Puerto Rico notes that physicians rarely call for epidemiologic services, and suggests that personnel are needed to "contact and cultivate them."

Interview of physicians' patients is a weakness in VD casefinding. Most physicians have little time or liking for interviewing. Yet the record shows that the sex contact interview is indispensable in casefinding.

Since physicians probably treat as much as 50 percent of the venereal disease in the country, and in some areas 100 percent, health departments have, in the past few years, extended interview service to them with increasingly favorable results.

Forty-two states and 76 cities interview some percentage of infectious syphilis patients of physicians. Twenty-two states and 41 cities interview from 80 to 100 percent of all infectious cases reported to them by physicians, and 14 states and 15 cities interview 40 to 79 percent of infectious syphilis cases reported to them by physicians. (See *Appendix*, Question 17.)

The problem is, of course, that in many areas physicians report very few cases. For the country as a whole, it has been estimated that they report about 25 percent of the syphilis cases they see.

United States Public Health Service experience shows that interview of 2,400 physicians' patients with early infectious syphilis produces about 8,000 sex contacts. It shows further that for every 2,400 patients interviewed there are about 12,000 patients who are treated and dismissed without interview.

If the 12,000 were interviewed, there would be some 40,000 additional sex contacts named; and from these would come some 5,500 persons with veneral disease, including 2,800 with early infectious syphilis and 400 with gonorrhea.

## Facilities

It is a lamentable fact that after over two decades of intensive VD control activity in the United States, there are still 21 states and 7 major cities that must reply "No" to the question: Do you have diagnostic and treatment facilities sufficient to meet the needs in the areas you cover with present techniques? Only 31 states answered "Yes." Cities are somewhat better off: 80 were able to answer "Yes." (See *Appendix*, Question 18.)

Many of the states reporting insufficient facilities are in areas where VD rates have been high over the years and where some state programs have been effective.

In New Jersey, where the answer was "No," the deficit does not lie in actual lack of facilities. "The poor quality of services rendered in some areas," New Jersey reports, "is a direct result of lack of organization and inefficient utilization of what could otherwise be classified as adequate physical facilities."

## Cluster Testing

Cluster testing is an innovation in VD casefinding. It operates on the principle that people who are found to have syphilis are often able to point out other people who may have syphilis, even though they have had no sexual relations with them.

Thus, patients are asked to name their sex contacts and in addition, persons who, while not sex contacts, nevertheless are thought by the patient to be having sexual experience that parallels his own approximately.

Thirty-one states and 51 cities have used cluster testing, but only 16 states and 36 cities are able to apply it to all cases of early infectious syphilis available for interview. (See *Appendix,* Questions 19, 20.)

The reasons given are: lack of personnel, lack of personnel trained in cluster interview technique, refusal of physicians to co-operate, reluctance of local health departments to experiment.

North Carolina reports that some cases, such as military personnel, do not lend themselves to cluster techniques. "Cases reported by private physicians are often not clustered due to the delicate relationship between private practice and public health."

Florida notes that physicians refuse cluster testing procedure.

Although cluster testing per se is certainly not the difference between effective and ineffective VD control, its use relates impressively with alert VD control practices. In 19 of the 28 states and one territory reporting increase in early infectious syphilis, the health department has used cluster testing procedure; and in 8 of these states is able to use it on all cases of reported early infectious syphilis. In all of the 18 states using cluster testing, epidemiologic services are provided to physicians who report early infectious syphilis.

In the 7 states reporting decrease in early infectious syphilis, not one was able to apply cluster testing to all cases of early infectious syphilis, and only 3 had applied cluster testing to any portion of the early infections.

All but one of the 18 states reporting use of cluster testing also reported increases in early infectious syphilis among 15-19 year olds. That one reported no change.

## Financial Support

Financial support of VD control in the United States has been reduced from roughly $29 million in 1950 to just over $20 million in 1959. The present $20 million is made up of $5.4 million Federal support and roughly $14.6 million state and local support.

The Federal support is focused on casefinding and other technical assistance; the bulk of the state and local support is operational costs of facilities and services (such as laboratories, drugs, clinic personnel, etc.) generally supportive of veneral disease control in concert with other health programs and services. These would continue at approximately the same level if there were *no* VD control program.

It is difficult to determine exactly what portion of state and local VD program support actually is applied to functions specifically focused on VD control; but one can safely say that it is a small part of total state and local support. It can further be said that very little of it is directly devoted to contact tracing and elimination of the scattered foci of VD infection.

Because of the nature of the veneral diseases and the methods involved in their control, the Federal Government has historically set the pattern for support. First of all, Federal military installations, widely spread throughout the country, create special demands on state and local VD casefinding facilities (See *Appendix,* Question 9); secondly, the widespread referral activity necessary for VD control among states and nations requires active Federal participation; and thirdly, recruitment and training of ivestigative personnel is much less difficult at the Federal level.

These factors are behind state and city need for additional venereal disease control funds in fiscal year 1961. 36 states find their VD programs will need an additional $760,410 in the coming fiscal year, but only 8 of them anticipate any increase in state funds — and that for a total of only $59,487. (See *Appendix,* Questions 21, 22, 23.)

The same roughly is true of cities. Thirty-four cities need a total of $793,300 in addition to what they now have. Only 9 of them anticipate local funds and those in the amount of only $55,500.

The need for additional funds has also been expressed in terms of personnel necessary for communities regarded as having inadequate venereal disease control coverage. (States estimated there were 49 cities, 34 counties and 14 other areas with a combined population of 23,270,667 without adequate venereal disease control coverage.) To provide coverage, states and cities estimated a need for 256 additional personnel, including 52 physicians, 44 nurses and 104 investigators. It

is not difficult to estimate roughly the cost of the 256 additional personnel eeded. On the basis of minimal entrance salaries of $10,000 each for physicians and an average of $5,000 each for all other, the total salary cost alone for one year would be over $1½ million — this, to supply only the needs of personnel in the areas considered by their health officers to be inadequately covered.

## RECOMMENDATIONS

### Federal Support

In view of: 1) the increase in reported cases of infectious syphilis and gonorrhea in the United States over the past two years, especially among teenagers; 2) the need reported by states for VD control coverage in 49 cities, 34 counties, and 14 other areas; 3) federal responsibility for military personnel, certain migrants and other important factors in VD control; 4) the need for increased VD control appropriation at all levels; and 5) the demonstrated unlikelihood of any significant part of the needs being met from state and local funds, we strongly urge that the VD control appropriation for fiscal 1961 be increased by at least $1,000,000 over the $5.4 million appropriated for VD control in fiscal 1960.

### Private Physicians

We believe and we strongly urge that every effort be made to bring the physician more realistically into the VD control program. Specifically, we would like to see started in fiscal 1961 an impressive demonstration of health department services to the private physician. Funds for this purpose should be made available to a number of states where the VD problem is especially serious, where VD program staff are especially competent, and where medical society leadership has demonstrated concern about the problem. Such funds should be in addition to the $6.4 million recommended for program. If a ten-state area were considered, additional cost of personnel, travel and education materials would require approximately $1,000,000.

### Community Support

To be successful, the VD control effort must involve community support beyond the health department and even the private physician. Continuing high prevalence of venereal disease among teenagers and children

at ever lower ages indicates that parents and teachers especially must be brought into the control effort in responsible roles. We therefore strongly urge that the Public Health Service work with the American Social Health Association, the National Parent-Teachers Association, the American Legion, co-ordinating bodies of the various religious groups, and other national agencies concerned with VD control and education to set up studies for determining what those roles are and how they can be implemented.

## Research

We believe with the Advisory Committee on Venereal Disease Control* that increased attention must be given to research with particular emphasis on behavioral science, Immunology, and gonorrhea diagnosis.

Nicholas J. Fiumara — *President*, American Venereal Disease Association

Adele C. Shepard — *Secretary-Treasurer*, American Venereal Disease Association

Frank B. Heller — *President*, American Social Health Association

Conrad Van Hyning — *Executive Director*, American Social Health Association

*Wilson T. Sowder* † — *President*, Ass'n of State and Territorial Health Officers

A. C. Offutt M.D. † — *Secretary-Treasurer*, Ass'n of State and Territorial Health Officers

* Committee recently appointed by Chief, Bureau of States Services, Public Health Service, to advise Federal Government on VD problem and program.

† By telegram: "Joint Statement approved in principle."

# APPENDIX

## TABULATION OF ANSWERS TO QUESTIONNAIRE
## 52 STATES[1] — 94 CITIES[2]

1. What is the general situation as regards reported VD in your state/city?

| | STATES | | | | | CITIES | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | P&S[3] | EL[4] | L&LL[5] | Total | GC[6] | | P&S[3] | EL[4] | L&LL[5] | Total | GC[6] |
| Increasing | 29 | 19 | 18 | 21 | 30 | Increasing | 49 | 34 | 28 | 31 | 49 |
| Decreasing | 6 | 15 | 20 | 14 | 6 | Decreasing | 14 | 20 | 28 | 19 | 13 |
| Stable | 15 | 15 | 10 | 9 | 14 | Stable | 24 | 30 | 28 | 23 | 30 |
| No data | 2 | 3 | 4 | 8 | 2 | No data | 7 | 10 | 10 | 21 | 2 |

2. Do you consider the reporting of syphilis sufficiently complete in your state/city to provide a reliable indication of incidence and prevalence?

| STATES | | | CITIES | | |
|---|---|---|---|---|---|
| Yes | No | N.D. | Yes | No | N.D.[7] |
| 30 | 21 | 1 | 56 | 30 | 8 |

3. Is there any change in the reporting of syphilis cases in your state/city from private physicians?

| | STATES | | | | | CITIES | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | P&S | EL | L&LL | Total | | P&S | EL | L&LL | Total |
| Increase | 25 | 18 | 19 | 14 | Increase | 27 | 17 | 20 | 24 |
| Decrease | 8 | 15 | 16 | 13 | Decrease | 7 | 16 | 13 | 11 |
| Stable | 14 | 14 | 12 | 17 | Stable | 38 | 37 | 41 | 34 |
| No data | 5 | 5 | 5 | 8 | No data | 22 | 24 | 20 | 25 |

[1] 50 states, Puerto Rico and the Virgin Islands.

[2] 91 cities over 100,000 population, Los Angeles County, California, Fulton County, Georgia, and the District of Columbia.

[3] Primary-Secondary: Early Infectious.

[4] Early Latent: Potentially Infectious.

[5] Late and Late Latent: Noninfectious.

[6] Gonorrhea.

[7] Includes report without information, insufficient or compromised information.

4. Approximately what percentage of syphilis cases reported in your state/city is from private physicians?

| Stage of | 0-19% | | 20-39% | | 40-59% | | 60-79% | | 80-100% | | N.D. | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Disease | State | City | State | City | State | City | State | City | State | City | State | City |
| P & S | 8 | 24 | 11 | 15 | 17 | 12 | 4 | 5 | 7 | 6 | 5 | 32 |
| EL | 6 | 18 | 10 | 13 | 11 | 20 | 12 | 5 | 4 | 5 | 9 | 33 |
| L & LL | 4 | 15 | 8 | 15 | 14 | 16 | 13 | 11 | 5 | 7 | 8 | 30 |

5. Have you undertaken surveys during the past year to determine the completeness of morbidity reporting of venereal disease from:

| | STATES | | | CITIES | | |
|---|---|---|---|---|---|---|
| | Yes | No | N.D. | Yes | No | N.D. |
| Private physicians | 23 | 27 | 2 | 30 | 57 | 7 |
| Private laboratories | 14 | 30 | 8 | 18 | 55 | 21 |
| Hospitals | 17 | 28 | 7 | 34 | 53 | 7 |

6. VD rates for large areas tend to conceal high prevalence areas within them. Please provide rates for three areas which demonstrate this concealment best in your state/city.

*The data in Question 6 do not lend themselves to tabulation.*

7. Have you noted any outbreaks[8] of VD not reported in previous questionnaires? If available, please supply descriptions and diagrams.

| STATES | | | CITIES | | |
|---|---|---|---|---|---|
| Yes | No | N.D. | Yes | No | N.D. |
| 24 | 27 | 1 | 16 | 70 | 8 |

8. Has your state/city experienced any change in the reported cases of infectious VD among younger age groups during fiscal 1959?

| STATES | | | | | | CITIES | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Ages | Disease | Rise | Fall | No Change | N.D. | Ages | Disease | Rise | Fall | No Change | N.D. |
| 10-14 | P&S | 10 | 3 | 33 | 6 | 10-14 | P&S | 8 | 5 | 59 | 22 |
| | GC | 19 | 9 | 22 | 2 | | GC | 21 | 6 | 47 | 20 |
| 15-19 | P&S | 29 | 4 | 15 | 4 | 15-19 | P&S | 21 | 6 | 49 | 18 |
| | GC | 25 | 17 | 7 | 3 | | GC | 43 | 7 | 32 | 12 |
| 20-24 | P&S | 24 | 4 | 20 | 4 | 20-24 | P&S | 25 | 8 | 46 | 15 |
| | GC | 27 | 11 | 10 | 4 | | GC | 41 | 4 | 37 | 12 |

[8] By "outbreak" is meant any significant rise in reported cases or chain of cases which are demonstrated to have been spread from a common source or sources.

9. Do any of the following groups create special demands on your VD program?

| | STATES | | | CITIES | | |
|---|---|---|---|---|---|---|
| | Yes | No | N.D. | Yes | No | N.D. |
| Indians | 13 | 35 | 4 | 8 | 65 | 21 |
| Merchant Seamen | 9 | 40 | 3 | 4 | 75 | 15 |
| Migrant Workers | 24 | 25 | 3 | 9 | 71 | 14 |
| Military | 34 | 17 | 1 | 21 | 59 | 14 |
| Tourists | 3 | 40 | 9 | 6 | 61 | 27 |

10. How many VD epidemiologic report forms were referred *to* your state/city health departments from out-of-state during the past year? Out of country?

| | |
|---|---|
| Number of states receiving forms | 38 |
| Number of forms received | 9,905 |
| Number of cities receiving forms | 57 |
| Number of forms received | 5,746 |

11. How many VD epidemiologic report forms were referred *from* your state/city to out-of-state health departments during the past year? Out of country?

| | |
|---|---|
| Number of states sending forms | 41 |
| Number of forms sent | 8,552 |
| Number of cities sending forms | 55 |
| Number of forms sent | 5,907 |

12. Are there cities, counties, census tracts, election districts, wards, or other areas in your state/city without adequate VD control coverage?

| STATES REPORT | Cities | Counties | Other | Estimated Population |
|---|---|---|---|---|
| 18 | 49 | — | — | 8,447,400 |
| 23 | — | 34 | — | 14,268,267 |
| 6 | — | — | 14 | 555,000 |
| | TOTAL | | | 23,270,667 |

| CITIES REPORT | Census Tracts | Health Districts | Wards Others | Estimated Population |
|---|---|---|---|---|
| 4 | 89 | — | — | 421,754 |
| 4 | — | 9 | — | 2,667,000 |
| 3 | — | — | 6 | 219,000 |
| | TOTAL | | | 3,307,754 |

13. If answer to above is yes, is this due to:

| | STATES | | | CITIES | | |
|---|---|---|---|---|---|---|
| | Yes | No | N.D. | Yes | No | N.D. |
| Lack of personnel? | 33 | 0 | 19 | 13 | 5 | 76 |
| Lack of travel funds for investigative personnel? | 12 | 3 | 37 | 2 | 12 | 80 |
| Other | 13 | 0 | 39 | 4 | 7 | 83 |

14. If lack of personnel is a major factor in the uncovered areas, how many additional persons would you need for adequate coverage?

| PERSONNEL NEEDED | STATES | CITIES | TOTAL |
|---|---|---|---|
| Physicians | 42 | 10 | 52 |
| Nurses | 35 | 9 | 44 |
| Investigators | 76 | 28 | 104 |
| Record Analysts | 2 | 4 | 6 |
| Lab Technicians | 6 | 5 | 11 |
| Health Educators | 5 | 4 | 9 |
| Administrative | 1 | 0 | 1 |
| Clerical | 15 | 14 | 29 |
| TOTAL | 182 | 74 | 256 |

15. Are epidemiologic services provided to private physicians who report infectious syphilis?

| Health Departments | Yes | No | N.D. |
|---|---|---|---|
| States | 51 | 1 | 0 |
| Cities | 88 | 2 | 4 |

16. If answer to above is "yes" how many of the patients of private physicians were interviewed by health department personnel?

| | Number Reporting | Number[9] Patients Interviewed |
|---|---|---|
| States | 38 | 1,364 |
| Cities | 55 | 1,124 |

17. What percentage of infectious syphilis cases reported by private physicians was interviewed by health department personnel?

| 0-19% | | 20-39% | | 40-59% | | 60-79% | | 80-100% | | N.D. | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| State | City | State | City | State | City | State | City | State | City | State | City |
| 3 | 16 | 3 | 4 | 5 | 10 | 9 | 5 | 22 | 41 | 10 | 18 |

18. Do you have diagnostic and treatment facilities sufficient to meet the needs in the areas you cover with present techniques?

| STATES | | | CITIES | | |
|---|---|---|---|---|---|
| Yes | No | N.D. | Yes | No | N.D. |
| 31 | 21 | 0 | 80 | 7 | 7 |

[9] Three states and six cities reported percentages which could not be included.

| | STATES | | | CITIES | | |
|---|---|---|---|---|---|---|
| | Yes | No | N.D. | Yes | No | N.D. |
| 19. Has your health department used cluster testing procedure? | 31 | 21 | 0 | 51 | 33 | 10 |
| 20. If answer to above is yes, are you able to apply cluster testing procedures to all cases of primary and secondary syphilis available for interview? | 16 | 13 | 23 | 36 | 11 | 5 |

21. How much additional *support* ($) do you feel your program will need in fiscal year 1961?

| | STATES | CITIES |
|---|---|---|
| Number needing | 36 | 34[10] |
| Amount | $760,410 | $793,300 |
| Number not needing | 4 | 27 |
| No data | 12 | 33 |

22. How much increased support ($) do you anticipate in fiscal 1961 from state and local sources?

| | STATES | CITIES |
|---|---|---|
| Number anticipating increase | 8 | 9[11] |
| Amount anticipated | $ 59,487 | $ 55,500 |
| Number not anticipating increase | 29 | 57 |
| No data | 15 | 28 |

23. How much increase in Federal support ($) do you think your program could use effectively?

| | STATES | CITIES |
|---|---|---|
| Number could use increase | 35 | 38[12] |
| Amount of increase | $640,710 | $759,590 |
| Number could not use increase | 4 | 23 |
| No data | 13 | 33 |

[10] Six of the 34 cities giving amounts ($) needed are in states which do not indicate need for additional support.

[11] Four of the 9 cities giving anticipated increases are in states not anticipating increased support.

[12] Four of the 38 cities indicating amount of Federal support ($) they could use effectively are not in states indicating such amounts.

## TABLE I

### CASES OF SYPHILIS AND GONORRHEA AND RATES PER 100,000 POPULATION REPORTED BY STATE HEALTH DEPARTMENTS FISCAL YEARS 1948-1959[13]

| FISCAL YEAR | TOTAL SYPHILIS[14] | | PRIMARY AND SECONDARY SYPHILIS | | EARLY LATENT SYPHILIS | | LATE AND LATE LATENT SYPHILIS | | GONORRHEA | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Cases | Rate | Cases | Rate | Cases | Rate | Cases | Rate | Cases | Rate |
| 1948 | 338,141 | 234.7 | 80,528 | 55.9 | 97,745 | 67.9 | 123,972 | 86.1 | 363,014 | 252.0 |
| 1949 | 288,736 | 197.3 | 54,248 | 37.1 | 84,331 | 57.6 | 121,931 | 83.3 | 331,661 | 226.7 |
| 1950 | 229,723 | 154.2 | 32,148 | 21.6 | 64,786 | 43.5 | 112,424 | 75.5 | 303,922 | 204.0 |
| 1951 | 198,640 | 131.8 | 18,211 | 12.1 | 52,309 | 34.7 | 107,133 | 71.1 | 270,459 | 179.5 |
| 1952 | 168,734 | 110.8 | 11,991 | 7.9 | 38,365 | 25.2 | 101,920 | 66.9 | 245,633 | 161.3 |
| 1953 | 156,099 | 100.8 | 9,551 | 6.2 | 32,287 | 20.8 | 100,195 | 64.7 | 243,857 | 157.4 |
| 1954 | 137,876 | 87.5 | 7,688 | 4.9 | 24,999 | 15.9 | 93,601 | 59.4 | 239,661 | 152.0 |
| 1955 | 122,075 | 76.0 | 6,516 | 4.1 | 21,553 | 13.4 | 84,741 | 52.7 | 239,787 | 149.2 |
| 1956 | 126,219 | 77.1 | 6,757 | 4.1 | 20,014 | 12.2 | 89,851 | 54.8 | 233,333 | 142.4 |
| 1957 | 130,552 | 78.3 | 6,251 | 3.8 | 19,046 | 11.4 | 96,856 | 58.1 | 216,476 | 129.8 |
| 1958 | 116,630 | 68.5 | 6,661 | 3.9 | 16,698 | 9.8 | 85,974 | 50.5 | 220,191 | 129.3 |
| 1959 | 119,981 | 69.3 | 8,178 | 4.7 | 17,592 | 10.2 | 86,776 | 50.1 | 237,318 | 137.0 |

[13] These data do not include migrant labor from other countries.
[14] Includes "Stages of Syphilis Not Stated."

## TABLE II

## NUMBER STATES AND CITIES REPORTING INCREASE IN SYPHILIS RATES OVER PREVIOUS YEARS

| FISCAL YEAR | TOTAL SYPHILIS | | PRIMARY AND SECONDARY SYPHILIS | | EARLY LATENT SYPHILIS | | LATE AND LATE LATENT SYPHILIS | |
|---|---|---|---|---|---|---|---|---|
| | States | Cities | States | Cities | States | Cities | States | Cities |
| 1953 | 15 | 15 | 8 | 11 | 6 | 16 | 21 | 17 |
| 1954 | 9 | 14 | 10 | 11 | 5 | 14 | 15 | 19 |
| 1955 | 16 | 19 | 16 | 20 | 11 | 17 | 21 | 20 |
| 1956 | 23 | 24 | 20 | 25 | 18 | 21 | 24 | 23 |
| 1957 | 21 | 22 | 20 | 25. | 21 | 19 | 26 | 25 |
| 1958 | 18 | 24 | 23 | 26 | 16 | 20 | 19 | 23 |
| 1959 | 21 | 31 | 29 | 49 | 19 | 34 | 18 | 28 |

## TABLE III

### VENEREAL DISEASE IN 147 BRITISH CLINICS BY AGE AND SEX

| | MALE | | FEMALE | | TOTALS | |
|---|---|---|---|---|---|---|
| | 1957 | 1958 | 1957 | 1958 | 1957 | 1958 |
| 14 or under | 1 | 9 | 29 | 51 | 30 | 60 |
| 15 — 19 | 886 | 1,095 | 960 | 1,138 | 1,846 | 2,233 |
| 20 — 24 | 4,361 | 5,034 | 1,407 | 1,685 | 5,768 | 6,719 |
| 25 — 29 | 4,310 | 4,861 | 804 | 924 | 5,114 | 5,785 |
| 30 — 34 | 2,786 | 3,044 | 481 | 502 | 3,267 | 3,546 |
| 35 — 39 | 1,714 | 1,889 | 267 | 250 | 1,981 | 2,139 |
| 40 — 49 | 1,428 | 1,551 | 225 | 206 | 1,653 | 1,757 |
| 50 — 59 | 406 | 456 | 60 | 70 | 466 | 526 |
| 60 or over | 81 | 79 | 15 | 13 | 96 | 92 |
| TOTALS | 15,973 | 18,018 | 4,248 | 4,839 | 20,221 | 22,857 |

## TABLE IV

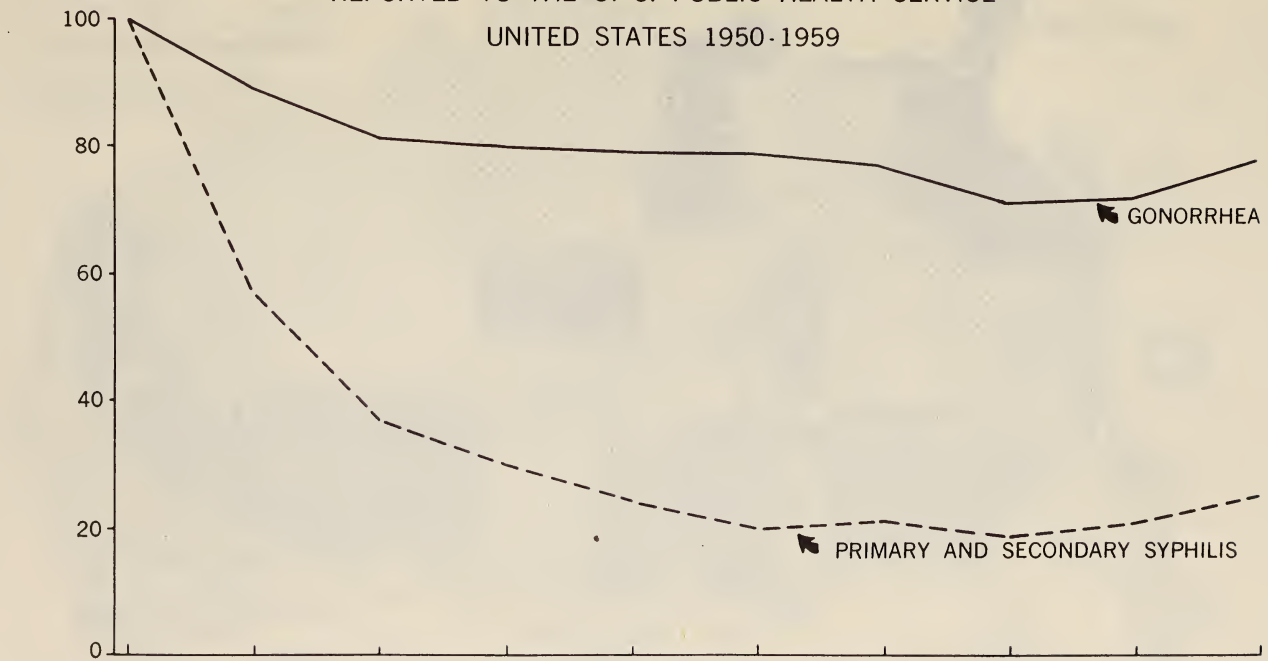
### NUMBER OF BRITISH TOWNS AND CITIES 100,000 POPULATION AND OVER — TRENDS IN VENEREAL DISEASE BY AGE 1957-1958

| AGE GROUP (years) | INCREASE | STATIONARY | DECREASE |
|---|---|---|---|
| 14 or under | 12 | 23 | 3 |
| 15 — 19 | 22 | 4 | 12 |
| 20 — 24 | 25 | 1 | 12 |
| 25 — 29 | 32 | — | 6 |
| 30 — 34 | 24 | — | 14 |
| 35 — 39 | 22 | 2 | 14 |
| 40 — 49 | 24 | 4 | 10 |
| 50 — 59 | 18 | 9 | 11 |
| 60 or over | 11 | 13 | 14 |
| TOTAL | 27 | 2 | 9 |

52692 O—60—14

CHART I

CASES OF PRIMARY AND SECONDARY SYPHILIS AND GONORRHEA
REPORTED TO THE U. S. PUBLIC HEALTH SERVICE
UNITED STATES 1950-1959

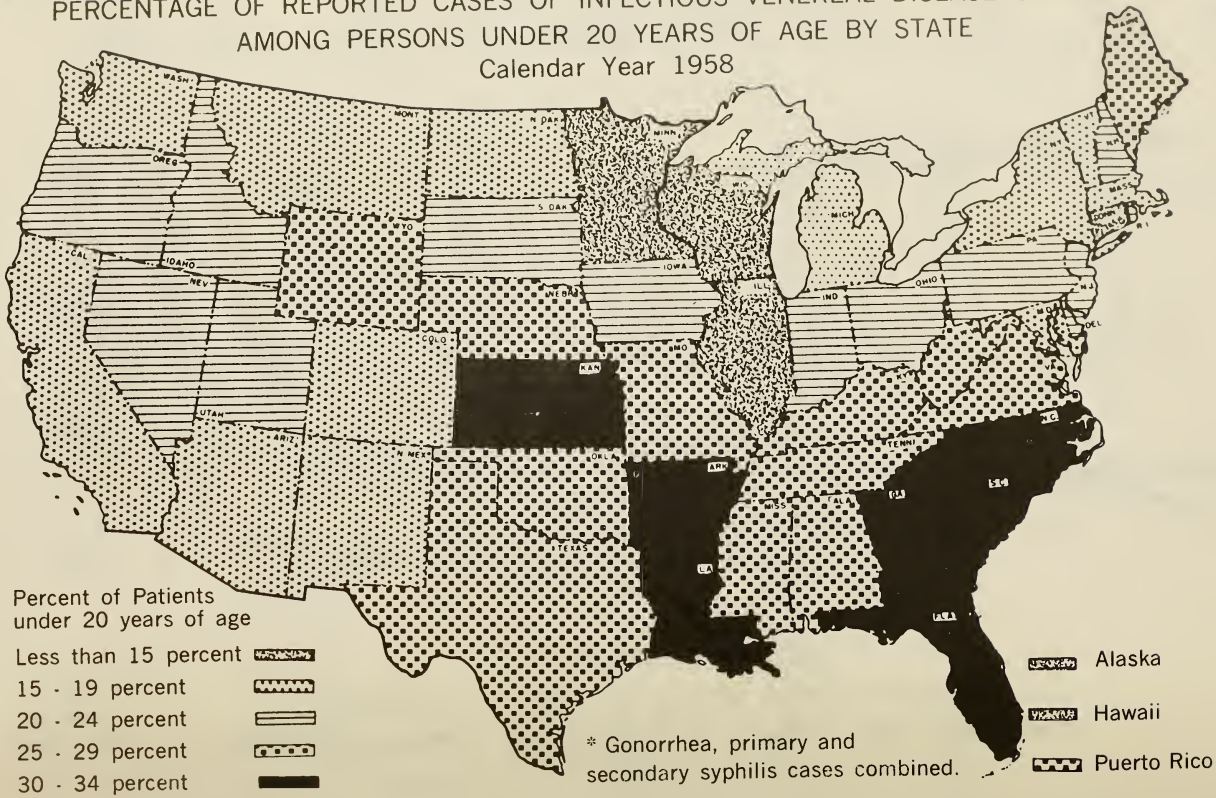



| | 1950 | 1951 | 1952 | 1953 | 1954 | 1955 | 1956 | 1957 | 1958 | 1959 |
|---|---|---|---|---|---|---|---|---|---|---|
| P & S | 32,148 | 18,211 | 11,991 | 9,551 | 7,688 | 6,516 | 6,757 | 6,251 | 6,661 | 8,178 |
| G C | 303,922 | 270,459 | 245,633 | 243.857 | 239,661 | 239,787 | 233,333 | 216,476 | 220,191 | 237,318 |

CHART II

PERCENTAGE OF REPORTED CASES OF INFECTIOUS VENEREAL DISEASE* OCCURRING AMONG PERSONS UNDER 20 YEARS OF AGE BY STATE

Calendar Year 1958




* Gonorrhea, primary and secondary syphilis cases combined.

CHART III

**PRIMARY AND SECONDARY SYPHILIS** - CASES PER 100,000 POPULATION

Fiscal Year 1959

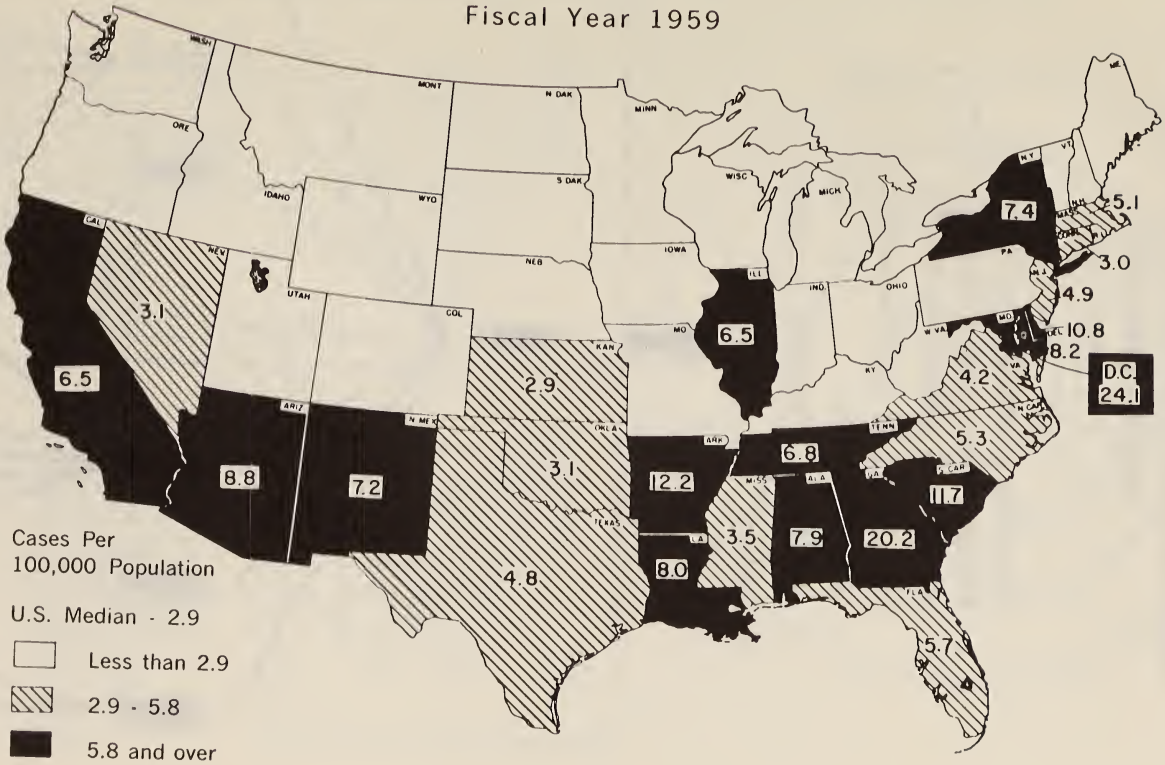


CHART IV

# INFECTIOUS SYPHILIS OUTBREAK AMONG WHITE GROUP INVOLVING PRIVATE PHYSICIAN PATIENTS NORTH CAROLINA 1959

Solid black — infectious syphilis
Diagonal lines — epidemiological treatment
Solid white — dispositions pending

Patients D, E, G, and R were from private physicians.

Patient D was diagnosed and treated in Oklahoma.

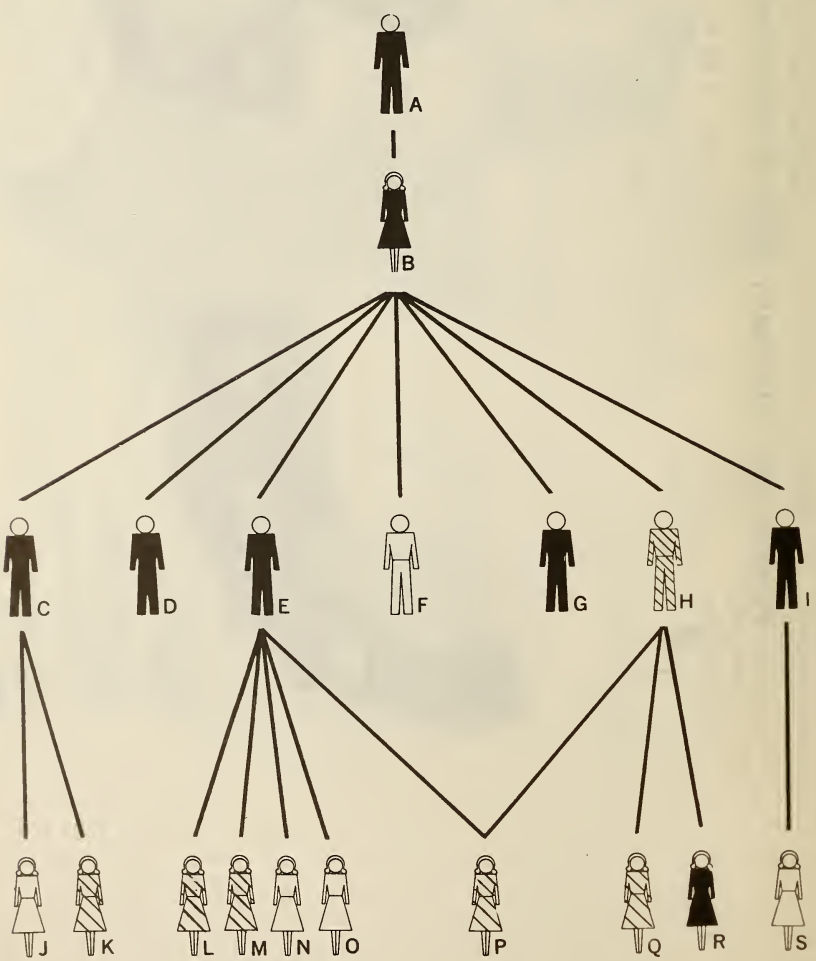
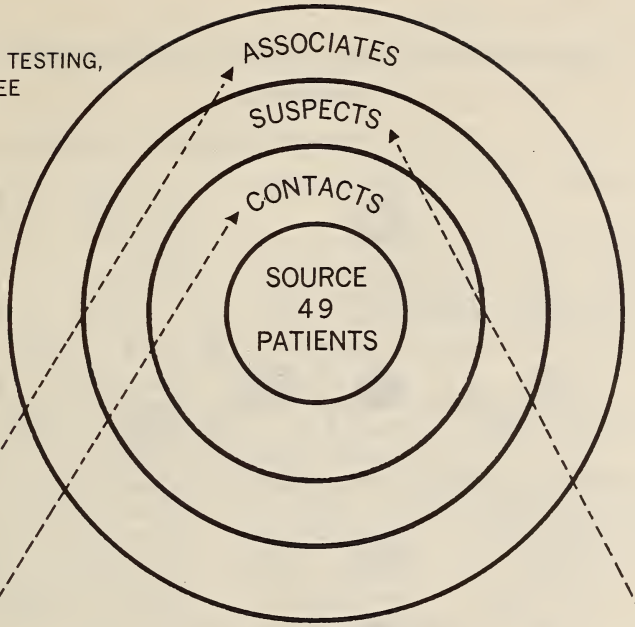


CHART V

CLUSTER TESTING, TENNESSEE




**CONTACTS:**

396 Contacts
21 P & S Cases
19 Early Latent Cases
2 Other Syphilis Cases
40 Total Early Cases
42 Total Syphilis Cases
38 Gonorrhea Cases

**SUSPECTS:**

322 Suspects
6 P & S Cases
4 Early Latent Cases
3 Other Syphilis Cases
10 Total Early Cases
13 Total Syphilis Cases
23 Gonorrhea Cases

**ASSOCIATES:**

679 Associates
1 P & S Cases
1 Early Latent Cases
5 Other Syphilis Cases
2 Total Early Cases
7 Total Syphilis Cases
50 Gonorrhea Cases

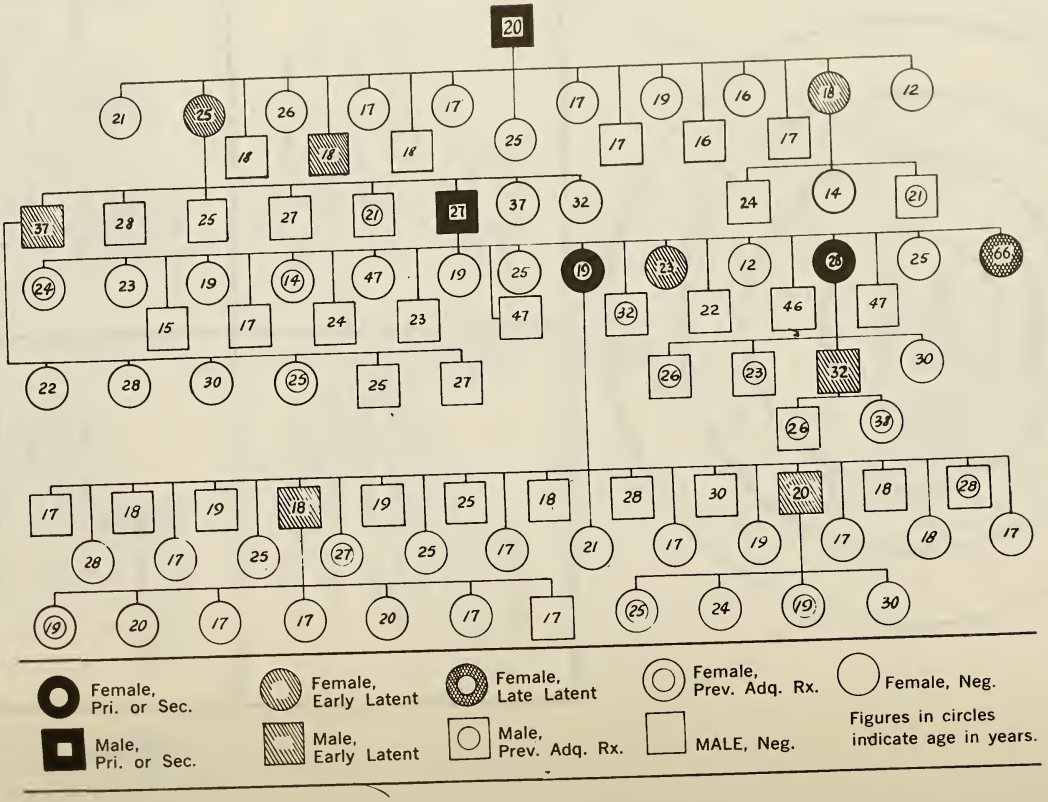
**TOTALS:**

49 Source Patients
1397 People Involved
101 Early Infectious Syphilis Cases Found
111 Total Syphilis Cases Found
111 Cases of Gonorrhea Found

CHART VI

# EARLY SYPHILIS OUTBREAK — SOUTH CAROLINA

February 1959



TUESDAY, MARCH 1, 1960.

## VOCATIONAL EDUCATION AND LIBRARY SERVICES

### WITNESS

**REUBEN JOHNSON, FARMERS UNION**

Mr. FOGARTY. We shall hear next from Mr. Reuben Johnson, representing the Farmers Union.

Mr. JOHNSON. Mr. Chairman, in past years we have had other representatives of the Farmers Union appear before your committee to testify on the appropriation for vocational education and library services. Congressman Denton will remember that Mr. John Raber, president of the Indiana Farmers Union, appeared here on behalf of vocational education several years ago.

I appreciate the opportunity to come here and to present the views of the National Farmers Union in behalf of appropriations for vocational education, and rural library services.

These are not the only programs in the Department of Health, Education, and Welfare in which we as an organization of farm families have a direct interest, but we feel that inasmuch as these programs are of special interest to us, that we would like to speak in their behalf this morning.

### VOCATIONAL EDUCATION

First, I would like to present some views on vocational education. We urge the subcommittee to restore the $2 million cut proposed by the administration for vocational education for the 1961 fiscal year.

During the past ten years, as the subcommittee knows, the administration has urged Congress to enact legislation which would cut all Federal support of vocational education.

The Farmers Union has vigorously opposed this recommendation. Congress not only has ignored the administration recommendation for doing away with the Federal support of vocational education, but it has given merited confidence and support to vocational education programs by substantially increasing the appropriations in recent years.

In spite of the evidence of overwhelming public support, the administration continues in its efforts to whittle away at appropriations whenever it has the opportunity to do so.

We are aware of the support of this subcommittee for vocational education, and we commend you for the responsible manner in which you have protested educational programs which continue to serve the vocational training needs of farm families as well as of other people who need training for work in industry and in distributive occupations.

In the kind of world in which we live, vocational education continues to make a contribution, not only in terms of increasing earnings to individual citizens, but to the overall defense posture of the United States. In this connection, Farmers Union is fully cognizant of the needs of the United States for trained manpower, but we submit that the needs of the country for people trained in agriculture and home economics to provide replacements for 5 million farm families are essential elements in maintaining the defense posture.

Moreover, Mr. Chairman, we urge the subcommittee to study carefully any proposal put before you in justification of a transfer of funds from high school level vocational education to post-high-school level.

Farmers Union is a supporter of vocational education at all levels, but we do not believe it is sound to proceed on the assumption that education at one level will replace education at a different level.

### RURAL LIBRARY SERVICES

Mr. Chairman, the success of the rural library services program is self-evident. The administration has requested almost as much as the Rural Library Services Act authorizes, but I feel that at this particular time in the operation of this program, the full authorization is warranted. If there are States that do not match funds or provide them under Rural Library Services Act, perhaps the reserve might be applied in other States.

Congressman Marshall, Minnesota, might be able to use additional funds—there are other areas, I am sure, which could use the funds that might be left over from some State not taking its quota.

Mr. Fogarty, I want to commend you for the very excellent work you have done in connection with health research in past years. I feel that farm people have a tremendous interest in the work that is being done in this field, as well as in programs to bring the results of health research to them.

Mr. FOGARTY. Thank you very much, Mr. Johnson.

On these two items that you mentioned, I assume you know you are talking to a friendly committee. Library services and vocational education are well thought of by the committee.

Mr. JOHNSON. We appreciate very much your concern for these programs, and urge you to continue to support them.

Mr. FOGARTY. The thing I feel sorry about is that we have a man on this committee whose constituents are not benefited by the Library Services Act.

Mr. JOHNSON. I am familiar with the situation. I assure you that farm families in Indiana are in support of the program.

Mr. DENTON. I wondered if you and I couldn't use John Raber to convince the Governor it would be perfectly safe for the people of Indiana to use that library service, and that they would not be brainwashed; 49 other States using it have not been brainwashed.

Mr. JOHNSON. I know you are familiar with the persuasive powers of Mr. Raber and, at your suggestion, I will make sure that he has a transcript of these hearings with attention directed to your remarks.

Mr. DENTON. Some of the Congressmen from Indiana are trying to get the State in the program. We hope to be in it next year.

Mr. JOHNSON. I think this is a logical point to make, and I would certainly like to support it.

Mr. FOGARTY. Thank you very much, Mr Johnson.

## Vocational Education

### LETTER FROM REV. CORNELIUS B. COLLINS, CHAIRMAN, RHODE ISLAND STATE BOARD OF EDUCATION

Mr. Fogarty. I have here an excellent letter from Reverend Collins, who is chairman of our State board of education in Rhode Island, which shows the effect of the $2 million cut on our State. The letter will be placed in the record at this point.

(The letter referred to follows:)

State of Rhode Island and Providence Plantations,
State Board of Education,
*Providence, February 16, 1960.*

Hon. John E. Fogarty,
*Representative from Rhode Island,*
*New House Office Building, Washington, D.C.*

My Dear Mr. Fogarty: The President's vocational education budget under the George-Barden Act titles I and II calls for an appropriation of $31,702,081 for the fiscal year ending June 30, 1961. This is $2 million less than the amounts appropriated under titles I and II for 1960. The budget for area vocational programs under title III for national defense is $9 million, which is an increase of $2 million over the amount appropriated last year. In other words, the President's budget recommends cutting the regular programs by $2 million and increasing the area programs by the same amount.

This budget, as presented Monday, January 18, 1960, notes that George-Barden funds budgeted to Rhode Island have been diminished by $3,599 from $143,358 in 1960 to $139,759 in 1961.

The proposed cut has been made in the funds apportioned to trade and industrial training, which is the largest of our vocational programs. This will mean that additional funds must be made on the State level for reimbursement to the towns on a matching basis. We have gradually, over the years, built up the State budget so that we might be on a 50–50 matching basis.

Under title III of the National Defense Act for area vocational programs for Rhode Island there is a proposed increase of $9,830 from $34,404 in 1960 to $44,234 in 1961. This gives a net gain of $6,251 for Rhode Island, however, the gain is in the national defense training area at the expense of the regular program and can be used only for new defense courses. It cannot be used for support of the regular programs. This might lead eventually to the elimination of George Barden funds, and the elimination of the title III defense funds when defense needs have passed.

For the first time in 3 years, the President's budget message does not recommend the repeal of the Federal Vocational Acts, however, bill S. 2832 was introduced in the Senate on January 14, 1960, by Norris Cotton, Republican from New Hampshire, which among other things calls for the repeal, as of July 1, 1960, of all vocational education laws including the area vocational education measure. The measure S. 2832 has been referred to the Senate Labor and Public Welfare Committee under Senator Lister Hill.

Since you are chairman of the House Subcommittee on Appropriations, the Rhode Island State Board for Vocational Education urges you to work for the restoration of the $2 million to the George-Barden fund for 1961.

With kind personal regards, I remain,

Very sincerely yours,

Rev. Cornelius B. Collins,
*Chairman, State Board of Vocational Education.*

## Vocational Education

### STATEMENT OF M. D. MOBLEY, EXECUTIVE SECRETARY, AMERICAN VOCATIONAL ASSOCIATION, INC.

Mr. Fogarty. Dr. Mobley, executive director of the American Vocational Association, has also submitted his usual fine statement on this program, which we appreciate and will place in the record.

(The statement referred to follows:)

STATEMENT BY M. D. MOBLEY, EXECUTIVE SECRETARY, AMERICAN VOCATIONAL ASSOCIATION, INC., WASHINGTON, D.C., MARCH 3, 1949

My name is M. D. Mobley. I am the executive secretary of the American Vocational Association, a 54-year-old professional organization with a membership of more than 30,000 vocational teachers, officials, school-board members, and others interested in the development and improvement of vocational education.

This statement is submitted on behalf of members of the American Vocational Association, whose official delegates at national conventions have on numerous occasions in recent years voted unanimously for resolutions urging Congress to continue full appropriations authorized under provisions of title I of the George-Barden Act.

The members of the American Vocational Association are grateful to the National Congress for the wonderful support given to this phase of education through the years. Vocational educators, who are devoted public servants, try constantly to perform their duties in such an effective and diligent manner to justify the great confidence of the American people in them as expressed through their chosen representatives in National Congress.

Members of the American Vocational Association are unalterably opposed to the proposed $2 million reduction in the appropriation for title I of George-Barden funds. Should Congress approve such a reduction in the appropriation, it would result in a cut of $674,215 in funds for vocational education in agriculture; $543,498 for home economics; $571,994 for trade and industrial education; and $210,293 in funds for distributive occupations.

State and local school officials are not in a financial position to replace such a reduction of funds, should Congress carry out the budget recommendation. Thus a cut in Federal funds would result in eliminating vocational programs in many communities throughout the Nation and crippling programs in many other communities This is due to the fact that school officials are presently experiencing great difficulty in finding sufficient funds to adequately support education in general. A reduction in funds for vocational education would result in either eliminating some vocational programs or shifting State and local money presently being used for other phases of education to make up the reduction in Federal vocational funds. Either alternative is undesirable since funds are too desperately needed for all phases of education.

Any action of Congress or other legislative body that would tend to reduce or cripple vocational programs would hinder our Nation's effort in its economic battle with Soviet-dominated countries of the world.

On numerous occasions Russia's Khrushchev has stated that one of the major goals of the Soviets is to lick the United States in an economic war. Not long ago he said to a newspaper publisher:

"We declare war upon you—in the peaceful field of trade. We declare a war we will win over the United States. The threat to the United States is not the intercontinental ballistic missile but in the field of peaceful production. We are relentless in this, and it will prove the superiority of our system."

In his speech to the Economic Club of New York during his 1959 visit to this country, Khrushchev said:

"All of you are well aware of the fact that we are offering you economic competition. Some describe this as our challenge to the United States of America. But, speaking about challenges, one might say, and that would be even more correct, perhaps, that it was the United States that first challenged all the world; it is the United States that developed its economy above that of all countries. For a long time no one dared to challenge your supremacy. But now the time has come when there is such a state which accepts your challenge, which takes into account the level of development of the United States of America and in turn is challenging you. Do not doubt that the Soviet Union will stand on its own in the economic competition, will overtake and outstrip you."

It is a well-known fact that Russia is now in the process of reorganizing its entire system of education, making it largely vocational in character. This is one of the major Soviet steps in an effort to increase productivity of the Russian people and thus use the schools more effectively in their effort to overcome and surpass the United States in economic competition.

The United States can ill afford to take any steps that would cripple any phase of vocational education. The economic well-being of the United States is tied

inseparably to the skill and productivity of all the people, regardless of the occupations in which they are engaged.

In light of the above facts, it is the sincere hope of the members of the American Vocational Association that Congress will appropriate for fiscal 1961 the same amount for vocational education under title I of the George-Barden Act that was appropriated for fiscal 1960. To cut the funds would not only be unwise but unsafe for the security and economic well-being of our Nation.

## Vocational Education

### STATEMENT OF GENE LEACH, ASSISTANT LEGISLATIVE DIRECTOR, AMERICAN FARM BUREAU FEDERATION

Mr. Fogarty. Mr. Leach, of the Farm Bureau, was scheduled to testify, but since we are running a little behind schedule he thoughtfully offered to leave his statement for our record instead of reading it. We will place it in the record at this point.

(The statement referred to follows:)

STATEMENT OF THE AMERICAN FARM BUREAU FEDERATION ON VOCATIONAL EDUCATION BY GENE LEACH, ASSISTANT LEGISLATIVE DIRECTOR, FEBRUARY 29, 1960

We appreciate the opportunity of presenting the views of the American Farm Bureau Federation with respect to appropriations for vocational education. The membership of Farm Bureau consists of more than 1,600,000 volunteer dues-paying farm family members in 49 States and Puerto Rico.

The members of this committee, we feel sure, are aware of Farm Bureau's longstanding legislative support of vocational education at both the State and National levels.

We are very proud of the many important contributions that vocational education has made and is continuing to make to our citizens and society. We are especially proud of the great contributions being made to American agriculture as a result of the vocational agriculture and home economics programs provided by the Smith-Hughes Act and title I of the George-Barden Act.

We are opposed to the President's budget recommendation to reduce title I funds of the George-Barden Act by 2 million for fiscal year 1961. As we understand, the budget recommends that this reduction be made in order to increase appropriations $2 million for area vocational education as authorized by the National Defense Education Act of 1958.

Member State farm bureau voting delegates adopted the following policy relative to area vocational education at our annual meeting in Chicago, Ill., December 17, 1959:

"We support adequate appropriations for vocational education under the Smith-Hughes and George-Barden Acts. We favor the present method of financing vocational education.

"We support the development of area vocational training schools, where needed, through utilization of State and local funds."

Farm Bureau opposed the passage of the National Defense Education Act on the basis that it was unwarranted and would establish legal authority for the Federal Government to assume decisionmaking powers relative to the operation of local schools—decisions that always have and should remain in the hands of State and local school officials. Although the act has been in operation for a short time, various States and some leading school administrators admit that it establishes Federal controls never before experienced in our American education system.

The National Defense Education Act does not authorize vocational education in agriculture and home economics. Therefore, if the budget recommendation were followed, it would mean a reduction in appropriations for fiscal year 1961 of approximately 7 percent below the amount appropriated in 1960. Such a reduction, we believe, would place these programs in financial distress and greatly impair their effectiveness.

We are convinced that it would be a serious mistake to transfer vocational education funds from a permanent, well-established, and accepted vocational education program over to a controversial and temporary program under the National Defense Education Act.

State and local governments take pride in vocational education programs as authorized by the Smith-Hughes Act and title I of the George-Barden Act. They have proved that these established programs are worthy of their support. This is obvious when it is considered that State and local governments are spending $5 of State and local funds for each $1 of Federal support for vocational education.

The American Farm Bureau urges this committee to recommend that title I appropriations under the George-Barden Act for fiscal year 1961 be maintained at the 1960 level and that the full authorization of the Smith-Hughes Act be appropriated for fiscal year 1961. Any additional funds for vocational education should be provided by the State and local governments.

## Vocational Education

Mr. Fogarty. I shall not burden the record with all of the voluminous correspondence I have received on this administration proposal to cut the vocational education program $2 million; however, we will insert some of the numerous letters received from Members of Congress. I guess 20 have talked to me about restoring the cut for every one who has actually written.

(The letters referred to follow:)

House of Representatives,
*Washington, D.C., January 26, 1960.*

Hon. John E. Fogarty,
Hon. Winfield K. Denton,
Hon. Fred Marshall,
Hon. Melvin R. Laird,
Hon. Elford A. Cederberg,
*House of Representatives, Washington, D.C.*

Dear Friends: This morning I received the following telegram:

"The Kentucky Vocational Association requests that you contact the members of the House Subcommittee on Appropriations regarding the proposed $2 million cut in the vocational education program, appropriations titles I and II for the Department of Health, Education, and Welfare. This cut would mean an 8 percent decrease in the funds for agriculture, home economics, distributive education, and industrial education which we feel will unduly reduce our services to students in Kentucky who need vocational training. We earnestly solicit your support in making these contacts with members of the subcommittee on behalf of the 900 vocational teachers in Kentucky.

"Jewell Colliver,
*"President, Kentucky Vocational Association,*
*"Park City High School, Park City, Ky."*

While I am not familiar with the implications of appropriation mentioned in the foregoing telegram, yet I trust you will give this matter your careful and conscientious consideration and I hope you wlil do what seems best for all under the circumstances. I do know that we are in a bad way economically in some parts of my State of Kentucky and I hope you will do your best to recognize these conditions and the needs of the people as you wrestle with this problem.

With all good wishes, I am

Your colleague,

Eugene Siler.

House of Representatives,
*Washington, D.C., February 20, 1960.*

Hon. John Fogarty,
*Chairman, Subcommittee on Appropriations,*
*Department of Health, Education, and Welfare,*
*House of Representatives, Washington, D.C.*

Dear Mr. Chairman: I am forwarding the attached communication addressed to me by Mr. R. D. Anderson, State director, vocational education, department of education, Columbia, S.C., for your consideration when you begin hearings

on the appropriation bill providing funds for the Department of Health, Education, and Welfare.

With kindest regards,

Sincerely yours,

ROBERT W. HEMPHILL.

STATE OF SOUTH CAROLINA,
DEPARTMENT OF EDUCATION,
*Columbia, S.C., February 9, 1960.*

Hon. ROBERT W. HEMPHILL,
*House Office Building,*
*Washington, D.C.*

DEAR CONGRESSMAN HEMPHILL: I am sure that you are familiar with the fact that President Eisenhower in presenting his budget to Congress recommended a shift in emphasis in Federal assistance for programs in vocational education. A decrease of $2 million for titles I and II of the George-Barden Act, which provide assistance for the regular program in vocational, agriculture, home economics, trades and industry, and distributive education. It is further recommended that this $2 million be used for increasing, in the same amount, area vocational education programs, under the National Defense Education Act. On the surface this move would not appear to greatly hamper the total program in vocational education; in South Carolina, however, if the recommendation of the President is carried out, our program of vocational education will be seriously damaged.

First of all, we would lose approximately $42,000 for our regular programs in the areas of instruction mentioned above. Although this same amount would be added to our allotment under the National Defense Education Act, we have been unable to secure the State appropriation necessary to match area vocational funds that are already available to our State, hence, we would not be able to use the additional $42,000 that would be allocated under the National Defense Education Act. It is doubtful that we would be able to get the State legislature to replace the $42,000 for regular programs, therefore, we would have to reduce the number of programs in local high schools and eliminate teachers in this amount.

I understand hearings will be held at a very early date and I shall greatly appreciate it if you will contact Mr. John E. Fogarty, of Rhode Island, who is chairman of the House Subcommittee on Appropriations, and who handles appropriations for the Department of Health, Education, and Welfare, which includes vocational appropriations, and express to Mr. Fogarty your desires in the matter and urge his support in the restoration of the $2 million. In the meantime, I shall appreciate your advising me of Mr. Fogarty's reaction to your request after you have had an opportunity to call him.

Assuring you that we in vocational education in South Carolina are most grateful for your efforts in our behalf in past years, and at the same time stating that we shall greatly appreciate your assistance in the problem with which we are now confronted.

I am,

Sincerely,

R. D. ANDERSON,
*State Director, Vocational Education.*

---

HOUSE OF REPRESENTATIVES,
*Washington, D.C. February 24, 1960.*

Hon. JOHN E. FOGARTY, *Chairman,*
*House Subcommittee on Appropriations,*
*Departments of Labor, Health, Education and Welfare,*
*House of Representatives.*

DEAR MR. CHAIRMAN: President Eisenhower in presenting his budget to Congress recommended a shift in emphasis in Federal assistance for programs in vocational education. A decrease of $2 million for titles I and II of the George-Barden Act, which provide assistance for the regular program in vocational agriculture, home economics, trades and industries, and distributive education. It is further recommended that this $2 million be used for increasing, in the same amount, area vocational education programs, under the National Defense Education Act. On the surface this move would not appear to greatly hamper the

total program in vocational education; in South Carolina, however, if the recommendation of the President is carried out, our program of vocational education will be seriously damaged.

First of all, we would lose approximately $42,000 for our regular programs in the areas of instruction mentioned above. Although this same amount would be added to our allotment under the National Defense Education Act, we have been unable to secure the State appropriation necessary to match the area vocational funds that are already available to our State, hence, we would not be able to use the additional $42,000 that would be allocated under the National Defense Education Act. It is doubtful that we would be able to get the State legislature to replace the $42,000 for regular programs, therefore, we would have to reduce the number of programs in local high schools and eliminate teachers in this amount.

I would like to urge you, as chairman of the Subcommittee on HEW Appropriations, to support the restoration of the $2 million for vocational education. I am most grateful for your efforts in behalf of vocational education programs.

Sincerely yours,

ROBERT T. ASHMORE.

---

HOUSE OF REPRESENTATIVES,
*Washington, D.C., February 11, 1960.*

Re appropriations for Department of Health, Education, and Welfare (Vocational Appropriations).

Hon. JOHN E. FOGARTY,
*Chairman, Subcommittee on Appropriations,*
*House of Representatives,*
*Washington, D.C.*

DEAR MR. CHAIRMAN: I am enclosing a letter from the vocational education director of the State of South Carolina Department of Education urging restoration of a $2 million cut in the recommended budget presented by the President (titles I and II of the George-Barden Act). This loss of $42,000 for my State on vocational education in the fields of agriculture, home economics, trades and industries and distributive education will be a most serious loss.

I should appreciate your support on restoration of this proposed decrease of funds for titles I and II. May I hear from you please relative to this request?

Thanking you, and with kind regards, I am

Sincerely yours,

L. MENDEL RIVERS,
*Member of Congress.*

P.S.—Please return the enclosure when it has served its purpose. Thank you.

---

HOUSE OF REPRESENTATIVES,
*Washington, D.C., February 11, 1960.*

Hon. JOHN E. FOGARTY,
*House Office Building.*

DEAR JOHN: We are all disturbed about the President's recommendation for decrease of $2 million for titles I and II of the George-Barden Act. I hope this money can be retained. We have always been grateful for your very kind consideration.

Sincerely,

WM. JENNINGS BRYAN DORN,
*Member of Congress.*

---

HOUSE OF REPRESENTATIVES,
*Washington, D.C., February 8, 1960.*

Hon. JOHN E. FOGARTY,
*House of Representatives,*
*Washington, D.C.*

DEAR COLLEAGUE: Even though I discussed this matter with you personally, I wish to again express my vital interest in the restoration of a proposed $2 million reduction in the George-Barden funds for fiscal 1961.

With kind personal regards, I am

Sincerely yours,

ARTHUR WINSTEAD.

Tuesday, March 1, 1960.

## Food and Drug Administration

### WITNESS

### HOWARD O. HUNTER, PRESIDENT, AMERICAN INSTITUTE OF BAKING

Mr. Fogarty. We shall now hear from Howard O. Hunter, president of the American Institute of Baking, Chicago, Ill.

Mr. Hunter. Mr. Chairman and members of the committee, my purpose in appearing before the committee today is to support the budget request of the Food and Drug Administration for the 1961 fiscal year.

To identify the American Institute of Baking, we are a nonprofit corporation primarily engaged in research and education for the baking industry and for the benefit of the consumer.

More than 80 percent of the wholesale baking companies are members and financial supporters of the institute. In addition to these baking companies, the institute has the financial support of many companies that supply the baking industry with ingredients. These companies include flour mills, yeast manufacturers, shortening companies and many others.

Today I represent not only myself but the board of directors of the American Institute of Baking in urging adequate support for the activities of the Food and Drug Administration.

The baking industry is well acquainted with the Food and Drug Administration. We deal with Food and Drug on standards of identity for bread. We work with them in our in-plant sanitation training and inspection. We are vitally concerned with the application and enforcement of the food-additives amendment to the Food and Drug Act which was passed by this Congress in 1958 and which goes into effect next week, March 6.

The request of the Food and Drug Administration for an operating budget for the next fiscal year of $16,852,000 seems to me to be very modest. This request is in line with recommendations made by the Citizens Advisory Committee in 1956. This advisory committee recommended at that time a gradual expansion of the personnel and budget for the Food and Drug Administration to be completed in a maximum time of 10 years. I need not go into the report of this advisory committee because it is well known to you gentlemen and to the whole Congress. We were gratified a year ago, Mr. Chairman, when your committee increased the original request of the Food and Drug Administration to bring their appropriation more in line with the recommendations of the Citizens Advisory Committee.

However, I would like to point out that the recommendations of the Citizens Advisory Committee were made before the Congress passed the food additive amendment and at the time the recommendations were made I doubt that any of the committee anticipated the extraordinary additional work which the Food and Drug Administration would have to undertake to enforce this amendment.

I feel without reservation that the request of the Food and Drug Administration for personnel expansion is very modest.

During the 18 months since the food additive amendment was passed there has been some unfortunate activity and publicity concerning this amendment.

There are two main lines of propaganda. One is aimed at scaring the daylights out of the public because of "poisons in food". A good example of this is a book which was put on sale yesterday. This book is written by a Mr. William A. Longgood entitled "Poisons in Food." This book cites as authorities such persons as Royal Lee, of Milwaukee, who has been cited by the Food and Drug Administration for fraudulent claims, and Adele Davis whose views on nutrition have been thoroughly exposed by the medical association.

The second line of propaganda is an effort to scare the daylights out of the people on the grounds that the Food and Drug Administration is either unwilling or is unable to protect the people as to the safety of their food. A good example of this form of propaganda is the February and March issues of a food trade magazine which I understand has been sent to each Member of the Congress. The essence of this magazine's attack on the Food and Drug Administration is that they are motivated by politics and not by science and that they are incapable of determining what food additives are safe. This magazine is proposing to you gentlemen in Congress that the application of the food additive amendment be postponed for another 2 years and in the meantime that the amendment be further amended to make it practically ineffective.

These things are unfortunate primarily because they are designed to frighten and fool the public.

Representing the second largest food industry and the fifth largest industry of any kind in the country, I desire to go on record as having confidence, both in the intent and integrity, of the personnel of the Food and Drug Administration. The major problem is that they do not have enough personnel.

I feel at liberty to make this comment because I, personally, and many officials of the baking industry, took the leadership as far back as the spring of 1952 in proposing a food additive amendment to insure the safety of additives to our food supply. We also secured the support of major national food processing organizations for this amendment and this support included, among others, the American Bakers' Association, Millers' National Federation, Dairy Industry Committee, American Meat Institute, American Farm Bureau Federation, and the Grocery Manufacturers Association.

Needless to say that in the administration of any act as complicated as this there are sure to be a few, and in this case a very few, administrative errors and certainly some public relations mistakes. These mistakes should not be magnified to a point where the purpose of the law is forgotten.

There is one further recommendation I would like to make to this committee which does not concern the 1961 operating budget. That is a recommendation that the proposal of the Department of Health, Education, and Welfare for a new building for the Food and Drug Administration in Washington be approved. The present activities of Food and Drug Administration have been scattered in so many buildings and temporary quarters that it can only make for inefficiency. I am not sure whether it is the function of this subcommittee to act on capital expenditures but I do want to go on record in saying that I think they are sorely needed.

Thanks very much for your attention.

Mr. FOGARTY. We do not have the responsibility of providing funds for a building at this time, as you know.

Mr. HUNTER. I didn't think you did.

Mr. FOGARTY. It is now before the Public Works Committee, and you have some problems there, I understand.

Mr. HUNTER. Frankly, we are very much more concerned with operating activities, anyhow. When we come here, we don't know whether we are going to the South Building of the Department of Agriculture, or to a temporary building, or where we will find the various branches of the Food and Drug Administration.

Mr. FOGARTY. I think you should be just as much interested in getting a new building, because their operations are certainly going to be affected if they don't get the building. I think there are six buildings now instead of five, and they are moving into another. That really affects their operation adversely.

If it had not been for the lease-purchase idea of constructing buildings, proposed by the administration 4 or 5 years ago, which turned out to be twice as expensive as the regular way of financing, this building would have been built 3 or 4 years ago. We got tangled up in that mess. As a result, we are still trying to get authorization to appropriate funds.

Mr. HUNTER. I don't want to take too much time, but I am concerned with this propaganda. Thursday morning—the day after tomorrow—I understood this new book I mentioned, which is a frightful sort of a thing, because it is so completely full of propaganda, is going to be aired on Dave Garroway's show, and the propagandists are going to try to scare the public into believing that every piece of food they eat is poisoned. We wanted this food additive amendment. The food industry is getting tired of hearing it said that we didn't want this amendment.

For 4 years we were the only people that tried to get one through, and we had a bill in here 4 years before Food and Drug Administration put one in.

The late Mr. Priest, of Tennessee, and Mr. O'Hara, of Minnesota, had three bills considered by the Congress before Food and Drug acted. We don't think by wanting that additive amendment that we are frightened by poisons in food.

Mr. FOGARTY. Do you remember when Mr. Keefe was chairman of this committee?

Mr. HUNTER. I do, indeed. I testified before him in Chicago when he first had hearings.

Mr. FOGARTY. He made two or three speeches on the floor—that he was concerned about some of the things being put in bread.

Mr. HUNTER. Bread is what we talked to him about. Standards of identity were adopted shortly after his committee had hearings, and pretty well cleared that up. We don't think food is poison, and we want to be sure it is safe for what we put in it, but Simon & Schuster, publishers, are coming out with this book that went on sale yesterday. It is a frightening sort of thing to people who read it.

Mr. FOGARTY. What are some of the examples?

Mr. HUNTER. It attacks all food, but particularly one special chapter on bread—the old gag about white bread, that because of the milling process from wheat to white flour, it is devoid of all nu-

trients, which is completely untrue. You remember, 21 years ago, that the Congress, the Government itself, the Public Health Service, put the bread enrichment program into effect. Doctors, the American Medical Association, nutrition scientists, have said that this is one of the greatest nutritional public health advances of the 20th century. It is a highly nutritious product. But this author scares people.

Incidentally, the baker who sells white bread instead of dark bread does so simply because the public wants it, and demanded white bread for a century; and it is a nutritious food, as nutritious as any food you can get.

Then he [the author] says that they put chemicals in bread, such as sodium or calcium propionate. That has been approved by the Government, to prohibit mold. It is a natural component of many foods, such as butter and cheese, and it has nutritious—or a nutritional value because of the calcium, and it does inhibit mold.

Because it has a chemical name, this fellow is trying to scare the public with it. He says the meat supply is being poisoned by the use of nitrates and other things used for preservatives. You cannot feed a population like ours without the use of chemicals in the form of pesticides, preservatives, and so forth, and we are only concerned with the fact that chemicals are safe and nontoxic.

If you did not use preservatives in bread, meat, and other foods, you wouldn't have a food supply.

Mr. Fogarty. You don't mention any amount which you think the Food and Drug Administration ought to have for 1961.

Mr. Hunter. Except their request to put it in line with the citizens advisory committee.

Personally, I think it is low, because they didn't anticipate the enforcement of this food additive amendment.

If I were reading the figures here I have on it, I would think of a figure of $20 million as much nearer the need for increased personnel. That is not including any capital expenditure.

Mr. Fogarty. It is about 5 years' old now.

Mr. Hunter. 1956.

Mr. Fogarty. I think their recommendations were good and sound, but I think they are out of date. I think their work should be reviewed.

Mr. Hunter. They didn't figure on this food additive amendment, for one thing. I think the figure of $20 million would be far more realistic.

Mr. Marshall. Mr. Hunter, I would like to compliment you for a very fine, intelligent statement. I would like to also say that unless something is done to bring some more rational thinking to some of these propagandists, they may undo all of the good that has been done. Some of these propagandists are causing the American people to lose sight of the fact that they are getting the best quality food produced under the best sanitary conditions you will find anywhere in the world.

Mr. Hunter. No question of that.

That other comment I made about the magazine that you gentlemen are going to get, the editor of this magazine—I have his letter—says that he has sent an issue to every member of Congress. That is just as bad propaganda, because he is trying to shake the faith of the consumer in the Food and Drug Administration and in the Govern-

ment. He makes a special case out of the so-called cancer amendment to the additive.

I frankly agree I didn't want that thing in there to start with. I don't think Food and Drug did, either. That is an amendment that should be wiped off. I see no reason to specialize on cancer any more than on diabetes, pneumonia, or syphilis. That is not the only disease.

And the act itself, without that amendment, would take care of any cancer-producing additive, without specifying cancer; but this fellow attacks the Government and the Food and Drug Administration. He represents, he says, the food-processing industry. He doesn't, at all. The magazine has wide circulation among the industry.

So you have an attack on one side that you are getting poisons every time you get food. You get an attack on the other side that there is no such thing as poison.

I have complete confidence in the sanitation and nutrition of our food supply, Mr. Marshall. I am not making any case against it, because I like this amendment. We have the finest food and the best-fed nation the world has ever seen. No question of it.

Mr. FOGARTY. Thank you very much, Mr. Hunter.

---

TUESDAY, MARCH 1, 1960.

## NURSE SUPPLY, TRAINING, AND CONSULTATION SERVICE

### WITNESS

### JULIA C. THOMPSON, WASHINGTON REPRESENTATIVE, AMERICAN NURSES' ASSOCIATION

Mr. FOGARTY. Miss Thompson, we are glad to see you back again. Please proceed with your statement.

Miss THOMPSON. I am Julia C. Thompson, Washington representative of the American Nurses' Association, the national organization of registered professional nurses. The association has 54 constituent State and territorial associations, with a membership of approximately 174,000.

For a number of years the ANA has supported the programs administered by the Department of Health, Education, and Welfare which are concerned with the problems of nurse supply, training, and consultation service.

The Congress has been generous and this subcommittee has given recognition to the requests made by ANA. Increases have been granted in some of the programs we are here to support.

The ANA supports the administration's request for traineeships for graduate nurses at $6 million. Last year Congress extended the traineeship program for another 5 years. The report of the Senate Committee on Labor and Public Welfare recommended a change in emphasis toward short-term courses for nurses already employed in hospitals, in administration, supervision, and teaching. The ANA believes that the major emphasis of the program should remain as was originally intended for full-time study in graduate programs to qualify nurses for positions in teaching, administration, and supervision.

For the past several years the ANA has requested an increased appropriation for the Division of Nursing Resources. At the present

time, the Division is approximately 1½ years behind in fulfilling consultation requests from various States and agencies. Funds for studies in State or local areas are financed by the agency making the request, and the Division only finances the services of the consultant. Funds for the Division have been increased slightly in recent years, but with rising costs this slight increase has not permitted an expansion of the program. The ANA again recommends an appropriation of $1 million for the Division of Nursing Resources. The studies in nurse resources and recommended practices in utilization of nurses made by the States under the guidance of a staff consultant have proved invaluable. Many of these studies have shown that the total nurse supply is short, which is an obvious statement; but, more important, they have vividly depicted the great need for well-qualified nurses in positions of responsibility, such as head nurses, supervisors, and public health nurses. These studies and others form the basis for the ANA's support for legislation introduced in Congress by Representative Edith Green and two of her colleagues; H.R. 5048 and H.R. 5635 have been introduced by Representative Cohelan, of California, and Representative Staggers, of West Virginia.

Last year, 1959, the ANA commented favorably in testimony before your subcommittee on the establishment of a Division of Public Health Nursing within the U.S. Public Health Service. At that time we urged an increased appropriation for the Division for additional career development positions, and the Appropriations Committee took cognizance of this request in its report to the Congress. However, no additional funds were appropriated at that time and the Division had funds for only two positions during this fiscal year. Since this program is designed to prepare highly skilled persons for positions in the Public Health Service, the lack of sufficient funds for preparing such personnel is indeed serious. Its seriousness will be intensified if Congress agrees that the Commissioned Corps Act should apply to officers of the U.S. Public Health Service, as well as the armed services, and officers may elect to retire after 20 years of service. The importance of nursing consultation and direct service to States and local public health agencies is such that it is essential that the corps be maintained at adequate strength. If this is to be accomplished, the ANA recommends that an amount be added to the $130,000 budget for fiscal 1960–61 to provide for an increased number of new career positions. A very modest request for eight beginning public health nurses would cost the Division approximately $35,000 for the first year.

Because of the increase in our older population, there has been a steady increase in demands for home nursing care. In many communities, public health nursing staffs are unable to cope with the demand. It is believed that if home nursing care were provided, the number of older persons who now are in nursing homes and hospitals could be considerably lessened.

If sufficient funds were made available, several demonstration projects might be utilized to determine the soundness of this approach. Several public health agencies could be supplied with funds to employ a staff large enough to meet demands. These persons might be full-time or part-time nurses, or other allied health personnel working under direction of a qualified public health nurse.

The budget estimate for the traineeships for public health personnel is $2 million. The ANA believes this amount should be appropriated

for nurses only, since there is such a demand for these traineeships by nurses. The demand is the result of the nursing education pattern. Over 80 percent of the nursing students graduate from hospital schools of nursing. However, public health nursing requies a collegiate background. Therefore, graduates of hospital schools need an additional year of education to qualify for positions in public health. Another 2 years is required to secure a bachelor's degree. Collegiate schools of nursing which integrate public health nursing in the basic curriculum prepare nurses for positions in this field in 4 years. In the absence of adequate facilities for baccalaureate programs in nursing, it is essential that Congress maintain the appropriation for supplemental education at a high level.

Incidentally, there are 73 schools which offer public health nursing courses in the basic curriculum.

Although funds are not earmarked in the overall request for nursing research and nursing research fellowships, the ANA believes that at least $2 million should be available for these programs under the budget for general research and services for NIH. It is encouraging that a gradually increasing amount has been allocated to nurse fellowships and nursing research. Studies and research in nursing, as well as in other fields, are a necessity in this rapidly changing world. Techniques, procedures, and knowledge, sufficient for the nurse to carry out the appointed tasks last year, may be outmoded this year. Changes in concepts of what a nurse is and what a nurse should do require constant study and evaluation. The complicated implements and treatments nurses must deal with require a high degree of skill—in electronics, physics, and engineering. The nurse must also be a pastmaster in human relations and know when and how to carry out the simple, comforting procedures so well known to the public as a part of the nurse's duties. No amount of automation can replace the human element in the care of the sick.

The American Nurses' Association was pleased to note that the salary survey on hospitals which was carried out by the Bureau of Labor Statistics under the Women's Bureau of the Department of Labor will be an integral part of the BLS survey of major cities and will be included in the survey every 3 years. This orderly collection of data will be invaluable, both to the profession and other agencies. It has confirmed the need for a reevaluation of the salaries and other benefits of hospital employees, who have none of the protective legislation and few of the benefits of most other employee groups. The ANA supports the appropriation of $10,519,000 for the Bureau of Labor Statistics.

Following is a summary of the ANA recommendations on budget items of vital interest to our members:

We support the budget request of $6 million for traineeships for graduate nurses, and request $2 million for public health nurse traineeships.

We urge an increase in the appropriation for the Division of Nursing Resources to $1 million.

We urge an increase in funds for the career development program of the Division of Public Health Nursing to add at least 8 to 10 more positions. We also recommend that allocations be made for demonstration projects in home nursing care and studies of the changing health needs of the population to determine demands for public health nursing.

We believe that at least $2 million of the total appropriation of $47,260,000 for general research under the National Institutes of Health should be allocated to nursing research and nursing research fellowships.

We support the appropriation of $10,519,000 for the Bureau of Labor Statistics which includes ongoing studies of salaries in industry and will include hospital salary data.

On behalf of the ANA, I wish to thank the committee for the opportunity to appear before you and present our views on the budget estimates for nursing programs.

Mr. FOGARTY. Thank you, Miss Thompson.

I think the Public Health Service agrees with the Senate recommendations, though.

Miss THOMPSON. Yes; they do.

Mr. FOGARTY. On this short-term training.

Miss THOMPSON. We believe the major emphasis should be on preparing people adequately, rather than filling gaps and that major emphasis should be on the long-term preparation.

Mr. FOGARTY. How would you go about that?

Miss THOMPSON. By administering the traineeships as they were originally set up permitting persons to apply for traineeship and to study for a semester, a year, or 18 months, which is the usual procedure, rather than having the emphasis put on the short-term training. This training will, of course, supply some of the skills that people need to carry on their jobs that they are now in, and that they are not prepared for, but over the long haul it is better to have them adequately prepared than always filling up the gaps.

Mr. FOGARTY. But would you just say, never mind filling the gaps now, let that immediate need go?

Miss THOMPSON. No; I don't think so. This is probably going to prove to be valuable in assisting the persons who are interested in doing a better job in the positions in which they are already employed.

Mr. FOGARTY. You say the ANA recommends an appropriation of $1 million for the Division of Nursing Resources. Is that over and above the budget?

Miss THOMPSON. Yes; the request is around $500,000 for the Division.

Mr. FOGARTY. You want a million, or a million and a half?

Miss THOMPSON. A million altogether.

Mr. FOGARTY. $500,000 increase.

Miss THOMPSON. That's right.

Mr. FOGARTY. You say the ANA recommends an amount of $130,000 to provide for an increased number of new career positions?

Miss THOMPSON. The $130,000 is the approximate budget for the Division of Public Health Nursing now, and in addition to that we are requesting some——

Mr. FOGARTY. Some amount be added?

Miss THOMPSON. Yes.

Mr. FOGARTY. How much?

Miss THOMPSON. We have said in here that a modest request of eight beginning positions would cost approximately $35,000, based on the beginning salary for public health nurses. If they should come in at a higher level, it might require somewhat more, but for beginning positions it would be about that amount.

Mr. FOGARTY. You feel that full nursing care for people in nursing homes and hospitals could be considerably lessened if such funds were made available. How much do you think should be made available?

Miss THOMPSON. I don't know whether we could estimate how much. It would depend on the projects that could be developed in the terms of supplying——

Mr. FOGARTY. Demonstration projects.

Miss THOMPSON. Supplying sufficient numbers of nurses in a given community to take care of all the requests for service that are made.

Last year, when we were collecting information for the subcommittee of the Senate, studying problems of aging and the aged, we found that visiting nurse services were devoting more and more time to the care of persons with long-term illnesses and older persons in their homes, and that requests for this service were cutting down on the kind of services it could give to other age groups in the population. Also the demands were more than they could cope with in terms of the present staff, and very often the people who could profit by having an hour of two of nursing service in the home would have to go to a convalescent home or nursing home, because they couldn't have this service at home. If we could set up several agencies that could be subsidized with enough public health nurses we might be able to show that people could be cared for in their homes, and we wouldn't need all of the expensive facilities.

Mr. FOGARTY. You say that no funds are earmarked in the overall funds for nursing research, and research facilities, and you believe $2 million should be available for these programs under the budget for general research and services. How much is being used now?

Miss THOMPSON. Approximately $1.5 million. Between 1 and 1.5.

Mr. FOGARTY. It would be an increase of half a million?

Miss THOMPSON. That's correct. Some of the administrative cost is not separated out from the actual money that goes for grants and fellowships.

Mr. FOGARTY. You apparently were happy with the Women's Bureau taking the lead in having Labor Statistics make the survey.

Miss THOMPSON. Yes, sir.

Mr. FOGARTY. What is the Women's Bureau of the Department of Labor doing now?

Miss THOMPSON. Not any special project so far as we are concerned. They continue to publish their career booklets and do some spot surveys of salaries, and that kind of thing.

Mr. FOGARTY. Do you think they could be doing something in the field of nursing that would help?

Miss THOMPSON. I don't think of anything at the present time, which would be especially related to their department.

### LETTER FROM CONSTITUENT

Mr. FOGARTY. I received this letter from a constituent of mine this past month. This letter is in regard to Public Law 911, title I, with reference to the availability of the baccalaureate program to nurses reaching the final year of study. She says:

> I am a registered nurse having graduated from Roger Williams General Hospital in 1952. I am now in my final year of study in the baccalaureate program in nursing at Boston University. I will graduate January 1961.

I applied to Boston University for a scholarship under the Federal grant, to be notified that there were no funds available for the bachelor student, as the masters degree level had used all the funds. When I first started this pursuit of higher learning in nursing I had been given the hope that a Federal scholarship would be granted in my final year, if my grades were high. I received a quality point index of 3.3 last semester and 3.5 this semester.

I am a 27-year-old mother of two children, and the pursuit of education is not easy. Commuting to Boston daily, for lack of facilities in Rhode Island, makes it even more difficult. Now to find I will not get scholastic aid is very disappointing.

Is there any other place I could apply for Federal grants on scholastic ability? I am not sure what field I will enter when I graduate. I would like to teach in a diploma nursing school, or in the field of public health.

I will appreciate any assistance that you could give me.

How do I answer a letter like that?

Miss THOMPSON. The traineeships were set up primarily for advanced preparation. However, there are some college and university courses in nursing which do give specialization in the baccalaureate programs. There are traineeships awarded to some persons in baccalaureate programs.

However, if all the traineeships for Boston University were applied for on a master's level. it is quite likely that they would allocate them to people getting their master's rather than to persons getting their bachelor's. That is the answer, I think. It would depend on how many traineeships Boston University had available, and how many applicants they had, and to whom they would choose to give them.

Mr. FOGARTY. I don't know, but I would assume they had many more applicants than they had funds.

Miss THOMPSON. They usually do.

Mr. FOGARTY. So we are not appropriating enough money, then, are we?

Miss THOMPSON. No, but we didn't support or request or ask that more money be appropriated for these traineeships because the number of persons coming out of the baccalaureate programs who are eligible to secure these traineeships for a master's study is being deleted because the number of graduates is so low, only about 8 percent of the nurses graduate with collegiate training. A certain number of those do drop out because of the difference in the career pattern of women and men, so that probably only a third of those continue working or will work for a while and drop out and come back into the profession.

So we have even less than 8 percent who are eligible to receive master's study, and if the money cannot be all used on the master's level, they do give some to persons in the baccalaureate level who are already specializing. But this is the reason why we didn't request more money than the administration asked for.

Mr. FOGARTY. You are satisfied?

Miss THOMPSON. It is possible to use this amount, but the possibility of using more is quite uncertain. We were not willing to ask for more than we could justify.

Mr. FOGARTY. You represent a very conservative group.

Miss THOMPSON. Usually, if you ask for more than you can use, the next time you come to ask for money, you will be asked why you didn't use all you had previously.

Mr. DENTON. You didn't say anything about your vocational education program to train practical nurses.

Miss THOMPSON. No; that legislation expires next year.

At the present time, according to the figures we have, the graduates from those schools are gaining in terms of numbers in proportion to the population of the registered professional nurses, and it is a question of whether we want to continually promote this kind of education and extend these programs so that we have such a large number of these persons in relation to the professional nurse.

Mr. DENTON. You are not recommending that program, that it be continued?

Miss THOMPSON. We are not asking that anything be done to it. Let it go on the way it is.

Mr. DENTON. Indiana is the only State that didn't take advantage of the program. Did they ever come under it?

Miss THOMPSON. I don't think they did.

Mr. DENTON. According to your recollection, they are the only ones; right?

Miss THOMPSON. They may not have. I cannot answer that specifically. I could check it for you, if you are interested in having that information.

(NOTE.—Indiana did not apply for funds.)

Mr. DENTON. They were not under it the last time I checked.

Miss THOMPSON. Indiana has done a very good survey of their mining needs.

Mr. DENTON. Indiana University has done a very good job.

Miss THOMPSON. They are planning, over a period of about 20 years.

Mr. FOGARTY. Is there anything else you want to say?

Miss THOMPSON. No; thank you.

Mr. FOGARTY. You have plenty of time to say it, if you want to.

Miss THOMPSON. I don't think of anything at the moment. We are eager, of course, for legislation that Mrs. Green is supporting.

Mr. FOGARTY. I asked questions about that legislation in the regular hearings. I hope that she will be successful in getting this legislation through.

Miss THOMPSON. We hope so, too, because this is the great gap in the training program now. We have a large number of graduates from hospital schools now, and a very small number from collegiate schools. It means the graduates have to spend, from 1 to 3 more years in addition to their 3 years of hospital training to secure a bachelor's degree.

Mr. FOGARTY. How many nurses do you represent?

Miss THOMPSON. We have about 174,000 in our organization now.

Mr. FOGARTY. If they all wrote Members of Congress, it would help that bill through.

Miss THOMPSON. We had tremendous response from our association last year when it was first introduced. Every State and every college, practically, in the country wrote to Mrs. Green and to their own Representatives about it. But that died down after a while, and we have to start over again.

Mr. FOGARTY. It takes time.

AFTERNOON SESSION

## Division of General Medical Sciences, NIH

### WITNESSES

**DR. PHILIP HANDLER, PROFESSOR AND CHAIRMAN, DEPARTMENT OF BIOCHEMISTRY, DUKE UNIVERSITY; MEMBER, NATIONAL ADVISORY HEALTH COUNCIL, PHS**

**DR. LEWIS THOMAS, PROFESSOR OF MEDICINE, NEW YORK UNIVERSITY MEDICAL SCHOOL; DIRECTOR, THIRD AND FOURTH MEDICAL DIVISIONS, BELLEVUE HOSPITAL, NEW YORK; MEMBER, PATHOLOGY TRAINING COMMISSION, NIH**

Mr. Fogarty. The committee will come to order.

All right, Dr. Handler, you may start with your statement.

Dr. Handler. Thank you, Mr. Fogarty.

It is a great privilege to be here and meet with you, sir, to discuss with you the appropriation for the Division of General Medical Sciences at the National Institutes of Health.

This appropriation is found under the appropriation title of "General research and services," as the NIH budget is presently prepared.

I have a prepared statement, which I have already presented, and I trust this can be inserted in the record.

Mr. Fogarty. Yes.

(The statement follows:)

### Statement by Dr. Philip Handler [1]

Representing the Federation of American Societies for Experimental Biology (American Physiological Society, American Society of Biological Chemists, American Society for Pharmacology and Experimental Therapeutics, American Society for Experimental Pathology, American Institute of Nutrition, American Association of Immunologists)

Mr. Chairman, honored members of the committee, it is a great privilege once again to discuss with you the budgetary appropriation for the Division of General Medical Sciences of the National Institutes of Health found under the appropriation title "General research and services." The membership of the Federation of American Societies for Experimental Biology earnestly believe that this appropriation should be increased for fiscal year 1961, and it is my pleasure to place their reasoning before you.

You will recall that the Division of General Medical Sciences of the National Institutes of Health was created in the fall of 1958 and, together with the National Advisory Health Council, was given responsibility for the support of research and training for research in those fundamental areas of biology which are basic to progress in medicine. The appropriation for support of the activities was increased in fiscal year 1960, thereby permitting the Division to support research in the following areas: biochemistry, genetics, pathology, pharmacology, physiology, the anatomical sciences, including histology, cytology, neuroanatomy, and embryology, biometry, and biostatistics, epidemiology, microbiology, virology, immunology, etc. In addition, in a few special instances, the Division has supported investigations in physics and chemistry which bear a direct relation to problems in medicine or the health-related sciences.

As you will see from the list above, the Division supports research along the entire front of biology as it pertains to human health. This, indeed, is research at the frontiers. In the main, but by no means entirely, it is research designed to obtain deeper insight into the structure and functioning of the human body at

[1] Dr. Handler is professor and chairman of the Department of Biochemistry at Duke University School of Medicine. He is a member of the National Advisory Health Council, member of the Executive Committee of the Board of the Federation of American Societies for Experimental Biology, member of the Council of the American Society of Biological Chemists, member of the Divisional Committee for Biology of the National Science Foundation, coauthor of a widely used textbook of biochemistry for medical students and of 145 publications in scientific and medical journals.

the most fundamental possible level. The program is too young to record any large number of great triumphs of research as yet. Nevertheless, all sophisticated scientists understand that it is only from such research that we can obtain the information necessary to guide the disease-oriented research which, we hope, one day will alleviate the physical ills which beset mankind. This has been the entire history of medical progress in the past, and we are confident that it is in such fundamental research that our hopes for the future must lie. A few illustrations of this frontier research may help to illustrate this concept.

In the year 1800 the Academy of the then French First Republic offered a prize of 1 kilogram of gold for the best answer to the question "What is the difference between ferments and the materials which they are fermenting?" That prize was never awarded. Today we would recast the question to ask, "What is the mechanism by which enzymes exert their catalytic activity?" Investigators in a variety of laboratories in the United States are currently intensively engaged in this problem and notable success has been achieved in several instances, particularly in gaining clearer insight into the mechanism of action of the digestive enzymes of the gastrointestinal tract. It is not unreasonable to expect that, when this problem has been solved, we will be in position to synthesize models perhaps even more effective than the natural enzymes which can be given by mouth to patients suffering from digestive disorders or who have been forced to undergo surgery for removal of the stomach, pancreas, or a portion of the intestine.

Last year it was my pleasure to discuss with this committee some of the advances which are being made in the understanding of genetic mechanisms. This year, as last, the Nobel Prize in Medicine was again awarded to a pair of American biochemists, Drs. Severo Ochoa and Arthur Kornberg, who have been studying the chemical basis for genetic activity. The work of both of these investigators is supported by the Division of General Medical Sciences and their findings have provided a clearer insight to the mechanism whereby deoxyribonucleic acid (DNA) and ribonucleic acid (RNA), the chemical conveyors of genetic information in the cell, are replicated as the cell undergoes division. In the years since World War II approximately 50 distinct human diseases have been identified as genetically transmitted disorders of metabolism and the list appears to grow with the publication of each issue of the medical journals. Clearly, it is not within the power of medical science to cope with these disorders at the present time and, to date, we have merely succeeded in identifying their genetic basis and the metabolic defect associated with each of these disease states. At this time we can hope, although we cannot promise, that studies of genetic mechanisms such as those of Drs. Kornberg and Ochoa will one day provide us with the means of treating and perhaps even of preventing genetic disorders. Please understand that this is not a trivial problem. While, perhaps, not as great a threat as that of cancer or heart disease at this time, it is quite clear that when these great killers have been tamed, then genetic disorders will rapidly mount as a cause of death in our population in a manner similar to the rise of cancer and heart disease after infectious diseases had been brought under their present degree of control.

Nor are these fundamental studies unrelated to the problems of cancer, heart disease, arthritis, diabetes, etc. Although the exact disturbance in the normally orderly affairs of the living cell which results in malignancy is not presently clear, it is apparent in a general way that such cells have escaped from the normal genetic control of their metabolic activities. Hence, no true understanding of the nature of cancer is possible until we have a clearer picture of the mechanisms whereby the information coded into the structure of deoxyribonucleic acid is utilized by the cell in the normal regulation of its metabolic activities. Such studies are underway in many laboratories and, again, are supported by the Division of General Medical Sciences. One of the exciting developments in this area is the discovery of feedback controls quite analogous to those employed in electronic devices. These operate in the following manner: The rate of synthesis of an enzyme is, in some manner, determined by the genetic components of the cell, DNA and RNA. This enzyme then catalyzes the transformation of compound A, which one has eaten, to compound B, which may be needed for some purpose in the body. When the concentration of compound B in the cell is sufficiently high, it serves as an inhibitor or brake upon the process whereby the genetic material causes the synthesis of the responsible enzyme. This negative feedback, therefore, serves to control the overall rate in which compound A can be converted to compound B and there appear to be a large number of such instances in cellular metabolism. Again, it is not too much to extrapolate from this concept to a large future vista for cancer chemotherapy. If one assumes that the uncontrolled growth of cancer cells is a reflection of some abnormality

in the means whereby the genetic components of the cell regulate the cell's metabolism, then once we have identified the disturbed area of metabolism we can hope to put brakes upon the aberrant process by the administration of an inhibitor of enzyme synthesis analogous to compound B in the illustration above. In this manner, fundamental studies of genetic mechanisms and cell metabolism may provide us, one day, with a rational basis for cancer chemotherapy.

Those scientists who have spoken with you concerning the fundamental problems which underlie the development of atherosclerotic cardiovascular disease, have emphasized the metabolism of cholesterol and other fatty substances in the blood. Many clinical investigators studying this problem are concerned with the effects of diet and hormonal activity on the blood level of these fatty substances. Investigators supported by the Division of General Medical Sciences are seeking a more fundamental understanding of the metabolism of carbohydrate and fats in the cells of liver and adipose tissue. These studies have just begun to reveal the circumstances in liver and adipose tissue which result in either the release of fat to the blood or its removal therefrom. You will readily understand that when these have been clarified, they may provide the basis for a rational procedure which may permit us to live our lives comfortably yet at low blood lipid concentrations and thus either prevent or defer the development of atherosclerosis.

Let us consider one more instance of this kind of investigation. Although it is 40 years since insulin became available for the treatment of diabetes it remains true that we do not quite understand its mechanism of operation. The Nobel Prize winning work of Fred Sanger in England demonstrated the structure of the insulin molecule and we know that, in a general way, insulin promotes the uptake of sugar from the blood by tissue cells, but the manner in which it does so is not at all understood. The programs of the Division have supported many investigators in the general area of protein chemistry. These are providing us with tools for modifying the structure of natural insulin and for the synthesis of insulin-like compounds. Incidentally, both approaches are also being used for the study of other protein hormones such as ACTH. With these tools it should become possible to probe more deeply into the mechanism of insulin action and, when this is finally understood, finally permit us to synthesize a compound with insulin-like activity. Nor can that time come too soon. Although insulin has permitted us successfully to treat diabetes, we have no control over the incidence of diabetes in our population, and our expanding population may soon result in a situation in which the supply of insulin from slaughterhouse material may be inadequate for our national needs. By that time, it is certainly to be hoped that we will find ourselves ready with a reasonably cheap synthetic substitute for native insulin.

I must emphasize that it is not possible presently to foresee the practical application in medical sciences of all of the studies supported by the Division. In fact, quite the contrary is the case. None of us has a crystal ball sufficiently clear to reveal which of the fundamental studies of the structure and function of living things supported by the Division will provide the information which will underlie some great advance in tomorrow's medicine. The history of medicine is replete with examples of instances in which an unheralded fundamental investigation serves, years later, as the basis for an important advance in medical practice. This concept has been well documented before this committee in the past and I shall not belabor the point.

The research program of the Division of General Medical Sciences is not restricted to such fundamental investigations. In addition, the Division is given responsibility for the support of research on aging, nursing, sanitary engineering, air pollution, and accident prevention. Each of these may be regarded as applied rather than fundamental research. The potential value of these programs will be obvious. Again, the program is too young to offer you any evidence of great triumph to date. The Division supports research in the fundamental biology of aging, research which seeks to understand why and how we age and why and how the aging process renders us ever more susceptible to the ravages of disease with the passage of time. Simultaneously, the Division also supports studies of means of supportive care for the aged, whereby the incapacitating infirmities of the aged may be prevented or deferred until still later in life, studies of the sociological, economic, and physiological aspects of aging. We are all aware of the rapid growth of our population with its skewed distribution in the upper age bracket. If research in this area can succeed in adding but 1 more year of useful, active life for each of us, a year in which we can contribute to society rather than be supported thereby, the economic gain for our Nation will be enormous.

It scarcely seems necessary, at this juncture, to defend support of research in air pollution, water pollution, or accident prevention. These unfortunate by-

products of our industrial civilization pose an ever more serious threat to human welfare. Our current plight reflects a serious lack of planning and it is imperative that these problems be swiftly analyzed and the resulting recommendations of our scientists and engineers be adopted before our urban centers destroy themselves. It is tragic that these problems have been allowed to get out of hand and that so little is known about either the causes or control of air and water pollution.

RESEARCH SUPPORT

In fiscal year 1960, the Congress provided $23,600,000 in support of the research program of the Division. This sum will suffice to meet the commitments already made for fiscal year 1961 and the existing backlog of approved but unpayable applications. However, it would not suffice if the Congress authorizes an increase in the rate of indirect cost payments to universities and other research institutions to 25 percent of direct costs. Moreover, if the program enters into fiscal year 1961 funded at the level of fiscal year 1960, it will not be possible to activate a single new project. The research program of the Division is new and the needs are acute both in the area of fundamental research and in the relatively applied fields of aging, sanitary engineering, accident prevention, and air-pollution research.

One emerging, increasingly important area of fundamental biological research is not supported by the Division of General Medical Sciences. A few years ago, before creation of the Division, it was decided by the Congress to expand support of research in biophysics and, as an administrative device, the funds to implement this decision were placed in the budget of the National Institute for Arthritis and Metabolic Diseases. The intramural program in biophysics is conducted within this Institute at a high order of excellence, but I would suggest that funds in support of the extramural program in biophysics should, logically, be placed in the budget of the Division of General Medical Sciences which is responsible for support of research in all other areas of fundamental biology as it relates to health. Dr. F. O. Schmitt, who is now a member of the National Advisory Health Council, has stated that he shares this view since the administrative device employed earlier is no longer necessary or logical.

The best estimates which we have been able to make indicate that we may expect a minimum of $20 million in new requests in fiscal year 1961. If one assumes that, based on their scientific quality, approximately 60 percent of these will be approved for payment, an assumption which has proved remarkably valid in previous experience, a total of approximately $12 million would be required to initiate these new projects in fiscal year 1961. The National Advisory Health Council has complete confidence that the Study Section mechanism which has proved so reliable in the past will continue to serve the interest of the Nation in the future and that no applications will be submitted as approved by the Study Section which have not met their rigorous scientific standards. As a double safeguard, the Health Council has monitored the actions of the Study Sections in the past and will do so in the future. Should the Congress increase the indirect costs payment rate to 25 percent of the direct costs, an additional $3 million will be required to make these payments. Should the indirect costs rate be increased without appropriation of new funds, the net result would be a drastic cutback in the funds now available to meet the direct costs of research, an action which would be even more severe in the case of the new programs of the Division than for the older established institutes.

TRAINING GRANTS

One of the most exciting and important ventures made possible by the creation of the Division of General Medical Sciences was the inauguration of a program of training grants in the basic sciences related to health. We have previously emphasized the fact that, over the years, the categorical disease-oriented Institutes at NIH have developed a program of training grants designed to train young physicians in the special research problems and techniques related to research in those areas for which the individual categorical Institutes had been assigned responsibility by the Congress. But the basic research which provides the information and techniques applied by those who study the special problems of research on a given disease must be provided by investigators who have been trained as experts in one of the fundamental biological disciplines, i.e., those fields of research supported by the Division, such as biochemistry, genetics, pathology, immunology, etc. If, indeed, the United States is to mount a program of medical research on the scale envisioned by the Bane-Jones report, if we are to expand the faculties of our existing medical schools so as to permit expansion of their

student bodies without deterioration in the quality of medical education while also creating the 20 new medical schools suggested by the Bane report, then it is imperative that we first produce those scientists-teachers who will both produce the fundamental information necessary to an intelligent large-scale attack on the problems of disease and also serve as the preclinical faculty of our medical schools and health related university departments. It is toward these goals that the training programs of the Division of General Medical Sciences are directed.

It should be recognized that the training of a knowledgeable and competent investigator in these areas is costly. For each trainee there is required the time of a variety of established investigators in an apprenticeship relationship, as well as costly laboratory facilities and equipment. As fundamental biological research becomes evermore quantitative, the equipment of the biology laboratory grows more complex and, hence, costly. Such research can no longer be done in a primitive laboratory armed only with test tubes, bunsen burners, syringes, and bench tops. Instead, there is required an array of diverse electrical, optical, mechanical, and electronic apparatus, all of which must be mastered by the neophyte biological scientist.

It is appropriate to ask, at this time, at what level of trainees and financial support this operation should be set in order properly to meet our national aspirations. But we are not in position to provide a definitive answer. As one who is currently unable to fill five budgeted positions in his own department with people trained in these areas, I can testify with firsthand knowledge to the fact that well-trained investigator-teachers are in desperately short supply. All of us engaged in such research and teaching are acutely aware of the shortage of such personnel and of the fact that the training programs currently underway are insufficient to meet even the present national need, to say nothing of those demands which lie ahead in the immediate future. Accordingly, the National Advisory Health Council has authorized the Division to support an intensive survey of the manpower needs in this area, as they exist at the moment, and as they may be projected over the next 10 or 15 years. It is our earnest hope that when your committee considers this appropriation item in the budget for fiscal year 1962 there will be available more concrete information as a basis for your actions.

At its last meeting, the National Advisory Health Council was in position to recommend payment of only a fraction of the highly meritorious and scientifically approved applications in support of training grants. Another group of such applications has been reviewed in anticipation of the March meeting of the Health Council, but there will be no funds to support any of these. As we enter fiscal year 1961, it may be rather precisely estimated that there will be a backlog of $4,900,000 in approved, meritorious, but unpayable applications. An additional $1,600,000 is highly desirable in order to adjust the commencement dates of those programs which are in being to a common fiscal year so that better fiscal control of the entire program can be maintained. In consequence, an increase of $5 million in support of the training grant program for 1961 would be required even if not a single new application were received during that period. But this is one of the youngest of all the ongoing programs at the National Institutes of Health and clearly one of the most important programs now in operation. We are aware that many first rate scientific departments in our medical schools and universities, fully capable of providing excellent training in these sciences, have been planning to make such requests during fiscal year 1961, and we consider it in the very best national interest that their activities be supported. A conservative estimate of the magnitude of the new requests would be of the order of $12 to $15 million, and we strongly urge that an appropriation of about $9 million be made to meet these new requests for the inauguration of training grants. This would necessitate a total appropriation of the order of $26,500,000 in fiscal year 1961 for the training grants program.

### FELLOWSHIPS

The research fellowship program at the National Institutes of Health is one of the oldest and most valuable programs in its total spectrum of activity. Training for a career in medical investigation is long, arduous, and expensive, whereas the financial reward, i.e., the salaries available to established investigators, are relatively modest as compared with a career in private practice, in industry, or in business. This disparity is even more marked when contrasted with the social and financial status of the research scientist in the Soviet Union. Accordingly, it is unrealistic to expect that after the expense of a college education and medical or graduate school our young people should be expected to go into debt to finance their further research training. As our research training programs yield returns in the form of trained young investigators, we must find means to support them

in their early research careers. Research training is by no means complete at the time of the award of a Ph. D. or M.D. degree. Biological and medical investigation have become so complex that all first-rate scientific institutions expect that the young investigator will have had at least 2 years of postdoctoral research training experience before he can be considered eligible for a position. But by this time the neophyte investigator is 26 or 28 years old and is probably married with one or two children. We must not penalize him as a human being and demand sacrifices which are not expected of the rest of our population.

The research fellowship program has been designed to meet this need and has done so effectively. But our training programs have begun to yield returns and the demand for fellowships are increasing strikingly. Thus, as we enter fiscal year 1961 there are already commitments in the amount of $4,250,000 and a backlog of $1,500,000 in approved but unpayable fellowships. No new applications can be considered during 1961 unless an additional appropriation is provided by the Congress, and it is strongly suggested that an additional appropriation in the amount of $2 million be given serious consideration.

This committee will recall the enthusiasm with which the Congress, the staff of the National Institutes of Health, and the Advisory Councils inaugurated the senior research fellowships program which is currently funded in the amount of $3 million annually. This program has recently been subjected to intensive scrutiny by the committee of scientists who have served to advise the Health Council in this regard, by the Health Council, and by the National Institutes of Health staff. This program has filled a serious gap in our total fellowship structure and provides a means for placing on the staffs of the preclinical departments of our medical schools well trained and eager young investigators. In each instance, the award of such a fellowship gives the university several years in which to arrange, internally, for the subsequent financing of the faculty position thus created. This device is extremely effective but the level of support is not adequate for the current national need. The recipients of these fellowships are at the peak of our training and fellowship structure. They are the most highly selected and talented young investigators produced by our educational and training programs. This group fully warrants our support and the program should most certainly be expanded in keeping with our national need. Accordingly, it is suggested that the appropriation for fiscal year 1961 be increased to $4 million. This would bring the total fellowship program sponsored by the Division of General Medical Sciences to the level of $8,750,000.

### EXPERIMENTAL RESEARCH TRAINING PROGRAMS IN MEDICAL SCHOOLS

A few years ago the Congress appropriated the sum of $500,000 annually in support of a limited group of experimental training programs in a few selected medical schools. This program has reached into the very fabric of the medical schools involved. A careful, statistical survey of the effects of this program has been conducted by a competent analyst and the results indicate that this program has proved to be even more rewarding that was anticipated. The ad hoc committee which has guided this program, together with members of the National Advisory Health Council, strongly urged that the appropriation in support of this program be increased to permit inaugurating similar programs in other medical schools commensurate with the individual ability of each school effectively to operate. Many of the students who have participated in these programs have conducted research of a quality sufficient to result in publication in a scientific or medical journal. Many who had not previously considered the possibility have been attracted into careers in academic medicine so that one day, after further training, they may take their places on the expanded total national medical faculty necessary to produce the number of well trained physicians commensurate with our national need. To expand this program to include each of the medical schools recognized as capable but which previously were denied the opportunity for lack of funds, it is suggested that an appropriation in the total amount of $3 million be made in support of this program.

### NEW AREAS OF ACTIVITY IN THE DIVISION OF GENERAL MEDICAL SCIENCES

*Experimental training programs in liberal arts colleges.*—The entire structure of support for research and research training under the aegis of the National Institutes of Health will be vitiated unless, as a nation, we can attract bright young minds into careers in investigative medicine and the health related sciences. But career choices are made relatively early in life. In universities which include graduate and medical schools, the undergraduate student is exposed to the research

activities of the faculty and of graduate students and fellows. The opportunity to be caught up in the research activities of his senior colleagues is easily at hand and thus the possibility that he may choose a similar career is forcefully presented to him. Unfortunately, this is not the case in colleges of liberal arts and sciences unaffiliated with a larger university. Yet available data on the origins of American scientists indicate that a substantial fraction, if not the majority, of our scientists receive their undergraduate training in such institutions. The large universities operate the graduate and medical schools but they do not have a monopoly with respect to bright young people in their undergraduate colleges. It is our hope that it be made possible to inaugurate, as an experiment, training programs for research in medically oriented biology in a selected group of undergraduate colleges.

Support of such a program is not outside the purview of the existing research training grants program of the Division of General Medical Sciences and, indeed, in fiscal year 1960 such an award was made to one New England liberal arts college. This college was inspected by a distinguished group of visiting scientists who found that the physical facilities, the faculty, and the student body all augured well for the success of such a venture. In recommending such an award to the National Advisory Health Council, this committee also submitted the following resolution:

"This ad hoc group considers that one of the major impediments to the future of progress in the life sciences is the lack of well-trained, highly motivated students eager to undertake training in a specialized area of science. Accordingly, the group recommends to the National Advisory Health Council that there be instituted a limited program of support to a small group of liberal arts colleges seeking to arouse among their students increased interest in careers in research in health and the health related sciences and to improve the preparation of such students by appropriate means. The group looks with particular favor upon efforts to convey a sophisticated picture of the current quantitative approach to biology in physical and chemical terms and upon attempts to provide the undergraduate student with opportunity to progress at a rate commensurate with his own potential and engage in research to the extent possible under the circumstances of the institution. This program should be regarded as an experiment, to be conducted in a limited number of selected liberal arts colleges which have indicated their own desire to undertake such a program and should be critically evaluated within a few years of its inception."

An appropriation in the amount of $500,000 for fiscal year 1961 in support of this program is suggested.

*Clinical research centers.*—In fiscal year 1960, in response to testimony by responsible citizen witnesses, the Congress appropriated to each of six of the Institutes at NIH the sum of $500,000 for the establishment of a clinical research center. This move was widely heralded in all quarters devoted to progress in medical research. By agreement among the councils of the various Institutes, the sum made available to each Institute was transferred to the Division of General Medical Sciences to be administered by the staff thereof together with the National Advisory Health Council. A letter announcing the program was transmitted to the dean of each of the American medical schools in late 1959. So great was the need for such a program that, by February 1, 19 medical schools had submitted complete documented applications seeking to locate such a center in the clinical facilities available to them. The National Advisory Health Council together with consultants from other Institute councils and the staff of NIH have carefully considered the appropriate terms of such an award and an ad hoc committee consisting of professional members of the National Advisory Health Council, members of several other councils, together with specially qualified consultants, has met to consider these applications.

Two distinct types of clinical centers have been described in these applications. One group would make possible the creation, in hospitals controlled and operated by a medical school, facilities for the conduct of clinical research expressly directed toward one major disease entity, e.g., cancer or heart disease. The other schools have sought facilities for the conduct of interdisciplinary clinical research, where each of the major clinical research groups and departments could have at their disposal, as needed, the special facilities necessary to permit intensive, quantitative study of patients for research purposes. Such a unit usually contains 12 or 15 beds plus the necessary supporting laboratories and personnel.

Those who have given most attention to this problem have considered it most appropriate to support, from the funds available to the Division of General Medical Sciences, institutions seeking to operate a general clinical research facility of the second type. The latter fits most readily into the framework of the

medical school and its allied operations and appears most urgently to be in general demand among medical schools and their affiliated hospitals. However, it is to be hoped that both groups will find support. Clinical research centers addressed to a specific disease or group of diseases should be supported by the original concept of grants made expressly through the National Institute most closely concerned with the specific disorder.

Each of the institutions which submitted applications for these centers was visited by a member of the staff of the NIH together with a small group of qualified consultants whose reports were then made available to the reviewing ad hoc committee which met on February 23 and made appropriate recommendations to the National Advisory Health Council. So impressed was this review committee that it drafted the following resolution:

"This ad hoc committee wishes to transmit to the National Advisory Health Council and, in turn, to the Director of the National Institutes of Health and the Surgeon General, U.S. Public Health Service, its deep satisfaction with the inception of the program for support of clinical research centers.

All medical scientists have warmly approved the orderly growth of the various programs of the National Institutes of Health, i.e., the research grants, fellowships, training, and health research facilities construction programs. In their aggregate these programs have contributed enormously to the national medical research effort.

"But, as recognized by the Congress, clinical research has been severely hampered for lack of adequately equipped and financed arrangements for intensive, quantiative studies of human biology in health and disease. The clinical research center program represents the first attempt to meet this urgent need. Accordingly, this committee wishes to commend those who have made possible its initiation and to transmit its earnest recommendation that, in the future, this program be funded at a level commensurate with the national need."

With the funds provided for fiscal year 1961, it is not possible to support more than a selected few of those institutions whose applications were received before February 1st. Those which were received by that deadline date came from those institutions whose plans had been made previously and which had been awaiting the opportunity to finance what they considered an operation of prime importance. Other institutions, equally good, had not formulated, on paper, their needs in this area and, hence, were unable to comply with the February 1 deadline and were limited to the filing of letters of intent. The resolution cited above states clearly the position of those engaged in clinical research. Accordingly, it is most strongly urged that the Congress implement the recommendations of that committee in fiscal year 1961. The best estimatate presently available of the sum which could be effectively utilized during that fiscal year is $15 million.

*Division of General Medical Sciences.*—It will be apparent from the statements above that the programs of the Division of General Medical Sciences of the National Institutes of Health are of paramount importance to future progress in medicine. These programs are remarkably diverse and broad in scope and will, in turn, have a profound impact on programs to be supported in later years by the categorical disease institutes. The programs of the Division will feed both trained investigators and information into the research programs supported by the categorical disease institutes. It is not extravagant to suggest that, from the long-range stand point, the programs of the Division will have the greatest influence on the health of the American people of all the programs now in being at the National Institutes of Health. It seems fitting and appropriate, therefore that in the very near future the Division of General Medical Sciences be granted a dignified status in keeping with its enormous significance. The Division should no longer be merely an administrative arrangement within the Research Grants Office of the National Institutes of Health but, rather, should become a creature of the Congress, a full-fledged institute among the other National Institutes of Health. Such an institute need have no intramural research program at the time of its founding but administrative responsibility for the diverse programs now managed by the Division of General Medical Sciences. Perhaps, in some future year, a laboratory for an intramural program may be deemed appropriate but it is not essential to the initial creation of the Institute.

May I urge, therefore, that the Congress consider at this time the creation of National Institute of General Medical Sciences.

BUDGET

The budgetary recommendations which have been made in the preceding paragraphs are summarized on the attached page. In their sum they suggest doubling the appropriation for the Division of General Medical Sciences and the reasons for so doing have been presented above. It might seem that such a request is audacious but such is not the case. This budget merely reflects the healthy growth, vigor, and significance of the programs of the Division which are the most recent of the extramural programs of the National Institutes of Health to be authorized by the Congress. They are far reaching and broad in their scope and significance and, in the future, the progress which can be expected in the areas of research supported by the categorical research institutes will be limited to what has been made possible previously by the programs of the Division. It should be an article of faith that medical research in these United States should be pursued with all the vigor and talent which can be brought to bear and that our goal is the maximum effort of excellent research compatible with our resources of manpower, facilities, and the national economy. There can be no better investment of the taxpayer's funds. The vigor and health of our industrial economy rests more and more on previous research accomplishment; dollars invested in research have been repaid many times over in later improvement in industrial techniques and diversity of both consumer and industrial goods. So, too, can we be certain that dollars expended in medical research will be repaid many times over in subsequent years by the improved health of the American people.

*Suggested budget, Division of General Medical Sciences*

| Program | Fiscal year 1960 | Fiscal year 1961 |
|---|---|---|
| Research grants: | | |
| Commitments, supplements, etc | | $21,000,000 |
| Backlog [1] | | 2,000,000 |
| New projects | | 12,000,000 |
| Total | $23,600,000 | [2] 35,000,000 |
| Research training grants: | | |
| Commitments [3] | | 13,000,000 |
| Backlog [1] | | 5,000,000 |
| New projects | | 9,000,000 |
| Total | 13,040,000 | 27,000,000 |
| Experimental training grants: | | |
| Liberal arts colleges [4] | 0 | 500,000 |
| Medical schools | | 3,000,000 |
| Total | 500,000 | 3,500,000 |
| Research fellowships: | | |
| Regular, special: | | |
| Commitments and backlog [1] | | 3,000,000 |
| New fellowships | | 2,000,000 |
| Senior: | | |
| Commitments and backlog [1] | | 3,000,000 |
| New fellowships | | 1,000,000 |
| Total | 5,300,000 | 9,000,000 |
| Clinical research centers: | | |
| Commitments | | 3,000,000 |
| Backlog [1] | | 8,000,000 |
| New projects | | 4,000,000 |
| Total | [5] 3,000,000 | 15,000,000 |

[1] Approved in fiscal year 1960 but unpayable for lack of funds.
[2] An addition to this figure would be required if the indirect costs rate is increased.
[3] Including sum necessary to adjust all fiscal periods to July 1 starting date.
[4] A single grant made in fiscal year 1960 from general training funds.
[5] Appropriation for fiscal year 1960 made as $500,000 to each of 6 Institutes and transferred to the Division of General Medical Sciences for administrative purposes.

Dr. HANDLER. Here is an additional copy, if you would like to see it as we go along.

I am a member of the National Advisory Health Council and the planning committee of that Council as well as its committee on training.

In that capacity I have been privileged to have a very close look at the operation of the Division of General Medical Sciences, its programs, and its needs.

In considering these needs, my colleagues and I on these committees in recent weeks have found ourselves in a rather embarrassing position. We knew that from the program as it shaped up we would come here today and suggest a rather substantial increase in the budget for this operation.

Since we had received a substantial increase in the previous year, I was rather embarrassed to bring this before you, and for some days I squirmed in this position, to be quite honest. Then the more I thought about it, the more my feelings changed. My reaction to the situation changed largely because these needs, as I shall present them, are not any form of avarice on the part of science but rather a reflection of the wisdom of the Congress in providing the funds which initiated this program.

The program of the Division of General Medical Sciences is just now coming of age. At this time these programs have the broadest scope of any programs now in being at NIH.

There are several sections: The research grants program; the training program; the fellowship program; the experimental training grants, about which we will say more in a few moments; and more recently, the program in support of clinical research centers.

Within the research and training programs there is a remarkable diversity of activity. The Division now is responsible for the support of research in a great variety of areas which are fundamental to progress in medicine, as we understand it. The programs, I do believe, have the long-range progress of medical research in their core and in their hands, and it is these programs which must ultimately provide the information, the techniques, the know-how, and the people who will make possible the research progress of the categorical institutes in later years.

I would like to submit, sir, it is time this program was brought to a more dignified status—if we may call it so. The Division of Medical Sciences should no longer be simply an administrative unit within the NIH. It is time now to create an institute, and the name I would suggest is the Institute of General Medical Sciences. This is the name in my prepared statement.

In discussing this in the last few days with several of my colleagues on the Health Council, others have proposed the name National Institute for Experimental Medicine and Biology.

I make no special plea for either of these titles. They say much the same thing, but I do think it is time to create a proper institute in recognition of the importance of these programs.

The research program already is a substantial one. I do not know offhand the total number of grants which are being supported, but the areas of interest encompass so diverse a spectrum of biology that it is very difficult to describe them in a brief time.

I would like to talk about a few instances, if I may.

One of these, which has just come into prominence in the last few years, is a developing field which has the rather dreadful term of immunogenetics. This is a field of research which has developed in response to a need—and the need is that for understanding what happens when one attempts to transplant tissue from one individual to another.

As you are well aware, it is possible to transplant skin or large organs from one identical twin to another. What we have not thoroughly understood is why we cannot make similar transplants from one individual to another who is not the twin.

It is our hope that if this program is supported adequately, and if we can bring enough brains to bear on the problem, we will one day understand why it is that we cannot perform these transplants.

At first it seems relatively simple. We thought the difficulty all lay in the host; that the individual into whom one makes a transplant reacts to it and reacts to it as tissue which is not his own; there is an immune response, and this immune response is what destroys the transplanted material so it cannot survive.

If it was that simple, the problem would have been solved sometime ago. Unfortunately, in recent years the day at which we can expect practical success is pushed a little further back. Thus it is clear, the host not only reacts to the transplanted material but it in turn can develop an immune response to the host.

It, too, can react to the host. And this is a much more difficult problem to tackle. Yet there are large numbers of talented people now going into this area; and in general this field is supported by the Division.

Yet another area to which I can speak, because it is something in which I have a personal interest, is the fact that the Division has now for several years supported studies of protein structure. Such studies did not seem to bear in any immediate fashion on problems of human health, but they really do. It was with techniques and knowledge obtained in studying this, as an abstract exercise, purely out of the interest to advance the understanding of protein structure, that we have developed a whole battery of techniques. These permitted the elucidation of the structure of insulin a few years ago.

While this may appear to be abstract research, it has its very practical aspects.

One day we expect to have this put to a much more practical or immediate use. For example, there is the fact that our population is growing. We know no means of controlling the incidence of diabetes, and one day we may wander into the problem of a simple lack of insulin from slaughterhouse material, sufficient to keep up with national demands.

Using the techniques which we now have available for studying protein chemistry, it is possible today to take the insulin molecule apart, chop it down, and make smaller pieces out of it and determine what there is about insulin that makes it physically useful in diabetes. When we know that, one would hope it will be possible with that information to synthesize insulin from ordinary chemicals and provide us with a truly synthetic insulin.

But what I am pointing out and stressing is that the people who developed the know-how did not do it with diabetes in mind. They started with the simple desire to understand protein structure. But

they have provided the tools which make now more practical aspects of this work possible. And such studies are now in support by the Division.

Last year you may recall that I spoke at some length on the support the Division has given to general research in the area of genetics. I am rather happy to note that the programs of the winners of the Nobel Prize in medicine and physiology, Drs. Severo Ochoa and Arthur Kornberg, were both supported by funds provided through the Division of General Medical Science.

And that, gentlemen, is working about as far as you can go, out at the frontiers of biology and medicine.

They have provided some information on how it is that the compounds of large molecular weight, compounds in the nuclei of cells, carry genetic information. These scientists made it possible to demonstrate that these compounds can be duplicated outside of a cell. Here again we can extend our imagination. Perhaps some years in the future their findings may have a direct application. No one can make any firm promises. At the last count, as I have been able to make it, I noted that there are now more than 50 known hereditary disorders related to human metabolism. The most, so far, that science can achieve is merely to catalog them, describe their incidence and the area of metabolism which is involved. In a few instances we know what to do with people who are so afflicted, but these are very few. Our hope for the future is that we may know better how to handle individuals who bear hereditary disorders. This is an exceedingly important problem.

When the present great threats of cancer and heart disease are brought under some measure of control, we are still going to have to live with ourselves, our environment, and our hereditary defects. Many of these diseases related to environment, to heredity, and to our aging population we can now see as being controllable. The reported incidence of hereditary disorders detected in our population will commence to soar, just as the reported incidence of heart disease did when the factors connected with it were discovered.

It is not at all too early to consider this serious problem. We have vast amounts to learn before the time that hereditary disorders become the great national killers. The programs of the Division are designed to seek out information on all of these major disease areas and in particular to understand more about genetic disorders and the genetics of man.

In another area the Division supports studies of cell biology and attempts to understand in as fine detail as possible what a living cell is, what its parts are, and how they interact with each other. Some of these studies are more properly cell physiology, while others deal with cell structure and are studied with the electron microscope.

These fields merge into what has been called biochemistry in the past and are really continuous integrated areas of investigation. The reason I would submit for support of such research by the Public Health Service is that it is through such studies that we will one day have a rational basis for chemotherapy.

I do not in any sense deny the validity of the current concepts of chemotherapy, and the various programs pertaining thereto of the National Institutes of Health. They are performing a wonderful service. But a rational chemotherapy must be based on knowing

how cells work in the most intimate detail, and when we do, whether the problem be cancer, or a disease of connective tissues, a complete knowledge of how cells work will make it possible to provide us with a rational chemotherapy. The people doing research in this field today will provide us the basic facts from which others tomorrow may develop specific chemotherapy against the major dread diseases.

Most of the scientists engaged in basic research are not thinking of a specific disease entity. Most of them are studying living systems for their intrinsic interest. Others will pick up this information and its techniques and use it.

The Division does also engage in support of some applied areas of biology, as well.

Support of many programs in aging research comes through the Division of General Medical Sciences. In these programs, investigators, are trying to determine what is, exactly, the process of aging; that is, what are the built-in time-dependent mechanisms, which, from the time we are born, increase our statistical chances of dying with each day, month, and year. This is not a study of disease but a study of the intrinsic nature of the aging process.

One of the most exciting and interesting studies perhaps in recent times is the study of the relationship between the delayed effects of radiation and the aging process. There are many analogies between what happens to an animal given a few doses of radiation, insufficient to cause an acute radiation disease, and the fate of an animal simply allowed to age naturally.

It is the hope of a group of investigators that by understanding what happens to this irradiated animal, we may learn more of what happens to the normally radiated animals.

Other investigators are convinced that aging is the result of the physical-chemical structure and behavior of the components of connective tissue, and are designing experiments which are intended to explore this general notion.

At the same time, the Division supports research in much more applied areas of aging, such as sociological studies and studies of better supportive care for our aging population, studies of the altered psychology of our older population, and the like. This is one of the more applied programs of the Division and the information forthcoming will be put immediately to use.

Finally, there are even more applied programs, if you will. These are research into air pollution, water pollution, sanitary engineering, and nursing research. This is applied biology at the furthest end of the spectrum from where we began.

It is certainly not necessary to defend research on air and water pollution. In the middle of the 20th century we are in danger of destroying our urban civilization, and it is the hope of some of the investigators we can prevent the destruction of our communities before present trends get out of hand.

All told, the research program of the Division in 1960 is supported to the extent of $23,600,000.

The commitments and supplements already made for fiscal 1961, together with the backlog of approved but currently unpayable requests, comes to $23 million.

When our planning committee of the Health Council met most recently, and discussed this program with some of the staff of the

Division, it was quite clear at the current rate we might easily expect some $20 million in new requests in 1961.

The previous experience of the Division is about 60 percent of these will be approved on scientific grounds, so it seems in order to suggest that appropriation for 1961 for the research grant program, alone, of the Division of General Medical Sciences, be brought to a total of about $35 million.

The second program supported by the Division is an exciting new venture. These are the disciplinary research training grants. These virtually had not existed until the Division was brought into being approximately 2 years ago.

At present there are about 300 research training grants in operation, involving virtually every medical school in the United States, and a number of grants which are outside the medical schools but made to university departments and health-related sciences, though in this sense the term "health-related sciences" is interpreted rather rigorously. It does not mean the support of zoology, for example, in any broad sense at all. These are the first training grants made through the National Institutes of Health, which recognized a disciplinary department, pathology, and the like, as a fundamental training unit which cannot and should not be subdivided into more specialized programs.

These training grants have been acclaimed by scientists all over the United States. It is too early to say we have great triumphs. Most of them are in being for less than 1 year. Some are for 2 years. There are a total of something under 2,000 persons at the present time, trainees, directly supported by these training grants, but the number of students, and possibly the doctoral fellows, who must be affected by these programs, must be three or four times that many. They are not drawing stipends from the grants but are working in a department where funds have been provided to improve the training facilities.

I would like to make a statement as to what level this program should be pegged for the future, but I cannot do so. I cannot provide any rational statement as to what our national need is in terms of trained manpower, in this general area of the health-related sciences for 1970.

I am well aware of the fact that in my own department I have five budgeted positions which I cannot fill today for lack of appropriate people, and I have been hunting for a year, and that story can be repeated many times over. Our training programs currently are clearly not producing people at the rate for which there is an immediate demand. But we do not have adequate data for saying at what level the programs should be set for the future.

At its last meeting the Health Council, through the Division of Medical Sciences, authorized the conduct of an extensive survey which will be contracted through the Federation of American Societies for Experimental Biology, and the contracting officer is Prof. John Coles, of the University of Pittsburgh.

We hope that a year from now we can bring before you quantitative, meaningful data to give some indication of the ultimate level at which such programs should be pegged commensurate with the national need.

At this moment we merely know they are inadequate. We cannot say how inadequate. But if this country is to mount a national research program on the scale envisaged by the Baynes-Jones report,

and if we are ever to implement the Baynes-Jones report and create 20 new medical schools by 1970 and expand the existing medical schools, these programs will have to provide the trained investigator-teachers to staff the expanded faculties. We could not create 20 new medical schools tomorrow. We would not know where to find the faculty.

These training programs will help produce such people, and the people who provide the research which is supported by the categorical Institutes as well as by the divisions of NIH.

The data provided to the Health Council indicate, as we now operate, indicates that we can expect approximately $15 million in new applications for research training grants in fiscal 1961, and our group would suggest that approximately $9 million more be made available in fiscal 1961 to support these new projects.

In addition, as we go into fiscal 1961, there is a backlog on hand of $5 million in scientifically approved and highly meritorious applications which cannot be paid.

Now, there are two other areas to which I would like to speak a bit, if I may. One of these is a program called the experimental training grants program, which was instituted 3 years ago.

This was made possible by an appropriation of a half million dollars to the Division of General Medical Sciences for each of the last 3 years. These funds have been used in a variety of ways among a restricted group of carefully selected medical schools. The objectives have been diverse, but in the main the attempt has been to make a career of medical investigation more attractive to medical students and to broaden their understanding of what research is and how research is done. As well, in some cases, the program seeks to point out to them that a career in academic medicine might be as rewarding as a career in practice.

These programs have been rather remarkable. They have been much more productive than originally anticipated.

The faculty and the students in every school in which they have been inaugurated have been enormously enthusiastic. Dr. Coles, the same gentleman to whom I referred earlier, has made a survey of the conduct of these programs and the impact on the various medical schools. I have seen a preview of this report. It is not quite complete, but it is cast in the most remarkable terms.

I am prejudiced in that we have such a grant in my institution. Dr. Thomas has one in his. We can speak from our own experience. The results in the schooling are far beyond the amount of money which is involved.

This being the case, it seems the better part of wisdom to extend this program to other medical schools which have been not so privileged in the past, not to all medical schools, but to those which can effectively demonstrate they can utilize such mechanism. To this end we would suggest that approximately $3 million be appropriated for 1961, as against $500,000 which we had available to us last year.

In the same vein, there is another program which cannot yet be called a program, because it involves only one institution.

The members of the health council, and particularly our training committee, have spent a good deal of time discussing the fact that the choice of a career is made rather late in life for many youngsters.

Those students who are at great universities which have graduate schools and medical schools, even during their undergraduate years,

come in contact to one extent or another with people who are engaged in research.

It is not frequent, perhaps, but it is sufficient so that the possibility of a research career confronts them from time to time as undergraduate students.

Moreover, the fact that research is in progress at such institutions affects the teaching and the philosophy of people doing the teaching in undergraduate colleges.

Statistics seem to indicate that a greater percentage of our talented investigators went to liberal arts colleges which were liberal arts colleges quite apart from any graduate or medical school.

What we would like to have is a program of grants to selected liberal arts colleges which would make it possible for them to inaugurate any honors program involving the highest quality instruction which would describe biology in the quantitative terms which scientists use today.

This is the quantitative physical and chemical approach to biology, as opposed to the classic one of liberal arts colleges, which is a taxomorphic approach to biology in general.

We have one such grant to a liberal arts college. This award was made sometime in the middle of this current academic year.

We will not be able to study it carefully until the conduct of the next academic year, which begins in September. We would like to make a series of such awards, no more than a half dozen, perhaps, all around the country, to a small group of selected institutions to see whether or not such programs can accomplish this desired goal of finding more bright young people and interesting them in careers of research and medicine or the health-related sciences.

There is no real point in appropriating men to build more medical schools and research centers or to appropriate money for research grants if you cannot lure bright, young people into the general area of biological and medical research and this is the hope and to this end, we would like to have available to the Division of General Medical Sciences about one-half million dollars in fiscal 1961.

There are two other areas which warrant your attention. One of these is the fellowship programs of the Division. The training programs are just beginning to bear fruit in regard to the need for fellowships. After several years which were relatively dry, there is now beginning to arrive, on a much larger scale than over the previous 5 or 6 years, requests for fellowships in the general areas of biomedical research, as opposed to the area of the categorical institutes.

The same Division of General Medical Sciences is supporting the program of senior research fellowships which was inaugurated a few years ago. Again, this program has met with remarkably enthusiastic reception. It has made possible the placing on the staffs of our medical schools, usually in the preclinical departments, people who are at the top of our training system. These are the selected scientists who have come through the whole training process of the medical school, postdoctorial training, apprenticeship, to an investigation or similar training, and finally at about age 35 they are able to embark on careers of their own. These people are supported from 3 to 5 years through the senior research fellowship program. During this time the university in question has the opportunity of arranging its own internal affairs so that when this fellowship terminates the

university can make arrangements for this person who will then become a member of the faculty.

The requests for these fellowships far outstrip the funds currently available. The appropriation for this program in fiscal 1960 was $3 million, and were it possible, we think that an additional $1 million should be made available in fiscal 1961 for this program.

Finally, I come to a completely new enterprise, and that is the clinical research centers. The concept of such centers was put before this committee last year by a group of citizen witness. Two different kinds of clinical research centers have been proposed. One conforms to the general framework of the categorical disease institutes of the National Institutes of Health. The proposal was and is that there be created, in affiliation with medical schools, universities, and research hospitals, centers for the intensive study of cancer in one institution, cardiovascular diseases in another institution, arthritis and metabolic diseases in another, and so forth. The alternate concept has been the creation of a clinical research center within the fabric of a university-affiliated medical school or hospital which bears a greater resemblance to the conventional organization of the medical school.

What is desired is the opportunity to perform quantitative studies of human biology in health and disease, studies which require the availability of hospital facilities, beds, the supporting laboratories to go with those beds, and the personnel necessary to operate these facilities. But in this second concept, rather than having the entire organization devoted to the study of cancer, for example, this would be a facility to make it possible for the entire faculty of the medical school to come into the operation with a selected group of patients. The beds, and the entire operation would make it possible to study the entire spectrum of human disease as it goes through any large teaching hospital but in the intensive fashion which is just not possible today under the budget of a university medical school.

This concept is not at odds with the other concept. An ad hoc committee of the National Advisory Health Council met in Bethesda about a week ago to consider the applications which had come in in response to an announcement of the existence of this program. Both types of proposals were brought before this committee. A few proposals specifically were addressed to a single disease or a single group of related diseases, but most of the proposals were of the broader variety which would provide for the clinical research effort of the entire faculty.

It is the current thinking of that committee and of the few members of the Health Council with whom I have been able to discuss this program, since our meeting in Washington last week, that both kinds of centers should be created. It is our feeling that the more general facilities should be supported through the Division of General Medical Sciences. We feel that support for the centers to be devoted to studies of a specific disease entity should come from the categorical disease institutes which already have been given responsibility by the Congress for studies of such diseases.

This is an enormously exciting program. With the training grants it presents the second departure from convention for the Division of General Medical Sciences. Both of these programs recognize there are areas of research and research training which cannot be sup-

ported by the research grant given an individual but which require the facilities of the larger organization within the framework of the medical school, university, or hospital. For the clinical research center it is an aggregation of the entire clinical research faculty and nothing else will do. You cannot do the same thing by making funds available to a large number of individual investigators. You either create the center or fail to create it, and there is no intermediate position.

For fiscal 1960 the Congress appropriated $3 million in the form of half a million dollars to each of the categorical research institutes. This money, for administrative purposes, was pooled at NIH, and each of the categorical institutes agreed to accept the recommendations of the National Advisory Health Council. All of the requests for these funds were considered by a large and rather distinguished ad hoc committee appointed by the Health Council. That committee met last week. I do not know the results of its actions completely. I know how many approvals and disapprovals there were, but no more than that, because we vote individually and the data will be available when the Health Council meets next week in Bethesda. I do know, however, that there were 19 applications on hand. There are insufficient funds to pay for more than a few of those that were approved.

The applications came in from those institutions which had long intended to set up such centers. They not only intended to, but had their plans on paper, so that they could be studied. Between the announcement of the existence of the program and the deadline for receipt of application there was only about 40 days, yet 19 applications arrived in this time. A larger number of medical schools, I don't know the exact number, filed letters of intent and these schools will submit documented applications sometime in the spring.

This program will have an enormous impact upon the future of clinical research in these United States. The $3 million appropriated for fiscal 1960 we believe should be viewed only as a beginning. It is clear that as we go into 1961 there will be a backlog of at least $8 million, in requests which have been scientifically approved, but will not be payable.

As a first approximation, and it is only that, we can estimate that as we enter 1961 another 6 million in new requests will come in, of which perhaps 4 million will find scientific approval. Accordingly we should like to suggest for this program, support of clinical research centers, that approximately $15 million be appropriated for fiscal 1961.

This returns me to where I started. As you will have seen, the programs of the Division of General Medical Sciences have expanded enormously, not merely in dollars, but in scope, in the varieties of areas of interest and types of program.

It is time that the Division became a creature of Congress, rather than an administrative device of the National Institutes of Health, and I very much hope that your committee will give earnest thought to the possibility of giving the Division status as an institute. As I said earlier, the name, Institute of General Medical Sciences, is suggested in this statement, but there may be other titles which you may find more appropriate.

I am afraid I have taken too much time. I thank you very much.

Mr. FOGARTY. Thank you, Doctor. How much additional are you asking that we appropriate?

Dr. HANDLER. I have not added the totals, sir. I have presented this by categories. I could add them. It comes to approximately $40 million additional funds.

Mr. FOGARTY. In addition to what the Administration budget has requested?

Dr. HANDLER. Yes.

Mr. FOGARTY. Suppose this committee could give you some of that $40 million, but then we run up against opposition in the House, because we have to balance the budget and can't afford to appropriate more this year, what is the best answer to people who argue like that?

Dr. HANDLER. I cannot regard the health of the people of the United States as a problem which you solve by balancing budgets. I recognize the need for financial responsibility on the part of the Congress, but the population of the United States is expanding very rapidly. Medical science has improved enormously during our life time but it has a long way to go. The ill are still with us, our mental institutions are crowded, our hospitals are crowded. We are aware of the fact that the improved health conditions in our civilization are filling the population with people at the aging end of the spectrum and people who are a drain on society because they are incapacitated by illness. I submit that if all this research accomplishes nothing more than adding 1 more year of useful life to the life of every American, a year in which he contributed to society rather than as a drain on society, the economic gain would be simply enormous by contrast to the cost. I hope that these programs will permit us to do this. I don't believe you can solve them by balancing the budget today, because we can't wait. The population is growing and the problems of the sick are still with us. I do not believe that we have the moral right to simply wait until it seems that we can balance the budget.

Mr. DENTON. Most everyone will agree these things in the long run are good investments. But they say they want to balance the budget this year and cut down expenditures and stop inflation. What would you say to that?

Dr. HANDLER. I would say if General Electric were to do that, it would go out of business. Its competitors would drive them out of business. I don't believe as a nation we can afford to disregard what General Electric could not. If we cut down on our research budget, research in other areas of the world would continue to be supported.

Mr. DENTON. You think we should do like DuPont during the depression when they increased their research?

Dr. HANDLER. They did, and it created an enormous pool of scientific advancement. I believe a dollar invested in health research will do the same thing.

Mr. DENTON. You think that as sound business it is very foolish to look at it just as of today and not for the long run?

Dr. HANDLER. Exactly so, and of all the programs of the National Institutes of Health, this is the one with the most long-range interest and most far-reaching consequence.

Mr. DENTON. You think if business pursued the same policy that some people are in connection with the Federal budget, just to balance

the budget today and not think of the future, they would go out of business?

Dr. HANDLER. Exactly so. This is a competitive area we live in.

Mr. FOGARTY. I think that is very good answer. Thank you very much.

STATEMENT OF DR. LEWIS THOMAS

Mr. FOGARTY. Next we shall hear from Dr. Lewis Thomas, professor of medicine at the New York University Medical School.

Dr. THOMAS. Mr. Fogarty, I am grateful again for the privilege of appearing before you to speak on behalf of the programs of the Division of General Medical Sciences of the National Institute of Health.

I am a professor and chairman of the department of medicine and director of the third and fourth medical divisions in Bellevue Hospital.

I am one of four members of the New York City Board of Health, and have a special interest in problems relating to public health.

My recommendations concerning the appropriations for the Division of General Medical Sciences are based upon my experience as a member of the Pathology Study Section, and the pathology training program and recently Special Advisory Committee of Clinical Research Centers, and they are also based on the discussion with members of the National Advisory Health Council.

In brief, I would say I agreed at the outset with all of Dr. Handler's testimony, including the actual budgetary figures which were recommended by him for fiscal year 1961.

Mr. FOGARTY. Do you think he asked enough?

Dr. THOMAS. Yes; I think so.

Mr. FOGARTY. He is generally most conservative.

Dr. THOMAS. Well, these are large sums of money. I think if they were appropriated, the objectives that he had outlined could be completed.

I would like to endorse, especially, the recommendation that the Division of General Medical Sciences assume the functions and the stature of the Institute, and whether this be called the Institute of General Medical Sciences or the National Institute of Experimental Medicine and Biology or whatever, seems to me less important than that an institute be created to administer the extremely important functions of the present division.

The basic research training program now supported by the Division has, as Dr. Handler indicates, been a tremendous success already. It has, as a matter of fact, transformed many of the preclinical departments in the medical schools across the country, and it has already succeeded in attracting considerable numbers of talented young people into careers of research and teaching who might otherwise not have been attracted.

I would recommend that the research training program be substantially expanded, and that part of this expansion include research training programs for certain selected clinical departments. Up until now, the training grants in departments of medicine, for example, have been supported in the main by funds from categorical institutes for training concerned with particular diseases, and there is need for programs without categorical limitations, and some of the clinical departments

in our medical schools are now in a strong position to undertake such research training.

I would like to add an enthusiastic word to Dr. Handler's comments about the new Clinical Research Center program. It seems to me the most ambitious, and, for the future, the most promising of the programs yet devised by the National Institute of Health. Up until now, research on human diseases has been made relatively easy, at every turn, up to the point of the disease in the human being himself. Here, for most of our institutions, impossibly bare years have been confronted.

To study human disease under proper controlled circumstances with the same opportunities for scientific research that exist in test tube or in animal research has been virtually impossible for most of our medical schools or hospitals.

For one thing, it costs a great deal more money than is available in the usual research budget. Every patient under investigation must occupy a hospital bed, and someone must provide the cost of this hospitalization.

In addition, research beds are not of much value, unless there are clinical research scientists available to study the patients and have appropriate well-equipped laboratories immediately at hand. To set up such an arrangement has been, up until now, an impossibility for most medical schools and university hospitals.

I must say the general tendency has been in many institutions to set to one side, temporarily, any ventures into direct research on human disease in patients and to rely more on results from the animal laboratories.

The new program, as it is presently envisioned, is an absolute breathtaker, from the point of view of clinical investigators.

Under it, they will be able to hospitalize and study patients with the disease in which they are interested and to design experiments with the assurance that supporting research laboratories will be immediately available.

Parenthetically, I know of no National Institute of Health program which has caused such a stir of excitement in scientific circles in our medical schools. The general reaction has been now that we can really get down to it.

This year, $3 million was appropriated for the purpose of supporting Clinical Research Centers, and it is already so obvious that this is the right direction to take that all of this money will be entirely committed this spring and many scientifically worthwhile proposals will have to go unpaid.

I would agree with Dr. Handler that this is one program which should have priority and which should be immediately and substantially expanded, and that a sum of $15 million be made available for the next year.

The research grant program, I think, needs no special recommendation from me.

I would just like to comment on the possible difference between Dr. Handler's interest in this part of the program, as a professor of biochemistry, and mine, as a professor of medicine.

The clinician is as interested as the immunologist, the basic scientist in microbiology departments, in the problem of homotransplantation, but his interest is not confined to being able to transplant organs

successfully. It is now suspected, on good grounds, that the mechanisms which are involved in the rejection of skin homografts are the same mechanisms as are involved in tissue damage in human diseases believed to be due to hypersensitivity. It is conceivable the damage caused in the heart and joints in rheumatic fever may be based on precisely the same mechanism which brings about a rejection of a homograft of skin.

Moreover, this same mechanism may constitute a fundamental defense mechanism against the appearance or development of newborn cells in the body. In other words, this maybe a defense mechanism directed against neoplasia.

It is my own belief the most promising approach to the cancer problem at the present time may be in the investigation of mechanisms which underlie the rejection of a transplated piece of tissue.

For a variety of reasons, therefore, the clinician finds this problem in basic research, to be of pressing importance and interest, and possibly of very direct practical applicability.

I would like to say a word about the training program.

Dr. Handler has mentioned it.

Under this program, in about a dozen medical schools funds have been provided for encouraging and training medical students in scientific research while they are still in medical school.

The success of the program in the past 3 years has been an astonishing phenomenon, and I would recommend strongly that the program now be made a permanent one, and expanded.

It is now certain that medical students can, with the special arrangements that can be provided through this kind of a training grant become involved in research and can turn out, if they are talented, high-grade and elegant research projects while they are still in medical school.

Now, the budgets which I have recommended and which are specified in my formal statement are essentially the same as those presented by Dr. Handler, and I am not going to go into them in any detail, except to comment that this is obviously a very large amount of money.

I would like to conclude, if I may, with a general statement of what I think is the justification for this kind of expenditure from the point of view, if you will,of the physician.

At Bellevue Hospital, I am in charge of seven general medical wards, and three wards for patients who are both medical and psychiatrically sick.

This is a total of a little over 300 beds, and it represents a fairly broad picture of what makes people sick in New York City today.

As a clinician, I am continually dissatisfied with what we can do with disease in general. To be sure, we cope nicely with bacterial infections, except for our staphylococci, and we do well with a few other diseases notably pernicious anemia and diabetes, but, by and large, the major diseases which confront us in Bellevue Hospital are diseases beyond our capacity to alter. Two conspicuous examples are heart disease and mental disease which comes with aging.

There is much talk about need for new hospitals and need for new medical schools to train physicians. I think there is no question in the immediate future we do need more hospitals and more doctors in our communities. But over the long haul, I think that our problems are insoluble by these short-range means. With the population in-

creasing at its present staggering rate over the whole surface of the earth, we will be, within the next 40 years, in a new situation in which I think it will be impossible for society to tolerate the scale of human disease which now confronts us.

In the year 2000, which is no further away from us than 1920 and which I remember quite clearly, if we are to have the same kind of medical and health problems before us which confront us today, there is no imaginable number of physicians nor imaginable number of hospitals that will be capable of coping with the disease problem on the scale that would exist in the huge population. A frontal attack on disease is the answer.

It seems to me the only solution is to undertake the virtual elimination of human disease through more research at all levels. This I think is our real long-range goal, and I think it is an entirely feasible one.

I do not believe in the inevitability of human disease, and I did not think for 1 minute that cancer or senility are part of the essential human condition. I believe it is possible to rid ourselves of this burden. I think if we are to have a tolerable society in the year 2000, 40 years hence, disease has to be controlled and conquered. I think it is a prudent and practical objective for us in 1960.

Mr. Fogarty. Thank you, Doctor.

Do you have any questions?

Mr. Denton. No questions.

(The statement submitted by Dr. Thomas is as follows:)

A Statement in Support of the Programs of the Division of General Medical Sciences of the National Institutes of Health

(By Lewis Thomas, M.D., professor and chairman of the department of medicine, New York University College of Medicine; director of the third and fourth medical divisions, Bellevue Hospital, and member of the New York City Board of Health. Member: Pathology Training Committee, NIH; Special Advisory Committee for Clinical Research Centers, NIH; Association of American Physicians, American Society for Clinical Investigation, American Association of Immunologists, Society of America Bacteriologists, American Pediatric Society. Formerly: professor and chairman of the Department of Pathology, New York University College of Medicine; professor of pediatrics and medicine, University of Minnesota Medical School)

Mr. Chairman and honored members of the committee, I am grateful for this opportunity to testify, once again, in support of the programs of the Division of General Medical Sciences of the National Institutes of Health, which appear in the budget under the appropriation title of "General research and services." I speak as a physician, an investigator, and a teacher of young physicians. I have served for 5 years as a member of the Pathology Study Section and am now a member of the Pathology Training Committee and the special consultant to the Committee on Clinical Research Centers of the National Advisory Health Council at the National Institutes of Health. I am one of four members of the New York City Board of Health, and have a special interest in public health problems of the present and future. I am professor and chairman of the Department of Medicine at New York University College of Medicine and director of the third and fourth medical divisions of Bellevue Hospital.

Before speaking on the particular needs of the programs of the Division of General Medical Sciences, I would like to say a few words about the reasons behind the need for more medical research in our society, and the urgency of this need. I have read statements in the press questioning the wisdom of increasing the expansion of medical research programs by the National Institutes of Health. The scale of the present program is alarming to some. "It is too expensive," they say. "It is a luxury which we cannot afford. Is it practical to encourage so much research? Is it necessary? Why can we not try to make the best of things as they are now, without spending all this money?"

One answer to such questions lies in considering conditions ahead of us, in the year of our Lord 2000. This seems a great distance away in time, almost a matter for science fiction, but it really isn't so far off. It is no farther from us than we are from 1920, and I can remember 1920 easily. Indeed, a great proportion of our population remembers 1920. Many, who were then in their thirties, are now in their seventies, and are confronting the appalling prospect of physical and, worse, mental incapacitation in senility. The advances of modern medicine can offer them another decade or more of survival, but for many these will be miserable years.

What will it be like in the year 2000? In 1920, the year 1960 must have seemed a tremendous distance away, but here we are. There are, in fact, more of us here now, in sheer numbers, than ever before in history. And if there is any certainty in human affairs today, it is the certainty that there will be still more of us, a staggering number of us, in 2000.

It seems to me that of all the vexing considerations posed by this expansion of humanity—the most alarming, from this distance—are the health problems of this huge population. If we are to drift along into the next century with the same diseases that confront us today, and with no better therapy and no greater knowledge of the conditions which we now find worrying, or puzzling, or expensive, then our lot will be almost intolerable. Things that are difficult for us now will be impossible then. Think of the frantic rate at which we are compelled to build new hospitals in 1960, and our concern over their lack of interns, and the recommendations by national committees that we create more medical schools and train more doctors forthwith. No one could have predicted in 1920 that we would have such problems today, and perhaps nobody cared that much about 1960. But we, standing equidistant between 1920 and 2000, can predict with certainty what it will be like for our children, and for theirs. The only course of action that we can take to avoid a disastrous situation is to undertake, now, on a vast scale, the elimination of human disease. No less. This strikes me as reasonable, practical, realistic, and down to earth. To put it off in order to save money, to postpone it as a luxury, seems to me quite unsound, unrealistic, and impractical.

Whether it can be done by the year 2000 is unpredictable, but if we keep at it we should be able to finish crucial parts of the job. If we don't do it, the prospects for our public health facilities are entirely hopeless. No conceivable number of physicians will be able to cope with human disease if our methods are the same in 2000 as now, nor is it imaginable that we can have enough hospitals for the chronically ill of that population.

I have no doubt that it can be accomplished, if we give adequate support to medical research and training; but I have no illusions about the scope of the task. It will be, if it can be brought off, the greatest accomplishment by human beings since time began. With it will come, as a sort of side benefit, a new understanding of ourselves and how we are made, and a new wisdom to aid society in general.

I do not believe in the inevitability of human disease. There is nothing preordained about senile psychosis, any more than there was about childbed fever a century ago. Cancer is not a natural aspect of the human condition, nor is heart disease, nor epilepsy, nor heroin addiction, nor multiple sclerosis, nor insanity, nor blindness, nor any of the lists of maladies which plague us today. Aging may be inevitable, and death is a part of nature, but disease is not, or needn't be, for humans. We have got to become a healthy species. This, it seems to me, is the task for medical research in the years that lie ahead, not for our own comfort, not for our remote posterity, but for the people who are the same distance from us in time as we are from 1920.

This is the task for which the expanding programs of the National Institutes of Health have been beautifully designed, in my opinion, and I am here today to speak on behalf of the several programs which I happen to feel most strongly about. I am one of those who believe that we are only at the very beginning of things in medical science. Our position is analogous to that of the physical sciences in the 19th century. To be sure, there have been a few spectacular advances in therapy: the bacterial infections, diabetes and pernicious anemia come automatically to mind. But this is still frontier country, and we are still ignorant about too many things. Before we can make frontal approaches to the formidable diseases which remain unsolved, we must have more information about basic mechanisms controlling the behavior of cells and tissues. For sound progress toward a greater understanding of man's basic nature and diseases, it seems to me that the research and research training programs now sponsored by the Division of General Medical Sciences hold the greatest promise for the future, over the long

52692—60——17

haul, because of the opportunities they provide for fundamental research and training without special concern for departmental lines or for particular diseases, and because of the rich harvest of information which they will eventually make available for application by investigators committed to particular disease states.

*Research grants program*

The research grants supported by the Division of General Medical Sciences are providing for investigations along fundamental lines in areas which do not conform to the disease-oriented programs of any particular institute, but which serve strongly to support them all. This kind of research must be fully supported, for reasons which are self-evident. In the coming year it is predicted that new approved basic research projects could be activated for which about $12 million additional will be needed. This means that a total of at least $35 million should be appropriated for this program. It is difficult to overemphasize the critical importance of this fundamental research support program and the needs are clearly apparent.

*Clinical Research Center program*

The newest and most ambitious addition to the programs of the National Institutes of Health will make it possible for investigators to study human disease under conditions never before possible. This is the Clinical Research Center program of the Division which is funded by research grant funds. Up until now, research on disease has been made relatively easy at every turn up to the point of the disease in the human being, and here, for most institutions, impossible barriers have been encountered. To study human disease, under proper scientific requirements, with the same opportunities for controlled conditions that are required in test-tube or animal research, has been virtually impossible. For one thing, it costs more money than is available in the usual research budget. Each patient must occupy a hospital bed, and someone must provide the cost of hospitalization. In addition, research beds are meaningless unless there are dedicated clinical scientists to care for these patients and appropriate well-equipped laboratories immediately at hand. To set up such an arrangement has been an impossibility for most medical schools and university hospitals, and the general tendency has been to set to one side any ventures into research upon human disease and to rely on results from animal laboratories.

The new program is a breathtaker from the point of view of clinical researchers. Under it, they will be able to hospitalize patients with the diseases which they wish to study, and to design their experiments with the assurance that supporting research laboratories will be immediately available.

I know of no National Institutes of Health program which has produced such a stir and excitement in scientific circles in the medical schools. The general reaction has been "Now we can really get down to it."

This year, $3 million was appropriated by the Congress for clinical research centers. It is already so obvious that this direction is the right one that the money will be entirely committed this spring. For the coming year, I would recommend that this clinical research center program be immediately and substantially expanded, and that a sum of $15 million be made available.

*Research training grant program*

This relatively new program continues to pay off in terms of the increasing numbers of talented young people who are being attracted to careers of research and teaching in the basic science departments of the medical schools. The fields of physiology, pharmacology, biochemistry, microbiology, molecular biology, genetics, and the like, have been greatly strengthened by this program, and the process must be continued. Much is still to be done. The appropriation for this year was approximately $13 million, but there are already approved programs for which funds are not available totaling about $4 million. It can be predicted that new scientifically approved programs will be submitted in 1961 for which at least an additional $9 million will be needed.

The experimental training grant program, under which a dozen medical schools have conducted a pilot experiment directed toward the introduction of training in medical research for selected medical students while still in school, appears to have succeeded beyond expectation. This program should be continued and, in my opinion, expanded. The present program receives $500,000 annually. I recommend that this be increased to the level of $3 million.

In sum, the total support for the training grant program of the Division of General Medical Sciences should be increased to about $29 million for 1961. This may seem a drastic increase for a relatively new program, but this is because

it is meeting a great long-term need on the part of the basic science departments in all our medical schools. The program is sound and represents one of the best investments for the future.

*Research fellowships*

Through careful selection and wise administration, the research fellowships program of the Division of General Medical Sciences has achieved prestige and high quality. The senior research fellowships in the preclinical sciences have been notably successful. I would suggest that the restriction of these fellowships to the preclinical departments be removed, and that they be made available to clinical departments as well. The sole stipulation should be that they are for senior investigators in the fundamental health sciences, irrespective of departmental affiliation. The present program of senior research fellowships in the Division of General Medical Sciences should be expanded by an additional $1 million, to total $4 million. This expansion of the senior research fellowship program will be especially desirable as the new program for clinical research centers goes into operation. As we increase our facilities for basic research on human disease in special research wards, there will be a need for basic science trained senior research fellows as members of clinical departments.

I would suggest that the total funds for research fellowships be increased from the present level of $5,310,000 to about $9 million. Such an increase is well merited and will provide for needed expansion in all of the separate elements of this most important program.

I would like to reiterate a statement which I made before the committee a year ago. My colleagues in the medical faculties and my associates on the study section and training committees share my enthusiasm for the programs of the Division of General Medical Sciences, and have absolute confidence in the administration of these programs. I believe that this is the best and wisest approach to the solution of the vast problems which confront us in the years just ahead.

In closing, Mr. Chairman and gentlemen, I am summarizing my estimates of the various program needs of the Division below:

*Program needs of the Division of General Medical Sciences for fiscal year 1961*

| | |
|---|---|
| Research grants (regular program) | $35, 000, 000 |
| Clinical research centers | 15, 000, 000 |
| Research training grants | 29, 000, 000 |
| Research fellowships program | 9, 000, 000 |

I wish to thank you, Mr. Chairman and the distinguished members of your committee, for the privilege of presenting these remarks to you today.

(The following was subsequently received by the committee:)

DUKE UNIVERSITY MEDICAL CENTER,
*Durham, N.C., March 2, 1960.*

Hon. JOHN M. FOGARTY,
*Chairman, House Appropriations Committee for Departments of Labor and Health, Education, and Welfare, House of Representatives, Washington, D.C.*

DEAR MR. FOGARTY: After leaving your hearing room on the afternoon of Tuesday, March 1, I found myself deeply troubled on two counts.

First, I did not feel that either Dr. Thomas or I had succeeded in our oral testimony in conveying to you the deep sincerity of our convictions with regard to the program of the Division of General Medical Sciences and the national importance of the increased appropriations for the Division of General Medical Sciences which we had requested. I do believe that the case which we would make is better stated in our formal statements, so that I very much hope that you will find opportunity to read those.

Secondly, I certainly did not believe that you had received an adequate reply to your question concerning the justification for a request for increase in the appropriation to the National Institutes of Health in the face of a widespread demand for balancing the budget in this fiscal year. I rather suspect that our inability to provide such a statement lies in the fact that we come before you as expert witnesses with respect to the scientific and medical aspects of the matters which we discuss. When, however, we enter the field of Federal fiscal policy, none of us can pose as expert witnesses and can serve only as interested citizens with personal opinions but these latter opinions are based on limited experience and cannot possibly be given the weight with which I hope our professional opinions are considered. Nevertheless, I should like to place before you my own

"citizen's" opinion with respect to the problem which you raise and which clearly requires an answer. Should you find some merit in the statement below, then you might consider having it placed in the record of that hearing as an amendment to my testimony.

I do not believe that it is morally appropriate or the better part of wisdom to approach the problem of the support of medical research by first applying budgetary criteria. In all honesty, I do not find this an appropriate approach to the problems of national defense and security either. But there is a real difference between these two problems which should be made clear. I firmly believe that an appropriate treatment of the defense budget requires that one first ascertain the national requirement for armaments, production, research in new weapons, manpower, etc., before determining what these will cost. But the philosophy here, it seems to me, should not be one in which we divert the entire national effort into armament, production, and maintenance. As a nation, what we require is the minimum total defense effort which will guarantee our national security. To be sure, this would require a margin of safety and some knowledge of the armament production, etc., of our possible enemies. But if one can establish this minimum effort necessary absolutely to guarantee our national security, then it is pointless to go appreciably beyond that level in maintaining our military posture. By contrast, I believe that with respect to medical research there can be no such minimum posture. Rather, as stated on page 10 of my prepared statement, "It should be an article of faith that medical research in these United States should be pursued with all the vigor and talent which can be brought to bear and that our goal is the maximum effort of excellent research compatible with our resources of manpower, facilities, and the national economy."

There can be no need to belabor the fact that mankind is still beset by disease in many and diverse forms, and that despite the triumphs of medical science within our time only the smallest dent has been made in the problems of maintaining the health of our population. Our population is rapidly growing and, as noted by Dr. Thomas, it is appalling to consider the year 2000 and the number of hospitals, sanitoriums, nursing homes, physicians, and nurses which will be needed to provide even minimal care at that time. The total annual national medical bill for the year 2000 will be a staggering sum. From the humanitarian standpoint, to prevent that situation is a goal truly worthy of our national effort. From an economic standpoint, it is entirely clear that dollars invested in research in the next decade or two will be repaid many times over. If we can prevent this need for wholesale construction of hospitals and sanitoriums, if we can even partially empty our ever-expanding mental hospitals, if we can add 1 year more of useful, constructive life to the lifespan of each American and substitute that year for a year in which he would otherwise have been a dependent of society, the total return to this country in wealth would be enormous. Clearly, if the research which we hope to support is successful, it will enormously lower the burden of those who must balance budgets in future years.

Please understand that, while I fully believe that from the long-range standpoint the fundamental research and training programs of the Division of General Medical Sciences will have greater impact on the future health of the American people than will any of the other ongoing programs of the National Institutes of Health, and that while, as a biochemist, I can see no reason to believe that disease as we know it is a natural aspect of man's inherent biological character, I cannot in sanguine fashion promise that the research programs which we propose will indeed result in the eradication of disease in any form. But I can be certain, and this you will surely understand, that if we fail to support research, then in the year 2000 disease will be with us just as surely as it is today.

In this sense, therefore, I suppose that I am asking that our Nation risk venture capital in the enterprise called medical research. As a fraction of our national economy the costs are small albeit not trivial. Certainly they are of sufficient magnitude that no other agency or instrument of the American people than the Federal Government can possibly provide funds in the amounts required, one day to achieve this most remarkable and desirable of man's aspirations, the eradication of disease. I fully and firmly believe that it is a risk worth taking, indeed, a risk which we must take. If one believes as I do, that the venture will be successful and that many if not all of the diseases to which man is subject can one day be brought under control, then to attempt to distribute the costs over a longer period of years is both inhumane and economically unsound for the reasons cited above.

The great research triumphs of the last 20 years are not such as to have made a large impact on the health of the American people. The only exception to that statement, truly, is the availability of antibiotics and the large degree of control

over infectious processes which we can now bring to bear. Rather have the great triumphs been achieved in the general area of fundamental biological research. As compared to the time when I was a student, we have enormously expanded our understanding of the biology of man. Those of us in medical research again must take it as an article of faith that from such understanding will come clinical progress in the future. Let us, therefore, capitalize maximally tomorrow on the information and understanding which we have already gained. if we lose this bet, if even the enormous research effort which I envisage for the future proves unavailing, then man will still be ravaged by disease as of yore. This is an appalling prospect but not to have placed this bet is more appalling still.

This, then, is the argument which, in good conscience, I would offer to all who would reduce the possible national medical research effort because of budgetary constraints. The possible returns to our people are so great, that nothing less than the maximal effort compatible with our total supply of well trained, competent, imaginative scientists can be regarded as satisfactory. No costs can be too great. If such an all-out effort proves to be a strain on the national budget when the latter has been pegged at some arbitrary figure, then I submit that the national purse is ample. The American people enjoy the highest standard of living humanity has ever known. To divert so trivial a fraction of the national income into research which may permit our children or grandchildren to live in a world where many of the major diseases of humanity have been brought under control seems to me completely justifiable. In this instance the power to tax is not the power to destroy but rather the power both to heal and, hopefully, to prevent disease.

I know that this statement has been overlong but I feel strongly in these matters and wish to place them before you as honestly as I can. I do believe that this statement expresses the philosophy of most of my colleagues in medical research. To say more than that, to make promises or guarantees of great medical triumphs in fiscal 1961 or fiscal 1962 would be to break faith with you and the American people. This I cannot do.

With kindest regards,

Sincerely yours,

PHILIP HANDLER, *Professor and Chairman.*

## ARTHRITIS AND METABOLIC DISEASES

### WITNESSES

**DR. WALTER BAUER, CHIEF, MEDICAL SERVICES, MASSACHUSETTS GENERAL HOSPITAL, BOSTON, MASS.**

**DR. FRANZ J. INGELFINGER, PROFESSOR OF MEDICINE, BOSTON UNIVERSITY SCHOOL OF MEDICINE**

Mr. FOGARTY. Next we shall hear Dr. Walter Bauer, chief, medical services, Massachusetts General Hospital in Boston.

Dr. BAUER. Mr. Chairman and members of the committee, I am Dr. Walter Bauer. I appear before you today to speak on behalf of the activities of the National Institute of Arthritis and Metabolic Diseases. I welcome the opportunity to speak in support of the budget for this Institute.

I am the Jackson professor of clinical medicine at Harvard Medical School and chief of the medical services at the Massachusetts General Hospital. My past experience has included postgraduate medical study under Sir Henry H. Dale, England, the private practice of medicine in Boston, Mass., and approximately 4 years as chief consultant in medicine, the U.S. Army Medical Corps, Eighth Service Command, during World War II.

Having been engaged in the study of the rheumatic diseases for over 30 years, I have been very impressed with the rapid, orderly, and requisite growth of this particular Institute and its invaluable programs of grants-in-aid for the support of medical research and training

in the fields of arthritis, diabetes, and other metabolic diseases, gastroenterology, hematology, and last but not least, the newly conceived, rapidly developing field of physical biology.

During the 4-year period, from October 1952, to September 1956, I was privileged to participate in the deliberations of the National Advisory Arthritis and Metabolic Diseases Council. I shall long remember this profitable tour of duty. It was then that I learned, firsthand, of the splendidly conceived and directed program which the National Institutes of Health administers.

The execution of this total program required funds. These were made available in adequate amount only because of the valiant efforts of you, Mr. Chairman, and of your colleagues and Senator Hill and the members of his committee. I would be most remiss if I did not take advantage of this occasion to again thank you honorable gentlemen for what you have done to make it possible for the physicians and the scientists of this country to wage a more intense battle against disease.

These appropriations are responsible for the ever-increasing interest and activity on the part of both professional and laymen concerning the importance of medical research in our efforts to alleviate and to prevent human suffering. The rewards, therefore, can be attributed in large part to the farsighted and aggressive leadership which you gentlemen have displayed so consistently. This, as I have said before, remains one of the great untold stories in the history of medical research in this country.

The National Institute of Arthritis and Metabolic Diseases was founded approximately 10 years ago. This marked the beginning of a new era in medicine. Yes, it was a most important innovation. It was much more than the establishment of one additional center for the study of certain of the baffling chronic ailments which relegate millions of our fellow citizens to lives of restricted activity and productivity, frequently accompanied by sustained severe pain. Although the contributions to increased medical knowledge by its own scientists would be more than sufficient to justify the formation of the Institute and its spectacular growth, there is another aspect of this undertaking which I think is of even greater significance. It meant that at least the tremendous moral and financial resources of the people of this great country were being brought to bear through their Federal Government in the fight against such chronic disabling diseases as arthritis and diabetes. Thus, attention was called to the importance of these afflictions in terms of their impact on the Nation as a whole as well as on the patient and his family.

Within a short time after the founding of the Institute came the programs which today are so vital to our growing knowledge concerning the cause, prevention, and cure of disease; namely, the grants-in-aid for research and for training. A perusal of the list of scientists supported in their endeavors by the National Institute of Arthritis and Metabolic Diseases reads like a "Who's Who" of a large segment of American medical research. They range from those investigators whose talents are devoted to determining the physical and chemical characteristics of a single enzyme to clinicians attempting to translate the increasing understanding of the fundamental nature of various disease processes into immediate improvement in the treatment of long-suffering patients.

My own field of rheumatology may well be used to illustrate these truisms. Just prior to the Institute's establishment had come the dramatic demonstration by Hench and his associates at the Mayo Clinic of the effect of cortisone in rheumatoid arthritis. This provided the practicing physician with the most highly promising therapeutic agent yet to be placed in his hands. Yes, it was probably the greatest single stimulus to an augmented research effort on the large group of diseases which are included under the heading of arthritis.

However, this markedly increased research interest on the part of a wide variety of top-flight investigators would have been to little avail if the National Institute of Arthritis and Metabolic Diseases had not been in the position to provide the financial support needed for these endeavors.

Thus, the Institute on its 10th anniversary must be accorded a share of this glory and with it should stand the many farsighted members of Congress, public-spirited citizens and professional people who have fostered the Institute's sturdy and productive growth.

Where do we stand as a result of the efforts of the past decade? Though the causes of these diseases still elude us, gigantic strides have been made toward that objective. On the very practical side a whole new family of useful drugs have been added to the physician's armamentarium.

While the initial claims of some of the discoveries and developments may have been unduly optimistic, nevertheless the advent of cortisone and its relatives have wrought welcome changes in the daily lives of many pain-racked, crippled vicitms of rheumatoid arthritis. The sufferers from another member of this same family of rheumatic diseases, gout, have also witnessed remarkable improvements in treatment through the development of new drugs and more effective use of older remedies.

Paralleling these visible achievements are others, however, which will prove even more important in terms of prevention and cure. For example, we now know vastly more about the tissues (the connective tissues) which are affected in the various forms of arthritis. Everincreasingly successful efforts continue on the chemical and structural characterization of the components of connective tissues.

Here we witness the contributions which the biochemist, the biologist, the biophysicist, the organic chemist, the physiologist, and other basic scientists are making in a field where a decade ago few scientists were at work.

With the recent discovery that rheumatoid arthritis patients have in their blood a substance which is not present in the blood of other individuals, the immunologist has joined the team. As yet the role of this so-called rheumatoid factor is not clearly understood. We do not know whether it is involved as a causative agent or rather results from the disease.

We do know, however, that it has certain of the characteristics of an antibody, which suggests that the disease may have an immunologic basis. We also know that it frequently may be found in healthy members of a patient's family. This leads to speculation that there may be a genetic factor implicated. At the present time, though, these are merely promising leads which beg for expanded study until they can be confirmed or discarded.

Although I could continue at length describing the exciting developments of recent years and the thrilling opportunities of the immediate future in the field of arthritis, I would like to discuss another of the major chronic diseases for which this Institute has assumed responsibility since its establishment.

Diabetes is one of the most important and certainly the most prevalent of that vast group of afflictions which we term "metabolic diseases." Like arthritis, it directly affects the lives of millions of people in this country. Its complications are varied and severe. As the aging of the population in the United States rises, the incidence of diabetes has increased.

As the life expectancy extends, this increased frequency of diabetes will be even more evident, for we know that the majority of cases of diabetes have their onset between the 45th and 65th years of life. Indeed, in 1956, diabetes was in 8th place in the list of causes of death in this country, whereas in 1900, it was in 27th place.

Furthermore, it is rapidly becoming a leading cause of blindness, especially in the younger age group. Diabetes also adversely affects components of the nervous system. In consequence, 70 percent of diabetics of 10 or more years' duration experience disturbing and disabling neurological complications.

Diabetes apparently aggravates and may actually induce coronary artery disease. As the ability to prolong life in the diabetic increases, this complication becomes an ever-growing problem and is now the major cause of death among diabetics generally.

What developments have occurred in this field and what does the future hold? Well, for example, we now know that diabetes is a very complex disorder involving not only sugar metabolism, as has been recognized for years, but also changes in the metabolism of fat and protein as well. In fact, the techniques which have been developed in diabetes research have played a most important role in opening up the whole new field of regulatory biochemistry, which concerns the vital controlling relationship between carbohydrate, fat, and protein metabolism. Another extremely significant development is the tremendous increase in our knowledge of the insulin molecule and its mechanism of action.

Several groups of firstrate investigators are continuing highly productive studies in these areas. One particular interest in this type of investigation is the determination of which portion of the insulin molecule is actually responsible for its biological activity. As for its mechanism of action, recent studies have shown that insulin plays an important role in facilitating the transport of glucose across cellular membranes so as to place this energy-rich substance at its site of action.

Incidentally, studies in this area beautifully illustrate the interdependent character of scientific investigation. The whole question of the nature of cellular permeability, that is, how substances pass into and out of body cells, is a natural for the newly developing field of physical biology. Furthermore, answers in this area are not limited in importance to diabetes alone, but are fundamental to the very riddle of life itself.

As a final example of a recent major advance in our conquest of diabetes, I would cite the advent of the oral antidiabetic agents, which like cortisone in rheumatology, have already proved a boon

to thousands of diabetics who previously had been forced to rely on daily injections of insulin. Again, like cortisone, they have provided a tremendous stimulus to accelerated and expanded research in this field. We still have much to learn about these agents, but the vistas are thrilling.

What of the future then? It seems likely that if the present growing pace of increases in our knowledge can be maintained, we will soon be able after a series of tests to predict those individuals who are prone to diabetes. Not long after that, it may be possible by appropriate means to at least delay the onset of clinical diabetes for appreciable periods. Though the ultimate goal of cure and total prevention may remain in the rather distant future, we can offer the expectation of major breakthroughs if these immediate opportunities are diligently pursued.

It is reassuring to observe the growth in this Institute as existing programs are broadened and responsibilities for new activities are assumed in keeping with the evolutionary processes of the medical research just described. Subsequent to my service on the National Advisory Arthritis and Metabolic Diseases Council, the Institute has given impetus to a number of new programs, among them gastroenterology, hematology, and physical biology, upon which I will elaborate with your permission.

As my esteemed professional neighbor in the Boston scientific community is also appearing before you today, I will leave a detailed discussion of the special problems of gastroenterology to him. However, in passing I would like to make a few remarks.

Reliable and current figures on the prevalence of a disease are always difficult to obtain and are subject to revision. However, it may serve to emphasize the magnitude of gastroenterological disease as a medical problem if the oft-cited figures are mentioned once again.

The diseases of the digestive tract are second only to circulatory diseases as a cause of attended illnesses in the United States. It is also estimated that 10 percent of the world's population is subject to peptic ulcer. To the more prominent diseases in this group, such as regional ileitis and ulcerative colitis, has been added cystic fibrosis. In addition, there are many digestive disturbances attributable to liver disease, gallbladder disorders, and malabsorption, as well as the various types of diarrhea and dysenteries of unknown etiology.

Although ulcerative colitis remains an enigma, its ubiquitous association with other disease processes is well known. One of the most tenable hypotheses as to the cause of ulcerative colitis is that it has an immunologic basis. The frequent association of ulcerative colitis with rheumatoid arthritis is being considered as more than a casual one in some circles. This latter possibility plus the accumulating evidence suggesting immunologic activity of unknown nature playing a prominent role in rheumatoid arthritis suggest common causal relationship.

This triumvirate could well hold the answer to some of the oldest and deepest mysteries of medicine. The establishment of such a relationship would be a classic example of the common mechanisms underlying biological processes of diverse external manifestations such as the physical biologists are seeking.

Hematology comprises the study of the numerous and various blood cells as well as the tissues and organs where blood cells are formed,

such as the bone marrow, spleen, liver, and lymph glands. In diseased states, the numbers and confirmation of the bloodcells may be altered. More subtle changes may also occur, such as alterations in hemoglobin composition and immunologic responses. Such changes may be manifest as hemolytic anemias, hypoplastic and aplastic anemias, hemostatic defects in blood coagulation, disturbances of hemoglobin formation, and gamma globulin disorders.

Hematological disorders are not as far from the traditional activities of this Institute as might first appear. Inadequate nutrition is the cause of certain deficiency anemias. Such gastroenterological manifestations as malabsorption, sprue, steatorrhea, and celiac disease also result in anemias. Likewise, hematological techniques offer an excellent tool for investigating such nutritional problems as the metabolism of iron, copper, and other minerals of the blood. Hematological diseases are unique in that much of the diagnostic data they provide are relatively unequivocal, and for a large part, numerical in form. These are all characteristics which lend themselves quite well to the application of computers to diagnosis which has so intrigued the physical biologists and engineers. The comprehensive and infallible memory of the digital computer is an obvious asset in diagnosis as is the possibility of elaborating a mathematical logic for diagnosis. Such investigations are in the most preliminary stages.

In physical biology, physicists, physical scientists, and mathematicians are applying concepts and methods of the physical and engineering science to biological problems. Immunochemical reactions, or the well-known antigen-antibody response in disease, is one of the problems of concern to biophysicists. Despite the numerous examples of such reactions, as the recently developed test for the rheumatoid factor, the rejection of tissue grafts, the unfavorable reactions in blood transfusions, the self-destruction of intestinal tissue by antibody reaction in ulcerative colitis, and the resistance to insulin, are all problems of grave importance to this Institute. Little is known about either the molecular structure, size, or shape of antigens or antibodies or the mechanism by which they combine.

The molecular size, structure, chemical composition, and arrangement of amino acids in proteins are being studied by X-ray, electrophoresis, ultracentrifuge, and electron microscope techniques.

Collagen, a component of the connective tissue affected so prominently in arthritis, is one of the fibrous proteins being actively and intensively investigated. The nucleic acide, deoxyribonucleic acid (DNA), the genetic material of all living cells, and ribonucleic acid (RNA) are likewise subjected to study by the same biophysical methods as are the enzymes, muscle, and hormones which RNA appears to control.

The energy storage and transfer in cells whereby the chemical energy of food is stored in tissues and may be transformed into mechanical energy in the contracting muscle, or into the needed energy in transmitting a nerve impulse, or the synthesis of living protoplasm essential to growth and reproduction, is likewise of great interest to the physical biologists. These are only a few examples which serve to show how physical biology is concerned with fundamental mechanisms, common to all living processes, whether they be normal or diseased.

During the course of this presentation, I have mentioned a number of the areas of medicine either by disease entity (diabetes) or by ana-

tomical system (gastroenterology) which fall within the interests of this Institute. From the foregoing, something of the breadth of the Institute's responsibility may be inferred. This, in itself, is worthy of further comment. The guidance of which this Institute is known to have availed itself, although at times perhaps visionary, we hope has always been tempered by the appropriate note of realism, although no claim can be laid to omniscience. The collective voice and opinions of such guidance have always been unanimous in the belief that the cure, treatment, or prevention of any given disease will not be found within the narrow limits of information available about that disease organ or system, but in knowledge of the wide horizons of medicine and biological sciences. This philosophy is not only symbolized in the name of this Institute, i.e., the National Institute of Arthritis and Metabolic Diseases, but is manifest in the programs as they are supported today and as you have heard them described during the course of your hearings.

Within the charter of this Institute lies the responsibility of supporting the investigation of many of the major problems of medicine as they are known today, and as we can be sure, of almost an infinite number of others that will turn up in the course of future investigations as we learn to recognize them. It is for these reasons that the need for funds with which to continue and expand research programs, as well as to train promising young researchers, continues to be great.

### BUDGET RECOMMENDATIONS

With these thoughts in mind, the Citizens Advisory Group has prepared a summary of the estimated financial needs of this Institute for the coming fiscal year. I am told that these figures, excpet those requested for new programs, have been prepared according to the methods employed in previous years. Therefore, they may well prove entirely too conservative, as have the estimates for each earlier year. Of this group, then, based on estimates submitted by the National Advisory Arthritis and Metabolic Diseases Council, the following sums represent a reasonable and justifiable estimate of the Institute's needs:

| | |
|---|---|
| Extramural: | |
| Research grants | [1] [2] $42, 500, 000 |
| Research fellowships | 800, 000 |
| Training | [3] 12, 700, 000 |
| Total | 56, 000, 000 |
| Direct operations: Research, review and approval, administration | 9, 764, 000 |
| Total | 65, 764, 000 |

[1] Includes $3,000,000 for metabolic research centers.
[2] Computed at 15 percent overhead; if raised to 25 percent, the figure would be increased to $45,881,000.
[3] Includes $4,200,000 for undergraduate training grants in fields of arthritis and rheumatic diseases, metabolic diseases, gastroenterology, hematology, endocrinology to 84 medical schools.

Of the increase in research grants, $3 million is included for the program dealing with support for "metabolic research centers." These centers are vital for the study of certain human diseases. They are designed and equipped so as to permit the doing of very detailed metabolic studies of patients. In this setting, the investigator is less concerned with thinking up questions to put to nature than with

trying to solve the problems that nature puts to him in the form of patients with maladies, crying for understanding.

Since patients are required for clinical research, and since hospitals are the places where patients can most easily be found and studied, it is in hospitals that "metabolic research centers" are located. But laboratories are just as necessary to this type of research as are hospital wards, and they must be in close proximity to patients; therefore, recent decades have seen a great development of research laboratories within the confines of certain hospitals.

Scientific research in medicine is, for the most part, within the areas of such disciplines as chemistry (physical and biological), biology (including genetics), physics, and other basic sciences. The social sciences are also necessary. The personnel for "metabolic research centers" may be drawn from any of these disciplines. Some are doctors of medicine. Some of these physicians have acquired further education in basic sciences and have become basic scientists in their own right as well as being physicians. A collaboration of persons with widely different skills and scientific approaches, focused on an object of common interest, has become essential. It is this type of team research which takes place in a metabolic research center.

Needless to say, patients who are studied and treated in such centers become active members of the research team. Some of us believe that these centers, where both basic and applied work is done simultaneously and often by the same people, constitute a highly favorable environment for research—quite possibly superior to isolated and specialized environments. I can cite any number of instances where the research of today in a unit of this type becomes the treatment of tomorrow—sometimes, complete cure of the disease.

I understand that the prototype of this program is now being developed, using funds appropriated by the Congress last year. The wisdom of the Congress in starting the program on a relatively small basis is evident, but from what I hear, the need has far exceeded the supply. In addition, in certain institutions, although topnotch investigators in one or several clinical and basic fields may be available, the ancillary personnel may not be sufficient to man a program cutting across all areas of clinical investigation. For this reason, it seems entirely fitting to support in certain institutions superior research of this nature in a specific categorical setting. The establishment of a facility for rheumatic diseases, diabetes, et cetera, within an institution would not only enhance the institution's own programs, but would bring into the picture the fulfillment of a long-standing, serious need for the execution of this type of clinical research.

Of the remaining increase in research grants, a sum is included to meet commitments, and to allow for the normal increase in the program, as measured by anticipated new approved applications.

Although this Institute is almost 10 years old, funds for graduate training grants have been available only since fiscal year 1955. At the present time, a little more than half of the medical schools of the Nation have established graduate training programs in one or more of the following areas: rheumatic diseases, diabetes, gastroenterology, hematology, and physical biology. This program has undergone orderly growth, and establishment of new centers has been coincident with turning out men of program director caliber from existing training programs. The funds requested for graduate training grants for

fiscal year 1961 would continue existing programs and would permit the formation of some new training centers. A total of $8,500,000 is needed for these purposes.

In spite of the desirable features of the graduate training programs, another need for attracting able young men into the important areas covered by this Institute has become increasingly apparent. This has to do with the training of undergraduate medical students in metabolic concepts. For a number of years, certain of the National Institutes have emphasized undergraduate indoctrination in their fields of interest by the award of grants to the schools for this purpose.

Such programs have been invaluable in providing funds in the several areas by strengthening departmental facilities for such training. Grants of this character make it possible for medical students to obtain training in areas which might otherwise be neglected, or at the best, only superficially treated. Such programs of training not only stimulate interest in research in the respective fields, but also give to the Nation physicians whose training is better balanced—men with a broader approach and fewer blind spots regarding the entire area of metabolic diseases. In addition they make for more balance within the institution, or the department itself.

After due consideration regarding the development of new programs for this Institute, we feel, Mr. Chairman, that the time has come to initiate in our medical schools undergraduate training programs in the field of arthritis, diabetes, gastroenterology, and hematology. The remainder of the sum requested ($4,200,000) in the training grants' area is to get such a program underway. This would make available approximately $50,000 to each school for coverage in arthritis and the other metabolic areas.

The item of $800,000 for research fellowships is in contrast to the $437,000 in the President's budget. I am told that the Institute has been unable to pay approved applications for research fellows this fiscal year in the amount of over $300,000.

Another important area of scientific investigation that is getting far too little recognition is the geographic study of diseases. Although human beings are fundamentally the same all over the world, there are great differences in disease patterns from one area to another, and many variations in disease susceptibility have been noticed between one population group and another.

Knowledge of these different disease patterns—why some populations are more susceptible to certain diseases than others—may well provide the vital clues we need to understand the diseases that have not yet been conquered.

No doubt a variety of factors are creating these disease differences. Some of them are very obvious, such as the particular eating habits of a population, or the climate and altitude of a country. But aside from these, there are probably many others that are much more subtle and perhaps have much greater significance. Specifically, more research is needed to determine what genetic effects may be involved, and what inborn characteristics may influence a person's susceptibility to disease. Concurrently, we must double our efforts to understand just what the gene is, and how it operates.

For example, in arthritis research, geographic studies would provide us with a better understanding of the predisposing factors as well as more definite information about the forms of arthritis and how they

may differ throughout the world. Apparently, certain groups of people within a population are more susceptible to arthritis than others and certain populations as a whole have a higher incidence of the disease than others. A careful examination of these differences on a worldwide scale might provide essential information about why some people get arthritis and some do not.

Another example is diabetes. There are striking geographic differences in this disease also. The highest mortality rate from diabetes is in the United States, with other English-speaking countries including Canada, Australia, and New Zealand closely following. The death rate is lowest of all in the underdeveloped countries. Studies of these reported differences are vitally needed.

Peptic ulcer, too, shows interesting geographical differences. About 10 percent of the U.S. population suffer at some time in their lives with this condition, while other countries, such as northern India and Malaya, report lower incidences. Geographic research would help clarify the roles played by seasons, diet, occupation, emotional stress, as well as genetic factors.

In general, I believe we need to increase all our efforts in geographical studies, not only to help solve local disease problems, but also to provide more accurate knowledge of man in general, and how he is affected by the food he eats and the environment in which he lives.

One of the Institute's programs in nutrition research which is particularly noteworthy is that of the Interdepartmental Committee on Nutrition for National Defense (ICNND). The principal work of the ICNND has been to organize nutrition survey teams of consultant specialists in medicine, dentistry, nutrition, agriculture, and food technology which, on the invitation of a foreign country, make 90-day surveys of the nutritional status of the population. The surveys are conducted in cooperation with counterpart personnel supplied by the host country and have rendered an extremely valuable service in pinpointing the major nutritional needs within the country, and recommending practical ways to correct them.

The surveys have helped to initiate much research in nutrition, not only in foreign countries, but in the United States as well. Scientists from more than 30 universities have participated in these surveys and have been afforded increased opportunities to contribute directly and indirectly to important new knowledge.

Until recently, survey emphasis had been largely on the military populations since the ICNND's program received its major financial support through the U.S. mutual assistance program of the Internal Security Agency of the Department of Defense. Now, it has become possible to expand, somewhat, the operations of the teams so that surveys of the civilian populations can be made as well, and the addition of these larger and more diverse civilian groups has provided much more additional information of research interest.

I believe that even greater support is needed in this area so that this civilian survey work can be further expanded. Not only does it have a potent international influence, but it provides us with the opportunity to study striking clinical deficiencies and nutritional disorders that are no longer endemic in this country. The basic information gained from such studies far overshadows the relatively small cost of the ICNND's program.

In closing, I wish to thank the committee for the privilege of being allowed to participate in these hearings. I hope that I have been

able to contribute something that will be of help to you in your deliberations.

Mr. FOGARTY. Thank you, Doctor.

That was a very fine statement.

You remember a year ago, when we were here, we were discussing the two or three budgets we had before us, because the Secretary and the President had not made up their minds at that time what final budget was going to be submitted to the Congress. I ask you now the same question I asked you then:

You are asking for about $18 million more than is in the President's budget. There are the same demands that we balance the budget. What is the best answer to people who say "we can't do this because we have to balance the budget."

Some of us believe in these increases, but that is what is often thrown at us by other Members of Congress.

Dr. BAUER. I do not know that I have any better answer than the one I had last year, but I feel very strongly that from the point of view of our having a more vigorous and better citizenry, I know of no better way to do this than to try to cure disease or understand disease so that some day we can prevent and cure it. And unless we do this, we are certainly going to be losing out on something which could otherwise be an asset.

As I said, last year, I am not too expert on how to balance any budget, but this would be my plea, if I had to appear before the Budget Committee, that I think this is something we owe to the people of our country and to the country as a whole.

Mr. FOGARTY. Could you tell us briefly what advances have been made in arthritis?

I have many items in the bill to answer to when I get before the House, and I cannot generally take more than 5 minutes on any one question to answer it. There are some people in Congress who do not believe in research, and just get up and make the general statement that there are still so many million people affected by arthritis and research that has cost millions of dollars still hasn't produced the answers.

How do I answer in just 5 minutes?

Dr. BAUER. If we do not know the cause and the cure of the one that really cripples, namely rheumatoid arthritis, we certainly can keep the patient in a more nearly normal state than we could 15 years ago.

In the case of the disease now called gout, which is not as prevalent as the one called rheumatoid arthritis, if they would adhere to the program outlined, after a few years, stand a very good chance of not having any further attacks of the disease; the high uric acid can be completely controlled, and you can actually change the life of this individual. The deposits of uric acids in the body can perhaps cause other changes in this individual, perhaps hardening of the arteries, in life.

It remains to be shown whether in people treated for years, some of the inroads which are eventually responsible for death in such patients can be prevented.

These are very substantial advances compared to when I entered the field 30 years ago.

Mr. FOGARTY. I would like to try to confine it to, say, the last 5 or, at most, 10 years.

Dr. BAUER. I say that these two that I have mentioned certainly come in the last 10 years.

Whether we will be ever able to achieve the end which we wish, prior to finding the cause of the disease, to find a means whereby we can control the incidence of the disease without having an ill effect such as cortisone and some of these other methods, are some of the possibilities we strive for, and we are closer than we were, say, 10 years ago.

Mr. FOGARTY. Do you think that would satisfy people who are opposed to increases in programs like this?

Dr. BAUER. Well, I think one of the most important things that is going on, and this is not anything immediate, from the point of view of being applicable to the man on the street, is, that we are going to have to know, before we really find the nature of the disease, and until we know the nature of the disease, how to come to grips with the causes of the disease or the cure, and that is the nature of the tissues that are afflicted in these diseases; what goes askew in them, and what this means in terms of a biochemical or biophysical or other abnormality. And certainly this is where some of our heavy investments have been made, and will have to continue to be made. So that now, as compared with 5 years ago or 10 years ago, our knowledge of the tissues afflicted in these diseases is materially advanced.

I don't think we can compromise anybody; that in the case of the chronic crippling diseases, that short of some unusual stroke of luck the answer in terms of prevention and cure is going to be at hand, in a matter of 5 or 10 years.

But we will accumulate information which will some day enable us, if we know the normal, to examine the abnormal in terms of the normal, and once we see the difference, we can then have a more direct lead as to what this means in the way of a disturbance and how it can be prevented and how it can be determined.

Mr. FOGARTY. The Secretary told us, when he was before us, that this is a budget that makes it possible for us to move forward in a significant manner, in all of these program areas.

Dr. BAUER. Yes.

Mr. FOGARTY. He was talking about his budget. But here you are asking for $18 million more than he was.

Do you think the budget that the administration is proposing would allow "significant advances in medical research"?

Dr. BAUER. Well, it won't allow one for recruitment of oncoming doctors. It won't allow for support of but few new research projects, on the basis of the increasing program demands. It won't allow for us to indoctrinate medical students, and create an interest in it, so that once they have obtained their general medical training, they will want to come back into these areas, to actually do investigative work, and this, of itself, represents a little over $4 million of this increase.

And then the special research centers would account for $3 million more, which, as you know, would be located in hospitals, where all of these people can come together in a much more concerted manner than they ever had before, from the point of joining hands and really trying to go to town.

Mr. FOGARTY. In other words, this budget we have before us, the administration's budget, would not allow for any real significant advances in research?

Dr. BAUER. It would not. It certainly would not.

Mr. FOGARTY. Mr. Denton?

Mr. DENTON. No questions.

Mr. FOGARTY. Is there anything else you would like to say?

Dr. BAUER. No, thank you.

Mr. FOGARTY. Thank you, doctor.

STATEMENT OF DR. FRANZ J. INGELFINGER

Mr. FOGARTY. Now we have Dr. Franz J. Ingelfinger. Please proceed, Doctor.

Dr. INGELFINGER. My name is Franz J. Ingelfinger. I am professor of medicine at Boston University School of Medicine, and my major professional interest during the past 20 years has been the field of gastroenterology.

I am chief of the Section of Gastroenterology at the Massachusetts Memorial Hospitals, consultant to the Boston Veterans' Administration Hospital, and vice president of the American Gastroenterological Association. As the digestive system editor of the Year Book of Medicine, it has been my duty during the past 6 years to review insofar as possible, the world's literature pertaining to gastroenterology and to select the most significant contributions in this field.

Mr. Chairman, I should like to tell you and your committee how much it means to me to be able to be here and testify in behalf of the National Institute of Arthritis and Metabolic Diseases. In the first place, I consider it a great honor to appear before you in behalf of this great institute.

In addition, however, I am grateful and devoted to the Institute for what it has accomplished in the sphere of gastroenterology within a very short time. The category of gastroenterology includes disorders of the esophagus, the stomach, the small bowel, the colon, the liver, the gall bladder, and the pancreas. But although disorders of these many organs must encompass a large proportion of human ills—at least one-quarter, I should judge—none of the National Institutes of Health was specifically interested in gastroenterology, which is an unpronounceable word for many people but not for you.

Mr. FOGARTY. It was until a couple of years ago when Dr. Barborha taught us a little about it.

Dr. INGELFINGER. Until 1956. At that time, the National Institute of Arthritis and Metabolic Diseases established two training grants in gastroenterology, and our section at the Massachusetts Memorial Hospitals was fortunate enough to be one of the first two recipients. That the Institute of Arthritis and Metabolic Diseases had recognized a great need is clearly evidenced by the fact that in the short 3½ years intervening since then, aid to gastroenterological projects has so mushroomed that currently some 300 research projects and 30 training grants are supported in that field.

During this rapid growth of support by the National Institute of Arthritis and Metabolic Diseases in behalf of gastroenterological research and training, I have had the privilege of serving on committees

of this Institute for the purpose of screening and reviewing applications for gastroenterologic support.

This opportunity that I have had has afforded me an intimate ide of how much the National Institutes of Health does do and can do for the health of the American people. It has shown me the wisdom and foresight of congressional leaders who, like yourself, Mr. Chairman, have laid and maintained the foundations of the world-famous unit now existing at Bethesda. It has allowed me to see the unbelievably fair, efficient, and considerate methods by which the programs of the National Institute of Arthritis and Metabolic Diseases have been administered. I have been able to witness the happy enthusiasm with which physicians interested in gastroenterology throughout the country have accepted and sought help from this Institute. But I hold still a fourth conviction: Although a great beginning has been made, it is only a beginning. Much needs to be done.

The program in gastroenterology is 3½ years old, but I think much needs to be done; and that is why I am here to support a request for additional appropriations.

Members of Congress may wonder, Mr. Chairman, why gastroenterology, if diseases in this category are so prevalent, should be such a relative latecomer on the scene as far as support by the National Institutes of Health is concerned.

It might even give some Members of Congress the false impression that such disorders are trivial, infrequent, or unimportant. Nothing could be further from the truth, Mr. Chairman.

But certainly, if you include things like heartburn, constipation, and indigestion—and when I came in, there was a well-known antiacid posted right over there, so whoever sat there before was suffering from some gastroenterological complaint—we realize it is with us all the time and we need to study them.

Mr. Fogarty. Do you have any problems?

Dr. Ingelfinger. Yes. I don't use that brand, though.

Dr. Bauer told you about the prevalence of ulceration, which is a common thing. If, as is maintained, nearly 1 out of every 10 Americans has a peptic ulcer of his duodenum or stomach sometime during his life, how can it be unimportant? Among males employed by the Metropolitan Life Insurance Co., moreover, diseases of the digestive system rank next to diseases of the respiratory system as the major causes of disability, outranking both diseases of the circulatory system and accidental injuries (Statistical Bulletin March 1958, p. 2).

In one year, nearly 1½ million people were hospitalized in our country for gastrointestinal conditions, excluding hospitalization for cancers of the digestive system.

In relation to the field of cancer, of course, the nonmalignant conditions of the digestive system are less urgently dramatic and less fatal, but what they lack in fatality they make up for in prevalence.

Furthermore, the suffering and tragedy caused by some nonmalignant gastrointestinal conditions rival or even exceed those attending cancer. Thus ulcerative colitis, for example, may run a fatal course or may require surgery that creates an artificial intestinal opening on the abdominal wall.

The same, of course, can be said of rectal cancer; but the cancer patient is usually past middle age, whereas the ulcerative colitis victim is usually in the prime of life, or frequently even a boy or girl in the

teens. And I think that is something that is often forgotten when talk is about incident of disease. Incidence of diseases at what age is another important factor.

May I next present some specific reasons for increased support of training programs in gastroenterology. Compared to his colleagues in other branches of internal medicine, the gastroenterologist is somewhat at a disadvantage because the organs with which he is concerned lie deep within the body. For the most part, he can neither see nor feel them. Fortunately, modern science and technology have provided him with instruments and techniques, such as X-rays whereby he may evaluate indirectly what he cannot appreciate directly. Proper use of such techniques and—even more important—proper interpretation of their results require, however, training and skills over and above those required by the good internist. Thus the average young physician preparing himself for gastroenterology a decade or more ago emphasized skills: How to perform and read X-rays, how to do endoscopy, that is, the passing of tubes and periscope-like instruments into the hollows of various digestive organs, and how to take biopsy samples of liver tissue safely by means of needles introduced through the skin. This emphasis on skills, however, had its deleterious as well as beneficial effects. The gastroenterologist became very adept at description; he could tell what was going on, but he had little time to wonder why it was happening.

But I think the gastroenterology training grants established by the National Institute of Arthritis and Metabolic Diseases have changed all this, for they have insisted that basic science, the study of mechanisms, and the why and wherefore of digestive tract disease be studied, as well as practice given in diagnostic techniques.

So now I think most of the training, influenced by this attitude of the Institute, has changed, and consequently a trainee still gets exposed to learning skills, but also a great deal through basic science and correlation of basic science.

The fact that this is often combined with research programs has, of course, helped this trend. You may wonder what this means in terms of the budget. To me it means that gastroenterological training is a pretty expensive thing, because not only do you have to train them in the usual medical science and arts, but have to provide them with facilities, and expensive facilities, these gadgets which they have to learn to use, because it still requires the use of such skills to practice the subspecialty.

With respect to these training grants, the question is why the amount devoted to them or appropriated to them should be increased. And the problem is this: that at present we still do not have enough trainees, graduating from these training grants, to fulfill the requirements. In many institutions they write asking, "Do you know of a young man who can head up our gastrointestinal program?" As I indicated in my statement, I get from three to seven letters from institutions every year looking for those people, so certainly at present there is a big need, from our medical schools and sometimes from VA hospitals, for capable people trained in the field of gastroenterology.

Incidentally, about half the medical schools in the country, a little less than half, do not have specific gastroenterological training at present, at least as far as I know.

In the field of research in gastroenterology you can cite many examples, and I would like to cite a few, to indicate what some of the needs are, as examples.

I have just mentioned before that we gastroenterologists have to depend upon gadgets to find out what is going on inside, because we cannot feel and get hold of the organs and we cannot apply stethoscopes too effectively, and we need instrumentation, but in spite of all the technological advances available to us there is one organ that is still almost wholly inaccessible, and that is the pancreas. This is situated high up in the abdomen, and there is no X-ray that will pick up a growth on the pancreas over on the left side. There is no test for it. Of all the screening tests in the world at present, I know of none that will pick up a tumor in that area. But this is something I think could really be solved by a massive attack. After all, somewhere in all the chemical knowledge and the isotopic developments that are going on, there must be a means for diagnosing diseases of this organ, and I am not referring to diabetes, which is another type of pancreatic disease. I am talking about inflammation or cancer of the pancreas. There must be some way of discovering and diagnosing disease in these organs at an early stage. At present it is so bad in the case of the pancreas on what is called the tail, on the left side of our body, that once a cancer is there it is incurable, as far as any ordinary circumstances are concerned.

Now, I would like to talk about two or three ailments which deserve research, two of them for one reason, and one for another. Two of them are rather uncommon, but I mention them because there are leads available, and once we have leads one can pursue leads, and there is promise of finding out something.

One is a condition called celiac disease in children, or sprue in adults, and the trouble about it is that a person who has it cannot absorb foods adequately, and no one knows exactly what causes it, nor until a few years ago was it known how to treat it. At that time a Dutch physician discovered some very dramatic treatment for this, and my friend, Dr. Sleisenger, of Cornell Medical Center, has been kind enough to send me some pictures to show you, before and after, of some old and young women with this illness.

Before and after, a 20-year-old woman, and here of a 60-year-old woman, one I think 6 years' difference and another one 2 years' difference. You see one is potbellied and skinny and the other picture shows blooming health. And the only thing done to make these people better was to keep them from eating what in effect is white bread. In other words, wheat starch is the offending target, or factor. In wheat starch is something called gluten, and these Dutch physicians found merely by eliminating gluten from the diet you can make people healthy who have been ill-nourished and sick and incapacitated.

This is a big lead. Many people are pursuing it in this country and elsewhere, and it should be pursued. Why gluten caused it or what is the trouble, we still have to find out, but I merely cite this to show it as one of the major advances made within the field of gastroenterology within the past 10 years.

Another condition which has been studied a lot in recent years is also not very common, to be sure. It is a disorder of the esophagus, the swallowing tube, which goes by the fancy name of either cardio-

spasm or achalasia. And although not common, the person who is afflicted, because he cannot swallow, considers it important enough.

The study of this disorder exemplifies that even studying a rare disorder helps in other ways, because this disorder happens to be or seems to be a disorder of nervous control of the esophagus, so if we find out what is wrong we will find out more about how the esophagus works normally or in other diseased conditions. There have been many theories about what caused this disease, cardiospasm, but nobody got much one way or the other until at a recent international Congress of Enterologists, to which the National Institute of Arthitis and Metabolic Diseases contributed, and was held here in Washington, it became apparent there is lots of this cardiospasm in Brazil, and particularly not far from Brazilia, where the President was, their new capital. In the hinterlands there they have thousands of these cases, where we see them in the United States in the tens or occasionally in the hundreds. They do not know exactly what the cause is, but it appears to develop in people who have been bitten by a bug there they call the "Barber." After they are bitten nothing happens for years, but then years later they may get this cardiospasm disease. They often get heart disease as well. They may get colon trouble and they may get swollen salivary glands.

Work supported by the National Institute of Arthritis and Metabolic Diseases has shown that the kind of esophagal disorder they have and the kind we have had in this country are similar, as far as the end results are concerned. In fact, you can't tell them apart by the way the esophagus works, or by looking under the microscope. But the cause must be different, because we don't have the what they call the "Barber" in this part of the world, or at least the northern part of the States. Then, nevertheless, it gives us a big lead how we can go about studying this disorder, because we know here is a similar condition which was started by an infestation which the patient suffered years ago.

I have cited these two examples of leads to indicate that they should be pursued, but Mr. Fogarty, as you know, since you have got a lead, what you like to do is follow it along this track, and that track, and of course each interesting lead in a way stimulates further research and further research requests, and this is one reason why demands for funds increase.

Now, the condition about which we really know nothing at all, but which is probably the most common gastrointestinal organic disease, is, where there is some change in the gastrointestinal structure, is peptic ulcer of the stomach, or duodenum.

In the last war it kept many young males from being drafted in military service, both here and in England. It is the kind of ulcer which accounted for the fact that in the years 1950 to 1955, in the Veterans' Administration hospitals, they did 30,000 removals of the stomach in order to treat this ulcer.

To treat ulcer, the idea is to remove the digestive capacity of the stomach, so that it won't digest itself. The self-digestion leads to the ulcer. And to eradicate this, surgeons have turned to removing a good deal of the stomach, sometimes with cutting a nerve. So at our VA hospitals they take out about 6,000 stomachs annually for this purpose. It is a very common disease.

You have been questioning some of my predecessors about justification for some of these increased appropriations we are recommending. And purely again from the monetary and long-range viewpoint, to say nothing about the humanitarian principles which Dr. Thomas mentioned, think of the saving if this number of operations could be reduced, and incidentally, usually it is my understanding that frequently following operation, disability allowances are increased as well. It is a big problem—ulcer, and it deserves a tremendous amount of work.

Now, some people call it a disease of civilization. It may not have existed very commonly over 100 years ago, and up in the Andes, the Peruvian Indians do not have much duodenal ulcer, and there is much evidence to indicate that stress and strain has something to do with it. I have cited some figures in my prepared statement, which are very fascinating to me, anyhow, that in London hospitals they kept count of the ruptured ulcers, month by month, and in a series of some 15 or 20 London hospitals they had 25 ruptured ulcers come in every month, year after year, during 1939 and 1940, until the fall of 1941; then in September, on October of 1941, ruptured ulcers went up to 80 or 90. That was the time of the blitz.

So everybody said this was the stress and strain and physical hardship of the blitz. But the interesting thing was, at the same time, in Glasgow, which was not bombed to any extent, ulcer perforations went up also. So this, of course, meant apprehension and fear and resentment. The Glasgow people thought they were going to be bombed too. So that was responsible for ulcer exacerbation.

They say the Germans had the following experience: In World War II the German units in the field did not suffer too much from ulcer, any more than you would expect it. But once they were stationed in Holland, with nothing to do and facing the hostility of the local population, ulcer became extremely prevalent.

I have cited these examples not merely to tell you stories about ulcer, but to emphasize that this may be a disease of our present way of living and some of the fears of anticipation and resentment and our thinking about our conditions surrounding us, and if it is a condition of our civilization and if it is not treated more effectively than it is now by medical men, I think this will be a major problem. And among those illnesses you recall Dr. Thomas mentioned, in the year 2000, I imagine ulcer would be a most prominent entity.

One more thing about gastroenterology, and this is the medical side of it. In discussing this field, I have discussed peptic ulcer, cardiospasm, sprue, colitis and pancreatic disease, and others, such as cirrhosis of the liver, gallstones, diaphramatic hernia, diverticulitis, appendicitis, and that viral affection which is serious sometimes, often sporadic and mild, but often serious in wartime; namely, hepatitis. Some of these illnesses can be cured surgically, gallstones and appendicitis, but it is a terrible fact that we gastroenterologists have to admit that we have no medical means by which we think we can cure that is, permanently cure, any of these conditions I have mentioned. Sure, we can change the situation—or make an ulcer better. We can heal it for the moment. But we can't cure it. We can make the cardiospasm disease better, or the celiac disease patient better, but we can't cure his condition. That is why I do feel that ulcer does offer us a challenge for further support, because there are many leads,

but also it is a challenge because it is such a big problem that it requires intensive investigation.

I should like to make one thing very emphatic, Mr. Chairman. I have been concentrating on gastroenterology, because it happens to be my field of experience, and I am acquainted with what it can do and I am acquainted with its needs. But after all, gastroenterology is merely a part of internal medicine, and many of us do not like to call ourselves gastroenterologists. We think we are internists who are interested in the gastrointestinal tract. So what I have said on the need for research and training in the field of gastroenterology is merely supposed to provide you with examples of needs in all the fields and branches that come within the purview of the Institute of Arthritis and Metabolic Diseases.

Dr. Bauer pointed out how after all the gut and other disorders are related—pancreas and diabetes, the gastrointestinal tract and hematology are almost like this, because one disease almost frequently leads to the other, so I will not belabor that point too much but I do hope I have made clear my long dissertation on gastroenterology was to give you examples in the field I know about, and not to emphasize it in any way above or different from the other fields supported by the Institute.

Finally I should like to mention something about this proposal to allocate funds for undergraduate training in the fields of arthritis, hematology, gastroenterology, et cetera. This is a program which is somewhat hard to present, in concrete terms, because there is no specific disease one is attacking directly. This is training at an earlier level and it is less easy, therefore, to speak in concrete terms and to explain why funds are needed here, as opposed to requesting funds for research or requesting funds for men further along in their training.

It seems to me, if we are going to graduate good medical students, we have to have good teachers, and good facilities and good teachers means plenty of teacher time, and that in turn requires money to pay them. And once there is more teacher time, there is more time for discussion, and integration.

I think our medical students today are well enough taught and have the time that they learn textbook facts quite adequately. But this is not enough. Integration of basic science and textbooks and of the specialty are things that are very important, and I think these are things that have to be pursued.

If a student is exposed to such stimulation at an early stage, a number of things can develop.

Again, my predecessors have emphasized that an early research potential might be detected that way, and I won't go over that again. But not everybody I think is going to be a researcher, or a specialist. After all, we need many good doctors today to take care of our population. But such specialized training is not going to hurt them one little bit. In fact, I consider it is absolutely necessary to give them an understanding of what they are learning, not only the facts. Because the person who has been given such an interpretative training will approach diagnosis, I think, with an imaginative and individualistic manner. He won't use laboratory tests, without knowing what they mean, and in the matter of treatment, he will not, as emphasized here in Washington recently, use the most recent, the most expensive, and the best advertised drug—he will use the drug which he knows is best, on the basis of his medical training.

I do not know whether you happened to see an article in the New York Times Sunday magazine section on February 20, but there was one, taking up the whole point of research support versus teaching support, and pointing out that in academic institutions the researcher has become the more supported, the more glorious figure, and the pure teacher has been considered more humdrum. I think this is true of medical schools as well as all levels of academic endeavor. I think it should be corrected, and the way to correct it it seems to me is to support teaching specifically to a greater extent and to make a simple analogy, if you have a football team, if you have a good backfield, research backfield, but if you have a poor line, a poor teaching line, it is going to be pretty unbalanced, and some may say, "Well, to put them on the par, let's reduce the quality of the backfield." But then the score is not going to be very good. You are going to have a poor team. I think to have a good team, you need a good backfield, but the basis is the teaching line.

That is all I have to say, but I would like the balance of my prepared statement to be placed in the record if it meets with your approval.

Mr. FOGARTY. Certainly.

(The balance of the prepared statement follows:)

The close integration fostered between research and training programs has of course implemented this refocusing of gastroenterological teaching; to train the young physicial to understand as well as to practice gastroenterology.

The physician who would become an adequate gastroenterologist must therefore acquire basic knowledge, interpretative imagination, clinical experience, and skill in handling delicate and intricate instruments. The training program which would educate him well must therefore be well equipped with a staff both research-minded and clinically adept, and with facilities and instruments which, because they are elaborate, are also expensive. A good training program in gastroenterology therefore requires money, and plenty of it.

Adequate financial support is however needed not only to support and strengthen training programs in existence, but good new programs should be gotten underway. Obviously this expansion of gastroenterological training programs cannot be endless. The pool of candidates acceptable for training will reach a limit as will the positions they can obtain. This situation, however, is far from at hand. Nearly half the medical schools in the country do not have sections devoted to gastroenterological research and education, and many of these schools recognize this as a deficiency. In support of this statement, I can state that I annually receive some three to seven letters from university or Veterans' Administration hospitals seeking to appoint able and well-trained young physicians in the field of gastroenterology.

I have spoken of gastrointestinal research as providing training grants in this field with vital orientation, but, of course, research in gastroenterology is crucially important for its own sake as well. Various examples may be used to illustrate facets of the need. Previously I mentioned the elaborate instrumentation and methods necessary for gastrointestinal diagnosis, but there is one organ in the digestive system which is the most inaccessible of all, and this is the pancreas. It lies too deep within the upper abdominal cavity to be felt, it cannot be delineated satisfactorily radiologically, and biochemical tests of its functions are too crude to detect minor changes. Thus diseases of the pancreas other than diabetes; that is, inflammations and tumors, cannot be detected and diagnosed at an early and treatable stage. Certain pancreatic cancers are for this reason one of the most hopeless of all malignancies. Gastroenterologists are not particularly proud that the most undiagnosable organ in the body lies within their province, but improved pancreatic diagnosis is a problem, which, if given sufficient attention, should certainly be susceptible of solution. Somewhere in the vast technical storehouse provided by biochemistry, radioisotopes and radiology, the germ of a better method for diagnosing pancreatic disease must be lying dormant, and with research, and with wholehearted support of research, it must be found.

Cirrhosis of the liver is often listed as the fifth most common cause of death in the United States. Some would argue that these are the rewards of intemperance, but this is hardly the physician's viewpoint. Moreover cirrhosis of the liver has

other antecedents than alcohol. What are the causes? We do not know precisely, but tremendous advances have been made in the fields of biochemistry and nutritional research with experimental animals. In the liver, the metabolic powerhouse of the body, the residue of foodstuffs are worked over and changed to suit the body's needs. The liver cells accomplish this by a chain of chemical reactions which pass the substance being metabolized from link to link, altering the substance slightly but steadily as it goes along until the final end product is reached. If one link breaks, the whole chain naturally gives way. The accomplishment of biochemistry and experimental nutritional research has been the identification of some of these links and the discovery of factors which potentiate or impair their action. Thus agents which damage the liver, whether alcohol, or dietary deficiencies, or viruses, or some of the drugs which doctors use for other purposes, may well wreak their effects on the liver by blocking or destroying merely one link in the metabolic chain. Exactly which links are first affected, or how they are affected in the disorders mentioned, is not known, but the researcher's direction has been well laid out, and his efforts should prove rewarding if pursued with vigor and intelligence.

Compared with cirrhosis of the liver, a condition called celiac disease in children and idiopathic sprue in adults is a rare disorder, but the stimulus given to it by recent discoveries has made it a rich field for exploration. This is a disorder of the small bowel, characterized by an impaired absorption of food. For years, as is true of most diseases of unknown etiology, celiac disease and sprue were blamed on many things, but in 1953 some Dutch physician showed—who would have believed it—that something in good, ordinary white wheat bread is responsible for making the condition much worse, and that if wheat is eliminated from the diet the patient often thrives remarkably. We now know that the offending material is gluten, a protein material in wheat, but why it should bother the patient with sprue, or how it does so is unexplained. By the same token, the incrimination of gluten has provided a rich lead being pursued in many parts of the world, and here in the United States by investigators supported by the Institute of Arthritis and Metabolic Diseases. If important results develop, they will not only help explain the causes of a relatively rare disease such as sprue but will provide principles applicable to problems of absorption from the human digestive tract in general.

Another gastroenterological condition which has been the object of considerable study in recent years is a disorder of the esophagus (the swallowing tube), and this disorder usually goes by the name of either cardiospasm, or achalasia. Again it is not a common disorder, but for the patient who has it, who can take his nourishment with only the greatest difficulty, it is important enough. Furthermore, the more we learn about cardiospasm, which appears to be the result of a deranged nervous control of the motor function of the esophagus, the more we get to know about esophageal function under many conditions, both normal and abnormal.

Although there have been many theories, no one has really had the slightest idea as to the etiology, i.e., the cause, of cardiospasm; but recently, through the medium of international meetings aided in part by the National Institute of Arthritis and Metabolic Diseases, a most intriguing fact has become apparent. In the Brazilian hinterland, some 500 miles inland from the new Brazilian capital of Brasilia, this condition of cardiospasm is endemic. Thousands of Brazilians in this area suffer from this affliction. Why? This is not completely settled, but the evidence is most suggestive that the Brazilians who get cardiospasm were bitten years previously by a cockroachlike insect they call "the barber." In this act, the "barber" transmits a parasite to the human victim who, a few weeks later, may get a swollen black eye and some fever. Then the patient gets well, but years and years later he apparently can turn up with one or a combination of several conditions including not only cardiospasm but heart disease, bowel troubles, and swollen salivary glands. Work supported by the National Institute of Arthritis and Metabolic Diseases has shown that the Brazilian esophageal disorder and cardiospasm in this country are similar as far as the end results on the esophagus are concerned. In most parts of the United States, we fortunately do not have parasite-transmitting "barbers." Nevertheless, the Brazilian experience gives us exciting leads. In looking for the cause of cardiospasm in the United States, we are stimulated to search not for some recent event but for something the patient had years before his esophageal symptoms developed. We are stimulated to look for something in the way of an infection that starts off a slowly progressive degeneration of the nervous mechanisms controlling the esophagus. Here then is another condition in which we have a good lead, but to follow this lead, it will not suffice to continue in one straight line; rather a series of possible directions will have to be explored. Thus a single promising research current leads to multiple endeavors which, commensurate with their success, tend

to split into additional subsidiary channels. In other words, in the ever-continuing effort to bring a research project to its successful culmination, those supporting the research must accept the responsibility of increasing the support if promising leads are to be fruitfully explored.

Perhaps the gastroenterological condition which should most compel our attention is peptic ulcer, in particular peptic ulcer of the duodenum, i.e., an ulcer situated in the first part of the small bowel, just beyond the outlet of the stomach. This is the kind of ulcer which is most common in our country, particularly in young males. This is the kind of ulcer which kept thousands of young men from being drafted into military service. It is the kind of ulcer which chiefly accounts for the fact that removal of a part of the stomach, the standard surgical treatment of duodenal ulcer was performed almost 30,000 times in Veterans' Administration hospitals in the years 1950 to 1955.

The interesting thing is that this duodenal ulcer so prevalent today in many parts of the world was apparently almost unknown 100 years ago, and even now, some populations, such as pure-blooded Indians living in the Andes, seem to have very little of it. Thus duodenal ulcer apparently qualifies as a so-called disease of civilization, and is subject to the individual and mass stresses characterizing this state of human social development. The populations of English cities provide a striking example of what happens when modern man is exposed to violent stresses. Here is a chart showing the number of patients admitted to 20 London hospitals because of a perforated ulcer, that is an ulcer which ruptured allowing gastric contents to spill into the abdominal cavity. Month after month, as you see, the incidence of these ruptured ulcers stayed around 25 until the fall of 1941 when they suddenly bounced up to 80 per month. Now these are exactly the months during which London was being subjected to the blitz. The relationship is not as simple as it may seem, however, for in Glasgow, a city which was not bombed during the fall of 1941, a similar increase in ulcer perforations was also recorded during the same time. In other words, the apprehension and resentment engendered by the blitz were probably more responsible for the worsening of ulcer rather than the actual physical hardships endured. In line with this reasoning is the observations alleged to have been made in German military personnel during World War II: duodenal ulcer and its complications were much less troublesome in troops engaged in active conflict than in occupation troops stationed in Holland and exposed, not to acute danger, but to the chronic hostility of the people.

I have elaborated upon the possibility that ulcer is a disease of civilization to emphasize the point that this condition is not only very prevalent and a major source of disability today, but promises to be with us, possibly with increasing prevalance and virulence. Yet our knowledge of exactly how ulcer comes about is disappointingly circumscribed. We know that it tends to occur in certain people under certain circumstances but these relationships are general and far from specific or sharply predictable. We know that to have an ulcer, a patient must have a good digestive capacity, that is, his stomach must produce plenty of acid and an enzyme called pepsin which digests proteins. We know that certain glandular substances may enhance ulcer formation and we know of various mechanisms that control gastric secretion. Beyond this we know very little, and we have no idea of how the pieces of what we do know fit together. Ulcer is treated by various dietary maneuvers and injunctions about smoking and drinking but although these factors may influence the course of ulcer, it is very unlikely that they really have anything to do with its causes. Thus duodenal ulcer, both because it is such an important disorder and because so little is really known about it, is a condition which deserves a vigorous and multipronged investigative attack.

In this discussion, Mr. Chairman, I have discussed peptic ulcer, cardiospasm, sprue, ulcerative colitis, pancreatic diseases, and cirrhosis of the liver. Other important gastrointestinal disorders are cancers of the digestive tract, gallstones, diaphragmatic hernia, diverticulitis, appendicitis and that viral infection which is apt to be mild and sporadic in peacetime but which sweeps catastrophically through armies during times of war, namely hepatitis. Now some of these illnesses such as gallstones and appendicitis can be cured surgically. Some like hepatitis are healed in the natural course of events. Some like ulcer of the stomach and duodenum can be improved symptomatically by measures which heal the ulcer, but in none of these conditions, Mr. Chairman, with the possible exception of celiac disease, are any strictly medical measures known which cure the condition. This is food for thought, Mr. Chairman, that in a specialty which embraces the abdominal organs of digestions, absorption, and assimilation, the best an internist can do is to treat the patient for his symptoms and not to interfere with natural healing. He has no positive methods for real cure. Is this not a great

challenge?—a challenge for the researcher and for those who share in the responsibility to see that this research gets done.

Mr. Chairman, I have been concentrating on gastroenterology because this happens to be my field, and I am acquainted with its accomplishments and its needs. I must emphasize in the strongest possible terms, however, that gastroenterology is merely a part of internal medicine in general, and many of us in the specialty like to insist that we are not gastroenterologists, a relatively unpronounceable name anyhow, but that we are internists who are particularly interested in the digestive system. Thus what I have said to illustrate the need for training and research in the field of gastroenterology is not to be interpreted as a plea for special consideration of this particular branch of internal medicine. Rather, by describing the conditions and needs in one of the fields that comes within the purview of the Institute of Arthritis and Metabolic Diseases, I have attempted to illustrate how great the demand is upon this Institute to support training and research in all of the categories of medicine that comprise this Institute's endeavors.

As a matter of fact, on medical grounds it would be grossly misleading of me to separate gastroenterology from the other interests of the Institute. Diabetes is after all a disorder of the pancreas, and in its manifestations the metabolic functions of the liver also play a crucial role. The functions of the gastrointestinal tract are significantly affected by the products of the endocrine glands, and material that is absorbed influences and is influenced by metabolism in general and metabolism in the liver in particular. Since pernicious anemia and similar anemias are the results deficient absorption of vitamin $B_{12}$, since bleeding from the gastrointestinal tract is a major cause of what is called an iron deficiency anemia, and since liver function is intimately related to a variety of other anemias, it is not extravagant to claim that hematology and gastroenterology are closely interdependent subspecialties of internal medicine. Even arthritis and gastroenterology are closely linked, for patients with ulcerative colitis may develop certain varieties of arthritis and it is even possible that immunologic basic mechanisms possibly responsible for arthritis on the one hand may also play a role in the development of ulcerative colitis and regional enteritis on the other. In this connection, a probably unintentional but nevertheless real benefit accruing from the practices of the National Institute of Arthritis and Metalbolic Diseases is that those interested in arthritis and gastroenterology have been brought together in one of its study sections, with a consequent interchange of ideas that has certainly been beneficial to us in gastroenterology, and I hope, also to those interested in joint disease.

Finally, I should like to support the concept of allocating funds for undergraduate training in the fields of arthritis and rheumatic diseases, metabolic diseases, hematology, endocrinology, and gastroenterology. Since there are no specific diseases to conquer, and no human suffering to be relieved by any direct action, the need for such funds is less easily explained and dramatized than are the needs for funds for research. It is axiomatic that to graduate good medical students one requires good teachers and good facilities. A good teacher, however, must also have time and adequate financial reward for the time spent in teaching. If I may again take the field of gastroenterology as an example, I am sure that the ordinary textbook facts concerning this field are adequately taught in most of our medical schools today. But this is really not enough; the meaning and implications of facts should be made clearer to the student, and such interpretation is made possible only by discussion, which in turn depends upon increasing available teacher time. Interpretive discussion fosters correlation between basic science, clinical observation and use of elaborate diagnostic and therapeutic maneuvers. As a result, the student comes to appreciate the fundamentals that determine medical action. In case of a subspecialty, such as gastroenterology, he is stimulated to think about its problems and to develop an inquiring mind at an early stage. In a few, as has been repeatedly pointed out, such groundwork may bring to light a man with real research potential, but not everyone can be a researcher or a specialist. Nevertheless, the inquiring mind will also well serve the regular doctor who shoulders the responsibility of directly caring for his fellow men. He will approach diagnosis with an imaginative and individualistic rather than a routine manner; he will give the results of the many laboratory tests currently in use proper evaluation rather than relying on them blindly, and, in the matter of treatment, he will not, as was charged here in Washington recently, use the most recent, the most expensive and best advertised drug peddled by the detail man with the nicest personality, but will use the medicine which his own thoughtful training has enabled him to select.

One other aspect deserves serious emphasis. Because of its importance and the fascination that the word research exerts, research has been justifiably em-

phasized, but teaching at all academic levels has been relatively neglected as hum-drum and unexciting. Thus at present the situation is unbalanced, especially in medical schools, where research is so predominant as almost to be detrimental to teaching. On February 20, the New York Times Sunday magazine carried an article on this point.

The situation may be compared to a football team with a pretty good backfield but a feeble line. Reducing the quality of the backfield to make it even with the line won't help the team record very much. What is needed to enhance the quality of the line of teaching and to bring it up on a par with the backfield. A good team requires strength and depth in all positions.

Mr. FOGARTY. You have made a real good statement, and I think you have taken good care of your colleagues in the field of gastroenterology.

Dr. INGELFINGER. As I said, I was not emphasizing gastroenterology. It is something I know about, and can therefore speak about. It is a field I can speak about with conviction.

Mr. FOGARTY. You do it very enthusiastically and very well.

Dr. INGELFINGER. I am more or less repeating what I read.

Mr. FOGARTY. What about this problem of the budget limitation as opposed to going ahead and getting something accomplished in these fields? What do you think?

Dr. INGELFINGER. Well, I think it is a matter of what is most important, and deciding to give up the least important of the two, and one is balancing health problems versus financial problems.

I do not want to be presumptuous here, but maybe I would like to even paraphrase Senator Johnson, when he said something I believe to the effect if we spent money, the most we do is lose money. I think this was a good statement. If we do not take care of more serious things, and at that time he was talking about defense, we lose more than money. If we turn this into terms of the present field we are talking about health versus the immediate financial balancing.

Dr. Handler, I think, gave a very good answer as to the importance of health versus the balanced budget. I would like to subscribe to what he said. I would like to add, in addition, that if it is necessary, to me, the health aspect is so important that, if necessary, more money should be raised to support health; more taxes, probably.

In other words, if both have to be done, if both are essential, I think the health support is essential, and if balancing the budget is essential, then I say, all right, the Government will have to raise some more money. If it is a question of which is the more essential, not as physician and as a taxpayer, but just looking for the future of my children, I am in favor of health.

Mr. FOGARTY. Do you agree with Dr. Bauer that this budget we have been handed by the administration is not a very progressive one, in view of the needs?

Dr. INGELFINGER. I say, if I may change what you said, Mr. Fogarty—it is not a progressive one. I will eliminate the "very."

Mr. FOGARTY. Say it any way you want.

Dr. INGELFINGER. It allows the Institute roughly to carry on at the level, even though at present I believe they have $300,000 worth of approved research fellowships that they can not pay. But the burden of some of the testimony you have heard, as well as mine, is that we have got to keep going. We have to expand. Our population, the incidence of illness require it, and therefore I think it is

absolutely essential that the budget, or at least that the appropriations be increased, in order to take care of these increased demands.

To put it another way, since the demands are increasing, if the budget is kept the same, in essence, health support, in terms of research, and teaching of our doctors is going backward.

Mr. FOGARTY. I think that puts it very well.

Do you have anything else to add to that?

Dr. INGELFINGER. No.

Thank you very much for listening so patiently.

Mr. FOGARTY. Thank you, Doctor, for coming down.

I think you have done a good job.

---

WEDNESDAY, MARCH 2, 1960.

## CANCER PROGRAM

### WITNESSES

**DR. ISIDOR S. RAVDIN, PROFESSOR OF SURGERY, UNIVERSITY OF PENNSYLVANIA MEDICAL SCHOOL; CHAIRMAN, BOARD OF REGENTS OF THE AMERICAN COLLEGE OF SURGEONS, PHILADELPHIA; CHAIRMAN, CLINICAL PANEL, CANCER CHEMOTHERAPY NATIONAL SERVICE CENTER; PRESIDENT, AMERICAN SURGICAL ASSOCIATION; DIRECTOR-AT-LARGE AND MEMBER OF LEGISLATIVE COMMITTEE, AMERICAN CANCER SOCIETY**

**DR. SIDNEY FARBER, PROFESSOR OF PATHOLOGY, HARVARD MEDICAL SCHOOL AT THE CHILDREN'S HOSPITAL; SCIENTIFIC DIRECTOR, THE CHILDREN'S CANCER RESEARCH FOUNDATION; CHAIRMAN, CANCER CHEMOTHERAPY NATIONAL COMMITTEE; MEMBER, NATIONAL ADVISORY HEALTH COUNCIL; MEMBER OF LEGISLATIVE COMMITTEE, AMERICAN CANCER SOCIETY**

Mr. FOGARTY. The committee will come to order.

Dr. Ravdin, are you ready to proceed?

We are very pleased to have you back with us again.

Dr. RAVDIN. I am very happy to be back here again with you, Mr. Chairman.

#### ESTIMATES FOR 1961

This first statement I am making, I am making for the American Cancer Society, which asked Dr. Farber and myself to present their report in support of the budget for the National Cancer Institute for fiscal 1961.

As shown in the accompanying table attached to this, the Congress appropriated the sum of $91,257,000 to support the activities of the National Cancer Institute for fiscal 1960. However, only $87,750,000 of that amount was released for spending by the Institute. Of the $3.5 million placed in reserve by the Bureau of the Budget, $2.5 million has been appropriated for programed chemotherapy projects, and $1 million for chemotherapy contracts.

The President's budget for fiscal 1961 recommends support to the National Cancer Institute in the amount of $88,869,000 in its total.

There are several reasons why an appropriation of this amount would result in a substantial reduction in support of research on cancer.

If the amount was limited to that originally considered by the legislative committee of the American Cancer Society in the amount of $88,869,000—the obvious reason is that a lesser amount of funds would be appropriated for fiscal 1961 if this second figure was appropriated then for the preceding year. A less obvious reason relates to the fact that the executive budget calls for increasing the permissible amounts for indirect costs from 15 to 25 percent of the amount of grants without at the same time requesting additional funds to pay these costs.

Having become aware of the increasing number of worthwhile applications for grants to support research on cancer that are being received by the National Cancer Institute and the American Cancer Society—due in part, at least, to the preceding Congresses having appropriated funds to be used on a matching basis to help defray the cost of constructing additional research facilities and to defray the cost of training many new investigators for careers in cancer research—the American Cancer Society recommends that funds in the amount of $104,505,000 be appropriated to support during fiscal 1961 the activities that are now engaged in by the National Cancer Institute.

In addition, two new activities totaling $16.5 million are recommended, making a total of $121.5 million.

NATIONAL CANCER INSTITUTE

*For continuation of present activities*

[In thousands]

| | 1960 appropriation | 1960 apportionment | 1961 President's budget | ACS Citizens' recommendation | |
|---|---|---|---|---|---|
| | | | | 1961 increase over 1960 apportionment | Total |
| Grants: | | | | | |
| Research projects, general | $29,618 | $29,618 | $30,241 | $8,182 | $37,800 |
| Programed chemotherapy projects | 5,800 | 3,300 | 3,300 | 1,500 | 4,800 |
| Field investigations | 2,400 | 2,400 | 2,400 | 200 | 2,600 |
| Total research projects | 37,818 | 35,318 | 35,941 | 9,882 | 45,200 |
| Research fellowships | 1,912 | 1,912 | 1,912 | 988 | 2,900 |
| Training: | | | | | |
| General research training | 3,675 | 3,675 | 3,525 | 825 | 4,500 |
| Teaching (increase rates $5,000 to $10,000 and $25,000 to $35,000) | 2,490 | 2,490 | 2,490 | 1,140 | 3,630 |
| Traineeships | 1,040 | 1,040 | 1,040 | 0 | 1,040 |
| Total training | 7,205 | 7,205 | 7,055 | 1,965 | 9,170 |
| State control programs | 2,250 | 2,250 | 2,250 | 0 | 2,250 |
| Community demonstration projects | 1,500 | 1,500 | 1,500 | 0 | 1,500 |
| Total grants | 50,685 | 48,185 | 48,658 | 12,835 | 61,020 |
| Direct operations: | | | | | |
| Research | 11,779 | 11,779 | 12,395 | 1,263 | 13,042 |
| Review and approval (includes six 208G's) | 1,031 | 1,031 | 1,032 | 200 | 1,231 |
| PTA: | | | | | |
| Environmental cytology and diagnostic | 2,907 | 2,907 | 2,916 | 0 | 2,907 |
| Concer control (1961 preliminary) | 680 | 680 | 683 | 0 | 680 |
| CCNSC (eight 208G's) | 1,363 | 1,363 | 1,368 | 100 | 1,463 |
| Virus activities | 250 | 250 | 250 | 250 | 500 |
| Total PTA | 5,200 | 5,200 | 5,217 | 350 | 5,550 |
| Chemotherapy contracts | 22,142 | 21,142 | 21,145 | 2,000 | 23,142 |
| Administration | 420 | 420 | 422 | 100 | 520 |
| Total direct operations | 40,572 | 39,572 | 40,211 | 3,913 | 43,485 |
| Subtotal | 91,257 | 87,757 | 88,869 | 16,748 | 104,505 |
| FOR NEW ACTIVITIES | | | | | |
| Institutional research grants | | | | | $1,500 |
| Grants to intensify research activities on cancer alone (cancer research centers) | | | | | 15,000 |
| Subtotal | | | | | 16,500 |
| Grand total | | | | | 121,005 |

The line items of the budget recommended by the American Cancer Society in its legislative committee, as compared with the amounts appropriated for these purposes by the Congress for fiscal 1960, are as follows:

1. An increase amounting to $8,182,000 recommended for support of research projects generally.

This estimate of need is based on increasing the maximum allowance for indirect costs from 15 to 25 percent of the grants, 85 percent continuation rate of present grants, 8 percent of dollar amount of current grants in the form of supplemental grants, and new grants at the program level of fiscal 1960, or $6,817,000.

Of the increased amount recommended, $3 million is needed to increase the maximal allowance for indirect costs from 15 to 25 percent of the amount of the grant.

Perhaps it should be noted at this point that the American Cancer Society, some 18 months ago, increased its maximal allowments for indirect cost to the recommended figure.

That this action was taken by the society at a time of stringent financial need, should be viewed as a most persuasive argument in support of this suggestion.

2. A reduction in programed chemotherapy projects amounting to $1 million. While the amount recommended, $4.8 million, is $1 million less than was appropriated for fiscal 1960, it is $1.5 million more than was apportioned.

3. An increase amounting to $200,000 for field investigation projects, of which all would be used to increase the maximal allowance for indirect cost in connection with the grants made to support this activity.

4. An increase amounting to $988,000 for research fellowships. These funds are required to provide training in research for an increasing number of qualified persons seeking such an experience.

5. An increase amounting to $825,000 for general research training, to provide the additional specialists, such as virologists, epidemiologists, and so forth, needed to make the research effort against cancer maximally effective.

6. An increase amounting to $1,140,000 to allow to expanding the amount of teaching grants to schools of medicine and osteopathy, and dentistry, from $25,000 to $35,000 per year for 4-year schools, and from $5,000 to $10,000 per year for 2-year schools. These grants provide for special instruction in cancer to the practitioners of these professions.

7. No increase is being requested for funds for traineeships.

8. No increase is being requested for funds for State control programs.

9. No increase is being requested for funds for community demonstration projects.

10. An increase amounting to $1,263,000 for the Institute's intramural research program—the program at Bethesda.

Of this amount, $350,000 will be used to purchase rather than to produce certain substances, such as amino acids, and to contract out research of relatively routine nature, thus freeing space and manpower for more original work.

Two hundred and ninety-seven thousand dollars to permit 40 key scientists to be paid salaries in the $15,000 range, and to defray the increased costs of research, about 2 percent, resulting from inflation.

One hundred and sixteen thousand dollars for mandatory items, such as employee health bill, and so forth; $150,000 for radiation studies and information activities, and $374,000 for increase in reimbursement.

11. An increase amounting to $200,000 for increased costs of review and approval of applications for grants, including six additional key personnel in the $15,000 range, so that these can be made as carefully as possible.

12. No increase is being requested for environmental cytology, and diagnostic services.

13. No increase is being requested for cancer control.

14. An increase amounting to $100,000 to enable the Cancer Chemotherapy Service Center to provide eight new key positions in the $15,000 range.

15. An increase amounting to $250,000 to provide support for maintenance of cell and tissue banks, seven of them. These are badly needed in connection with our screening program.

16. An increase amounting to $1 million for increased support of chemotherapy contracts; an increase amounting to $100,000 to provide for increased costs of administration.

Two additional requests are being made, and these constitute recommendations for undertaking new activities; and the amount for these is included in the rough figure of $121 million, Mr. Fogarty. These constitute recommendations for undertaking new activities in this area.

INSTITUTIONAL RESEARCH GRANTS

First. The first of these is the growing need for the National Institutes of Health to make institutional research grants to support the preliminary exploration of new and imaginative young students and scientists who have not had the time to establish themselves sufficiently to compete successfully for grants made in national competitions. The funds of these grants could be used also to provide support for those other meritorious activities on cancer that cannot be supported effectively by other types of grants now available.

While it would appear to be desirable for the National Institutes of Health to make institutional research grants to support research of the types indicated above, over the whole spectrum of medical and biological science, it is believed that funds amounting to at least $1.5 million could be used in fiscal 1961 to support these activities in the field of cancer alone. This new activity is being proposed to the Congress after experience, extending over some 10 years, during which time the American Cancer Society developed these grants to their present unexpected level of productivity.

CLINICAL RESEARCH CENTERS

Second. There is one further need that is worth serious consideration by your committee and by the Congress. Some mechanism should be developed to permit certain institutions which wish to do so, to develop a more intensive research effort oriented to the patient with cancer. While there are many different and exceedingly different biological models that can be employed for the purpose of conducting important research bearing on the cancer problem, our principal objective is to find a practical means for the control of cancer in man. It is axiomatic that such models are not more than a means to an end, the end being the practical means for preventing or curing the disease in man. It is becoming increasingly apparent to serious students of this disease that suitable experimental models are not at hand to permit thorough study of all aspects of this disease in man.

It follows, therefore, that more attention should be paid to the human subject. While most institutions engage in the management of patients with cancer and are able to provide many of the essential

requirements for productive clinical research, few, if any, of these institutions can provide all the requisite needs.

For example, some institutions are in need of funds to defray the cost of hospitalizing patients for definitive studies. You gentlemen well know what the cost of hospital care per day per patient is in the good hospitals of this country. Other institutions, who may have support for adequate numbers of research beds, find themselves without sufficient funds to attract full-time clinical investigators and to defray the cost of supporting laboratories and so forth.

It is suggested that the Congress appropriate the sum of $15 million which can be used in fiscal 1961 for making grants to institutions which wish to intensify their research programs related to cancer alone. It is expected that these funds would not be used to replace funds already available to defray the cost of activities of the types described, but that the applicant would request funds only to defray the cost of those additional activities that would need to be financed to enable the institution to intensify its research efforts directed at cancer in man.

This is in the report of the legislative committee of the Cancer Society. If I have your permission, I should like to make a short report, a personal report of my own.

Mr. Fogarty. Go right ahead, Doctor.

Dr. Ravdin. I make this statement as a citizen, as a surgeon, and as the vice president for medical affairs of the University of Pennsylvania.

Mr. Fogarty. I assume you are also a taxpayer.

Dr. Ravdin. Yes, sir; I am.

Many operations of nearly unlimited extent have been made possible as the result of technical advances in surgery, and a broader knowledge of normal physiological function and the abnormalities of function imposed by disease. Operations of great magnitude can now be done for malignant disease in an attempt by surgeons to achieve long survival or cure.

Thoughtful surgeons now freely admit that once the cancer has spread beyond the organ of its origin, it is ofttimes impossible to eradicate it.

We need desperately to be able better to assess the biological activities of a given tumor. Such knowledge will come, we hope, from one or more of those who are devoting their activities to extending our knowledge of the basic problems of cell growth under a variety of biological circumstances. We are awaiting such new knowledge with the hope that it will provide the means through which cancer can be prevented, controlled, and cured.

While basic research will provide a better understanding of the complex mechanisms associated with the growth of the cancer cell, clinical research in cancer patients will provide us with more exact knowledge of the life history of a variety of the cancers common in man.

It is well to repeat the statement that of the 250,000 Americans who die each year from one or another form of cancer, many would be saved had the diagnosis of the presence of the cancer been made

sufficiently early and adequate surgery or irradiation as was indicated instituted promptly.

It is data such as these which have led me to state before this committee on a previous occasion that the available methods of therapy are not sufficiently good to still the search for better methods.

The problems of malignant disease will not be completely solved until, as the result of basic and clinical research, it will be possible to prevent the initiation of cancerous lesions.

The tremendous advances in the therapy of a wide variety of disorders through the utilization of chemical agents have led many clinicians and scientists to believe that more adequate therapy of cancerous lesions will come through a wider understanding of chemotherapeutic agents and their activity.

In many of our university institutions and in certain of our distinguished cancer institutes, individuals are concerned with the use of chemical agents in the therapy of late malignant disease with the hope that through the use of these agents we may find better methods for the complete therapy of malignant tumors.

Cooperative effort is a frequent vehicle in university life. Closely coordinated efforts are more easily accepted in a wartime effort, but are also achieved, to a lesser degree, in peacetime.

I can assure you that this program has advanced in regard to cancer during peacetime.

I am reminded of what Mr. James once said in his dissertation on the moral equivalent of war, in which he found it exceedingly difficult in peacetime to find the moral equivalent of mobilizing forces during war; but I think in this program we have made a good beginning in that effort.

It has been said that certain aspects, as you gentlemen well know, of the chemotherapy program constitute a somewhat irrational approach to the major problems of malignant diseases.

I would take issue with certain of these statements.

The history of other significant advances in therapy would suggest to me that perhaps all of those who believe that progress will be made solely through basic research are not fully conversant with previous contributions to medicine,which, over the years, have come to significally affect a variety of serious disorders.

I would say that the development of antiseptic surgery by Lister revolutionized the whole field of surgery. And I would say that Lister did not anticipate it or knew nothing about it. Banting and Best, in the development of insulin, one a country doctor and surgeon, and the other a third-year medical student, revolutionized the therapy of diabetes.

And while this was done, for 20 years thereafter, scientists were trying to find out basically how did insulin work, and I could go on indefinitely with this.

I would admit that the chemotherapy program has contained some imbalances; yet, in spite of this, a sound basic structure has been built on the framework of cooperating scientists and organizations throughout this country. As this program has developed, a number of indirect

effects have become evident. Two of the most outstanding effects are that the program has brought more scientists to study the problems of cancer than would have been done in the normal course of events, and that a more universal definition of the cancer problem and its treatment has been made.

We have recently made a seriously critical evaluation of the entire cancer chemotherapy national program. Certain generalizations may now be made in regard to this. To the best of our knowledge, no scientist has been denied support for any project which suggested a rational approach to the chemotherapy of cancer. This program has been accelerated, carefully accelerated, as a result of the funds which you gentlmen have recommended, and it has been facilitated to a degree which would not have been possible had not the Congress each year provided additional funds for this work.

Now, while all of this was being done, a group of dedicated scientists, in the main young clinicians, have been examining a wide variety of chemical agents with the hope that certain of these agents would demonstrate cytotoxic activity. This program, as you well know, must be largely empirical. This program must of necessity continue in this direction until new knowledge is made available.

We are working desperately to find new and better screens which will guide us in evaluating these agents and selecting them for use in man.

Certain of these agents have been found to be useful, but all of us are anxiously awaiting more potent agents.

The cooperative clinical studies now being carried out with the support of the Center through its Clinical Panel have been responsible for achievements which could not have been brought about by any other organizational pattern or sponsorship, to my knowledge. Data emanating from the cooperative studies permit analysis which otherwise would not have been possible.

An important byproduct of the cooperative chemotherapy program has been the collection of information concerning the life history and biological behavior of various forms of cancer. These byproducts alone, in my opinion, are worth the entire effort and cost of the entire clinical program so far.

It is my considered opinion, and it is shared by many others, that the programed chemotherapy projects should not be reduced in the amount of $1 million merely because certain of these funds were withheld during fiscal 1960. I believe this penalizes this program. If we are to move forward, the Congress should increase the amount of money for this area over and above that allocated for fiscal 1960.

My good friend, Dr. Sidney Farber, will testify at considerable length concerning other matters of a financial nature in the proposed budget. I wish to indicate that I find myself in complete accord with what he has to say.

Progress in our knowledge of the malignant diseases is being made, gentlemen. It would be unthinkable to me that the Congress would take any action which might in any way lower the tempo of the research now underway. We must train more research workers, both for our basic research and for our clinical research.

It is important for you to know that clinical research, good clinical research, is frequently more difficult than basic research. The application of new knowledge must find the clinicians adequately trained to apply this knowledge.

While all of this is being done, I can assure all of you that the care of the cancer patient in this country, today, is better than it has ever been in the history of this country.

There is one aspect of this entire problem that I finally wish to address myself to. We must all of us face the fact that if this entire program is to go forward as we would wish it to go forward, and I know you would, from the support you have given to it, provision must be made for meeting the total costs of medical research. It is my personal opinion that an increase of the so-called indirect costs of research from 15 to 25 percent is inadequate in many instances. It is hardly reasonable for the Congress to provide increasing amounts of money for research and thereby force many of our great universities and institutes, and I am thinking particularly of my own, in which I occupy an administrative post in addition to my other responsibilities, I can assure you gentlemen that if we are to continue in the work we are doing, it is important that the funds necessary for meeting the total cost of research should be met. It is my personal opinion that the total costs of research can be met better by the utilization of the amount, the A–21 plan, than others.

You gentlemen might wisely consider that it is better to add a sufficient amount of money adequately to meet the costs. I am not here to plead one or the other.

It is my personal opinion that the A–21 mechanism more adequately meets this. It is not reasonable to use this type of mechanism, such as the A–21, when the total costs of research are met through contract mechanism as part of our program is carried on, and the failure to do so, when the grant mechanism is used.

I believe this should be corrected. I would hope that it would be faced just as forthrightly as the Congress has faced many other important matters.

I am deeply grateful to you, Congressman Fogarty, for giving me the opportunity of coming back before you and your committee, which has done so much to permit those of us who are interested in the health of our people, from the scientific and medical point of view, to carry forth the effort that American scientists and clinicians are carrying forth; and you have done a magnificent job, for which we are very grateful to you.

Mr. Fogarty. Thank you very much, Doctor.

### THE BUDGET SITUATION AND APPROPRIATION REQUIREMENTS

We have problems, too, on this side of the table, as you well realize. In trying to keep these programs progressing, we have had our problems. It is distressing to some of us, anyway, to find the budget as it is today, holding the line and going backwards instead of going ahead.

Even though the $400 million figure is the same for the Institutes this year as it was last, when we take into consideration increased costs and other factors, we find that in many areas we are going back, not ahead.

Then you come in and ask us to appropriate about $30 million more than the administration is asking for in this particular disease category.

But before we even get to you, there are many important programs for which the budget that we have before us makes cuts way below the current level. There are important programs in this budget that are very popular with Congress and the people that the administration is cutting back.

Before we can start increasing funds for some of these programs that you are asking for this morning, we are short about $180 million that most of us feel must be restored.

The President has cut back hospital construction $60 million, aid to federally impacted areas—school areas, that is—down about $80 million; grants for waste treatment plants for water pollution control are cut $25 million; and grants for medical research facilities, one of the most popular program we have, they are cutting back $5 million. There are others that involve smaller amounts.

All of these add up to around $180 million. Most of us on the Committee think that these cuts should be restored, and we think that would be the will of the majority of Congress.

And then we get to your area. The Secretary appeared before us, telling us that this is a progressive budget, allowing us to expand and go ahead. When he was here he was questioned at considerable length, and in many NIH programs it was found that we are not going ahead, but we are going back, especially in some of the things that you mentioned, such as training and research fellowships. They are not going ahead but they are going backwards.

Then we have people in Congress that don't believe in research, period. I have had this thrown at me several times, using the same figures you used, that here we are spending $91 million this year on cancer, and still the same figures apply as did 10 years ago—250,000 people are going to die of cancer this year. That was the figure 10 years ago.

These same people will say: There isn't a doctor in the world that knows the cause of cancer. Even though we are spending more money than ever, we still don't know the answer. We don't even know the cause.

In that way, they try to show that we are wasting a lot of money.

Then, also, we have people who think more of a balanced budget than they do of saving lives through medical research. We have a terrific campaign going on throughout the country, headed by business groups and the chambers of commerce and others, to balance the budget at all costs. They don't want these budgets increased, even though, as you say, it might save some lives.

So we have those problems, those of us who want to do something in this area, and keep progressing. I, for one, want to spend more money in this field. What is the best answer?

Dr. RAVDIN. Mr. Fogarty, I am older than Mr. Denton. We were born and raised in the same community and went to the same schools. I have had a long history in medicine. My father and grandfather were doctors and my only brother is a doctor. What is more precious than the life of people?

Mr. FOGARTY. I don't know, but some people seem to think more of dollars than they do of lives, and we are going to have to contend with it, just as surely as you are sitting on that side of the table.

Dr. RAVDIN. I have never sat down and calculated what it cost to take care of the people who finally die from cancer. It is my con-

sidered opinion that the major breakthrough will have saved this country many, many times the amount of money which the Congress has given for these efforts.

I am sure that you are as familiar as I am with the Frank Bayne report: Physicians for a Greater America.

Mr. FOGARTY. And also the other one.

Dr. RAVDIN. The Bayne-Jones report, before it.

Mr. FOGARTY. There is another report just about to be issued, is that right, Doctor?

Dr. FARBER. Yes, sir.

Dr. RAVDIN. It also sums up to the fact that we need well over 3,000 more doctors between 1970 and 1971.

Now, we must have people to train these doctors. Part of the funds you are putting up money for, for training scientists, will teach in the schools, the new schools that we will have, and they will assist in enlarging the student body in those schools that are now in existence. It is unthinkable to me that people would focus their attention solely upon this immediate problem of saving money. A keener insight into this problem would lead me to believe that those who really consider it will believe that this is an investment, an investment in the future of this country, and I believe, sir, that it is a good investment.

Mr. FOGARTY. I agree with you, but there are going to be a lot of people that won't agree with you or me.

Mr. RAVDIN. I am sure that that is true. Things that have been so important in this country——

Mr. FOGARTY. I made a lot of speeches last fall when I was home, mainly to scientific groups and nonpolitical gatherings.

I told them how we had cut the President's budget, practically every one he sent up here, with the exception of this one. I told them we increased this one. Even the chambers of commerce didn't find fault with increasing the budget for these programs when I had a chance to explain what it is for.

I quote people like you and Dr. Farber and others. They seemed to think, after hearing an explanation of why we increased this budget, that it was good business. If we can help people and prolong their lives, and save more lives, it doesn't bother me about spending a few more million dollars.

Dr. RAVDIN. Doesn't bother me, sir. One of the President's first questions addressed to Mr. Flemming was: Could these funds be spent wisely? I believe that is a question that we have to ask ourselves.

Mr. FOGARTY. That is what we try to do.

Dr. RAVDIN. Surely.

Mr. FOGARTY. We want to make sure that what funds are appropriated are expended in a good way. If there is a little more than can be wisely spent in any program, as is true this year, we expect it to be returned to the Treasury. You will agree with that?

Dr. RAVDIN. I certainly do. I think the important thing to think in regard to this is: Is it more important that we this year balance the budget, or is it more important that we should be sure we are doing everything possible to improve the health problem. What is more pressing than that in our population? Not only in our population, but in the underprivileged countries of the world, where they do not

have these advances which help to make people more understanding. It is my considered opinion that the improvement of international health is of the greatest importance and I realize it. I released a message in Boston last Sunday afternoon, stating that the International Federation of Surgical Colleges and kindred societies, which was formed a year ago last July in Stockholm, has now been recognized by the World Health Organization in Geneva as an adviser in surgical problems that have occurred throughout the world.

The first purpose of the International Federation is to improve the standards of surgery in those countries in which the standards are not high, and its purposes are closely correlated with the purposes that you and others have been forwarding for international health.

Mr. FOGARTY. You have friends in that area, too, especially Mr. Denton on my left. He has had a great deal of experience on the Appropriations Subcommittee for Foreign Aid. I am sure he would agree with you that this is one area that we certainly should pay more attention to, and perhaps we could do a much better job with fewer dollars.

Dr. RAVDIN. There is one thing about a Hoosier, especially a southwestern Indiana Hoosier, that they stand together.

Mr. FOGARTY. I am sure Mr. Denton agrees with you, and I think if he had charge of this foreign aid bill, he could find a way of saving a billion dollars, and put a couple of hundred million more in medical research.

I don't think he would have a hard time doing that, at all.

Mr. DENTON. I don't believe anyone would have a hard time doing that.

Mr. FOGARTY. Is there anything else you would like to say?

Dr. RAVDIN. No, sir.

Mr. FOGARTY. Do you understand the problems that we are faced with?

Dr. RAVDIN. I do understand them, and I want you to know that we are all very grateful.

Mr. FOGARTY. Give me another answer to this statement, because it has been used several times in debate on this bill: Why we are spending all these millions of dollars and still 250,000 people are going to die of cancer this year and the doctors still don't even know what causes it. What is a quick answer to a statement like that?

Dr. RAVDIN. Breakthroughs come through momentarily. I can remember in 1921 when a doctor who was a clinical pathologist in one of the fine clinical hospitals came into the university hospital to have luncheon. A distinguished internist asked him to luncheon, and asked him how his younger son was, and he said, "My wife and I wish he were dead. He is a total diabetic. He is 13 years old. He isn't any larger than a 6-year-old boy; never can grow up."

This internist looked at this man and said, "Tom, you oughtn't to talk that way. Who knows, next week, next month, next year, nobody can be sure, somebody will come forward with a treatment for diabetes. If you keep Tom alive, he will grow up."

The very next day Banting and Best announced the discovery of insulin. The day before it looked dark. And that Dr. Minot, and he is in Dr. Farber's community, was the first patient treated in this

country, and this lad was the first treated in Philadelphia. In 3 months he was in Germantown Friends School. In 3 years he was in Haverford College. And 4 years later he went to our medical school, from which he graduated. He was married. He carried on his medical activities in New York State. He led a full life. He died 2 months ago, but he didn't die from diabetes, but a coronary infarction. That is the way these great breakthroughs come through; none of us can prophesy when it is coming through. But I am sure that it will come. Then everybody will be very happy that they spent these funds.

Mr. FOGARTY. I don't know whether you said it in your statement or not, but I think it has been said before that 50 percent of all the people who have cancer, if they went to a doctor in time, could be saved. Is that so?

Dr. RAVDIN. If the cancer is still contained in the organ in which it began. When cancer moves from there, surgery isn't good enough, and X-ray isn't good enough.

Mr. FOGARTY. We were told that cancer of the pancreas is a type of cancer that even the gastroenterologists cannot find until it is too late. Is that so?

Dr. RAVDIN. Cancer of the pancreas is one of the most serious to diagnose. Once the patient becomes jaundiced and the cancer is involving the common bile duct, that is too late, sir.

Mr. FOGARTY. How can we get people to go to a doctor sooner?

Dr. RAVDIN. The American Cancer Society has given the American people what it calls seven danger signals.

Mr. FOGARTY. They are doing a good job.

Dr. RAVDIN. That is a splendid educational job.

Mr. CEDERBERG. I want to concur in what the chairman said. I have some differences of opinion as to degree, never as to the results we want to obtain. I certainly think that the record ought to be clear that, from 1951 through fiscal 1960, there has been an increase of roughly 450 percent in the appropriations by the Federal Government to the National Cancer Institute, which is considerable.

Certainly, I don't know of anyone that would in any way want to hamper these programs, because they are very important. During a trip that I took this fall, I had lunch with Dr. Farber, and the opportunity to visit his Children's Hospital, which was very enlightening to me.

I would like to go off the record just a second, Mr. Chairman, if I may.

Mr. FOGARTY. Certainly.

(Discussion off the record.)

Mr. DENTON. We both came from the same town, and I have great respect for the Ravdins in the field of medicine. I certainly agree with what you said about the reasons for research, about the prospects of a breakthrough, and about the progress that has been made by research, and that in the long run it is a good policy.

We are confronted with these people who say to us, that is all true, but we have to balance the budget this year, and we cannot spend all this money.

What is your answer to that?

Dr. RAVDIN. This comes down basically to the conscience of the committee. Is it better to recommend the appropriations for those

funds which, in your wisdom and from the testimony presented to you, is important, or is it better to balance the budget?

Mr. DENTON. I don't think you have a bit of trouble with most of the members of this committee. We have the same conscience that the people in southwestern Indiana have. But how do we answer a man that makes that statement? There is not much you can say to him, is there?

Dr. RAVDIN. You can say that after considering the factors, major factors, on both sides of this issue, that you believe the most important thing for you to do within our conscience is to provide those funds which are necessary adequately to meet the health programs of this Nation.

Mr. DENTON. I agree with you about foreign aid. You have spent a good deal of time in India, and money spent for health, education, and a certain amount of training would go a tremendously greater way and improve our relations much more than playing parlor politics.

Dr. RAVDIN. I received a letter from Dr. Melvin A. Kasper, who was formerly Assistant Secretary of Defense, Health and Medical. He has gone to India from the University of Texas, where he was vice president for medical affairs, to head the Christian medical colleges of India. He has sent me a document, and tried to get published in this country as an editorial, showing how important it is that we in a major way assist in improving the health problems of India. I intend to get it published.

Mr. DENTON. You have firsthand knowledge, as you spent some 3 or 4 years in a hospital in India, as I remember?

Dr. RAVDIN. That's right.

Mr. DENTON. You didn't say anything about cancer and virus. Is there anything new on that this year?

Dr. RAVDIN. This is very energetically being pursued. As you know, one of the most distinguished virologists in the world, Wendel Stanley, head of a great department at the University of California at Berkeley, has expressed his opinion, and many others now agree with it. It may be well demonstrated that many of these malignant lesions are due to viruses.

We are going to get an additional amount of information showing that this might well be true, and we may at any time have a major breakthrough in this area.

Mr. DENTON. I think that is all.

Mr. FOGARTY. Thank you very much.

Dr. RAVDIN. Thank you, sir, for giving me this privilege.

Mr. FOGARTY. We will hear now from Dr. Farber.

### STATEMENT OF DR. SIDNEY FARBER

Dr. FARBER. Mr. Chairman and members of the committee, I want to express my gratitude to you for this opportunity to be here. I speak in complete agreement with my colleague, Dr. Ravdin, and also in agreement with the recommendations of the various citizens who are appearing before you this week in support of the entire National Institutes of Health program.

I want to say a special word at this time to you, Mr. Fogarty, and to your colleagues on this committee, and to your colleagues of the counterpart committee in the Senate. You have created a

revolution in America, and so in world research which has altered for the good the medical schools, universities and research institutions of this country, by providing research support in sums which have never been available in the history of medicine before; money in amounts which could not come from volunteer organizations alone. When the voluntary agencies and private donors join with the Federal Government, and they are spurred on to greater private giving by the example you have set the effect on medical schools and universities of the country is a tremendous one. This has enriched teaching as never could have been done by private funds alone.

Students and young doctors come where brilliant research workers can inspire them by example. Patients come where they can get better care and where, because of such research, there is a better opportunity for the saving of their lives. Physicians, scientists, students, and patients create medical centers. The mostimportant functions of a medical school or that part of a university concerned with biology and medicine, are those which have to do with the saving of human life, the eradication of disease, and the enrichment of our knowledge for the generations that are to come. A balanced program of research and teaching and medical care in any medical school changes in definition with advances from research. And as these advances come, and as diseases are eradicated, the balance is put in one or another spot for greater efforts in behalf of human beings.

Your committee must accept its share of responsibility for these tremendous changes which have taken place. If they had the opportunity, the people of the country would express their gratitude to you, as I do today.

I want to speak particularly about the National Cancer Institute program. I said I am in agreement with the remarks of Dr. Ravdin, and that includes an endorsement of the minimum budget which is recommended by the legislative committee of the American Cancer Society. As a citizen, if I may speak now personally, I think the budget is too small. I could document this with evidence which can be gained by making a visit to the various research institutes,medical schools, and research hospitals of the country. When we speak of something being too large, or when we speak of a large percentage increase in appropriation within a period of 5 or 10 years, we must define our basic premise: Where did we begin? We began very near zero at the end of World War II. We have to go an enormous distance before we can reach the level where we can stand as physicians before you and say, "Gentlemen, we are now dealing with medical research on a truly professional basis." By "professional basis" I do not mean to speak disparagingly of the valuable research which has gone on in medical schools and research institutes before this present era of the promise of adequate research support.

But I know of no institution staff in this country which has ever had enough experts with sufficient laboratory facilities, enough apparatus, and enough money to tackle adequately the medical problems confronting them. I know of no institution in the country which has ever had the opportunity to achieve its full potential as measured by

the magnitude of the problem of disease, such as cancer, or the other dread diseases.

The largest cancer programs which have been made possible by the action of this committee and your counterpart in the Senate concerns the cancer chemotherapy program, the virology and cancer program and that concerning the search for cancer diagnostic tests.

Dr. Ravdin has reported on the cancer chemotherapy program. As chairman of the Cancer Chemotherapy National Committee, may I say that I support completely what he has said. I think there has been important progress this past year. This progress could not have been made without the aid of the organizational pattern that has been created through the Congress, with the aid of your Appropriation Committees.

The virology and cancer program grew from very little 2 years ago when you made your first appropriation to a very live, exciting program, which has brought into it large numbers of young people, as well as some of the older virologists of the country, who, having solved other problems, were looking for new worlds to conquer. This has come at just the right time for them. I want to emphasize, however, that large numbers of young virologists interested in the field of cancer have entered this field with the aid of support given through this committee. This program has been a worthwhile one, and an important activity is going on. Dr. Heller, I know, has given you a detailed report. You may expect from time to time reports of progress which will be both heartening and important to the cancer patient.

### CANCER DIAGNOSTIC TEST PROGRAM

The next program, the cancer diagnostic test program, concerns the search for a simple, inexpensive, objective and accurate diagnostic test which may be carried out on human beings in mass screening to see if cancer is present. We have no such test.

Mr. Chairman, if we had such a test, the number of patients cured today could be increased markedly with the aid of the techniques that we now have available for treating human beings with cancer. I am happy to tell you that the million dollars which you appropriated has been more than allocated by excellent contracts recommended by a special advisory board to the National Cancer Institute, and that scientists are working in a number of institutes in the country in an attempt to find such diagnostic tests today.

### CANCER RESEARCH CENTERS

The final point I would like to mention concerns the Research Center. There are many names for this. I will put this, too, in a separate statement to be submitted without presenting it in full to you. May I remind you that 2 years ago, before this committee, the mention was made of the support of the independent programs and independent institutions throughout the country of the same kind of support as the magnificent Clinical Center in Bethesda.

These were not to be of the same size, nor of a single pattern. Deficiencies in institutions which are already grappling with the problem of cancer in a given territory were to be made up through this center plan. Why centers? In the first place, there are population centers all over the country. Wherever there are masses of people

who have the problem of cancer, those people should be given the benefit of the latest therapeutic and diagnostic advances from anywhere in the world, and some of that research should be done locally. I believe in the decentralization of care and research. This is a great country, and wherever I have traveled in this country I have found men of ability in institutions which were willing to take the challenge under proper conditions of carrying out further research programs.

A second reason for the center plan is that it permits the grouping together of experts under one roof, with better apparatus, and techniques, who can make studies on the human being with cancer. That is what we are here for, to cure cancer in the human being.

Last year, a specific recommendation was made. Because of the administrative expediency, with the amount of money which was finally allocated for research centers, this center plan was placed in the hands of one of the councils, the National Advisory Health Council.

When I speak of centers for cancer, I want to say at once that I want to speak strongly in behalf of centers in each one of the dread disease categories of the NIH. In addition, I want to endorse the recommendation of my colleagues who were here yesterday afternoon, Dr. Handler and Dr. Thomas in behalf of the General Clinical Research Centers, which go across disciplines in medical schools and teaching hospitals, these we are now implementing with the $3 million which you awarded last year. In regard to these research centers, I have never seen such enthusiasm for research programs supported by the National Institutes of Health to the Congress, as I have when I visited many institutions and talked to scientists and physicians from different parts of the country. The manpower is there, working at a fraction of their potential because of the lack of research beds and support for research and because of the lack of equipment and metabolic and other kinds of research wards.

May I speak strongly in favor of all of these, and not merely in favor of research centers in the field of cancer. These are needs which vary from place to place, from institution to institution. The centers should not only be medical schools, but also in research institutes and hospitals.

One final point, Mr. Chairman: the research training grants have been a great boon to the country. They are training the men of tomorrow. Once they are trained, we must support them. May I, as a citizen, make a recommendation that the Congress allocate money specifically in every one of the categorical areas, and also in the division of general medical sciences, for the support of research professorships in medical schools and colleges, awarded to institutions which will make the selections of their own choice.

After we have trained research men, let's not force them to go out into private practice just when they are capable of adding to our store of knowledge. Let us then support them in the same way that the American Heart Association and the American Cancer Society are now supporting investigators on a small scale. Let us do this on a realistic basis in adequate numbers, so that we can keep these young men where they belong, doing the kind of work which all of us need to have them do.

I am going to stop at this point, and put the rest in a written statement.

BUDGET FOR CHEMOTHERAPY PROGRAM

Mr. FOGARTY. Doctor, a few years ago you were the one who advocated a Federal program in the field of chemotherapy. I thought last year that program was going on pretty good, but apparently, from the legislative report of the American Cancer Society, they are recommending a cutback in that program. What has happened?

Dr. FARBER. May I explain that? The program is going along beautifully. We had in November, the 10th and 11th, in Washington, a meeting where reports were read from the research of 500 doctors in 200 instutitions in this country based upon cooperation and pooling of their knowledge. This work was supported through the chemotherapy program by Federal money and was carried on under Dr. Radvin's direction as chairman of that panel.

We are continually studying that program of chemotherapy of cancer, and continually improving it. Just recently, for the last 3 months, we have had special committees making a more intensive study to improve it. I am perfectly content with the progress of the program. I think it is a splendid one, and I think it is just hitting its stride.

Why did they cut back? The American Cancer Society legislative committee saw that the Bureau of the Budget had held back $3.5 million in fiscal 1960. They gave $2.5 million more in the belief that this was adequate for this year, holding back $1 million of the $3.5 million which we were not permitted to use this past year.

I do not understand, Mr. Chairman, this holding back of money that has been allocated by the Congress, when the program is there and the need is there. Dr. Ravdin and his panel of clinical investigation of cancer chemotherapy could use not only $1 million more but $10 million more immediately if the full strength of our clinical programs could be employed.

Mr. FOGARTY. I thought we were told by the people from the Institutes of Health, the Surgeon General, and the Secretary that, if additional applications are approved, this $5 or $6 million that is being held back will be released by the Bureau of the Budget.

Dr. FARBER. Mr. Chairman, there is a law of grantsmanship in applying for research grants. When the rumor goes out that money is not there, or that it has been held back, people do not go to the immense amount of labor to prepare detailed requests.

Mr. FOGARTY. I think it is in the record, I am sure they said that if applications came in and they were approved, that these funds would be released.

Dr. FARBER. Mr. Chairman, I don't know.

Mr. FOGARTY. I am not sure how they said it, but I think it is about the way I said it.

Dr. FARBER. I have heard this, too, Mr. Chairman. I do not understand it. I do know, however, that the need is there, and that if encouragement were given the research workers of the country, the program requests would come in——

Mr. FOGARTY. You heard what I had to say earlier to Dr. Ravdin about our problems on this side of the table, in trying to make up some of these cuts and find a way of providing more funds for research in

these areas that you are interested in. What is your best answer to people who think more of a balanced budget than they do of spending a few million more dollars for research in these areas? I think I asked Dr. Rhoads, God rest his soul, the same question 3 or 4 years ago.

I think maybe you were here at the time. He gave a pretty good answer, that I have used several times, about extending the life expectancy in the last 10 years and the advances that have been made.

Dr. FARBER. Mr. Fogarty, the best answer is, I think, the presentation of facts before such people about the great gains in the survival of people in the country and the eradication of a number of diseases.

Mr. FOGARTY. One of the problems we have with people who think that way is that when you attempt to present facts, they are not listening; they are looking out the window, they are not concerned about the facts; they just have their mind made up.

Maybe some of these neurologists can give us an answer on how we break into the minds of people like that.

Dr. FARBER. I am sure that they can, because they are two distinguished neurologists, but I know that when they meet with the family of a patient who has an incurable disease of a neurological nature, they go through the same kind of discussion that I do when I talk with the parents of the child with acute leukemia, or a malignant tumor that has disseminated throughout the body. What we tell these people is, to give them encouragement, after we tell the truth about the diagnosis, is to point to the amount of research which is going on. We tell what has been accomplished, and describe patients who are alive and well even when they did come with diseases which were once considered incurable.

Finally, we tell them that because we have research programs in hospitals and laboratories we will never give up. Their only optimism can be that the next forward step may come in time for their own child, husband or wife. We see progress daily of lifesaving importance to individual patients, even if we have not yet reached our goal.

Now, Mr. Chairman, since we are living with this constantly, and this is your point of view, I know, and that of the members of your committee, it is so clear that it is very difficult for me to answer something which I cannot understand as a question. You raised a question to Dr. Ravdin about 250,000 that are dying of cancer this year, the same number. May I answer that?

In the first place, the figure, 250,000, which appears to be the same as 10 years ago, is not the same. Ten years ago, one patient in four with any kind of cancer was cured by the methods available. Within the last few years, that has changed to one patient in three. This is an enormous gain—from 25 percent to 33 percent—it is an enormous gain if you or a member of your family is a member of that additional group of survivors.

In addition to this, the population has increased. Longevity, too, has increased, and cancer increases as people grow older, so the actual number of cancer patients has increased.

Furthermore, with our diagnostic studies and educational programs, we are getting more and more patients with cancer correctly diagnosed. Our gains are covered up by this figure which some say is apparently

the same. The answer, Mr. Chairman, is that there have been great gains, and that we are not standing still. Anyone who had the opportunity to come into a cancer hospital 10 years ago, or the cancer ward of any large hospital today, and compare it with what is now going on, would see a picture that is of great progress in behalf of the patient.

Mr. FOGARTY. I think I remember Dr. Rhoads, a few years ago, talking about the field that you are very much interested in, leukemia. If I remember correctly, he said that 10 years ago if a child was diagnosed as having acute leukemia the parent was told to take the child home because there was nothing that could be done. As I understand it, you don't have the answer yet, but at least they are living 2, 3, 4, or 5 years, instead of a few weeks.

Dr. FARBER. I saw a child yesterday who was in perfect health. She came to us 6½ years ago, as an extremely sick baby with acute leukemia. She is in complete remission, and has had more than 6 years of normal life. She has not been cured. Unless we learn something more than we know now we will lose her, but we still have her, waiting for the next forward step in research.

Mr. FOGARTY. Is it a fact that 10 years ago that child would have died in a few weeks?

Dr. FARBER. Within a few weeks to few months all children with leukemia were dead. As you state, the patients were not even kept in children's hospitals prior to 1947 when the diagnosis was made and verified. A transfusion was given and the child was sent home with the burden on the parents, and with nothing more that could be done for the sake of the child. That picture has changed.

Mr. FOGARTY. That is a good example of the advances that have been made.

Dr. FARBER. The change from one survivor in four to one in three. That is a tremendous change in the total picture of cancer.

### DIAGNOSIS OF CANCER

Mr. FOGARTY. I was interested in your proposal for doing more in trying to discover a better way of diagnosing cancer. Is there anything else we can do as a committee to encourage it? That might be a long-term process.

Dr. FARBER. I am happy you asked that, Mr. Fogarty. This is a long-term research program. Those who enter it are entering a field where success has never been attained before, and where success seems very, very dim. It may be that we are going to require many different diagnostic tests.

The suggestions that I have, Mr. Chairman, and members of the committee, are: you will receive regular reports from the NCI concerning the progress of this program, that you continue to support it, and that when it is apparent that more money is needed rapidly to follow a breakthrough, we will be given the opportunity to present such evidence before you. That is not the case today, Mr. Chairman. We are in a stage of hard work now, and I feel elated—I choose that word elated, that we have been as able to attract as many fine brains in the country to work into a field that seems so hopeless.

STATUS OF UNOBLIGATED FUNDS

Mr. FOGARTY. Getting back to unobligated funds, Doctor, we were told by Secretary Flemming that they expect to have $5.8 million unobligated at the end of the year. He said:

> You do appreciate that in some of the Institutes they will not use all of the funds appropriated. In other Institutes they have approved projects in excess of funds appropriated.
> In other words, as you know, we could not use $5.8 million, for example, in order to take care of the $3,992,000 in other Institutes.

I said, "Has it been firmed up that $5.8 million will not be used?" Secretary Flemming said:

> The best estimate we have been able to get up to the present time is that they will not use more than $150,000 to $250,000 of that at the most. That is the best figure we have had from NIH. Is that correct?
> Mr. KELLY. That is an estimate. It is based on all projects that have been received. It is based on prior action of study sections and the percentages of approval. It still has to be finalized. The nearest estimate is that $169,000 of the unapportioned funds may be needed.
> Secretary FLEMMING. I might say if they request release of that amount, a larger amount from the reserve, that request will be approved by us and submitted to the Bureau of the Budget, and I feel confident that the Bureau of the Budget will release whatever amount we request.

That is what I was referring to. That, I think, is about what I said.

Dr. FARBER. I am as much disturbed about that as you are, sir. For a number of years I have been trying to understand this holding back of funds. I do know this, that once they are held back, the chances of getting the money out again are very poor. Such an act discourages, research workers from putting in requests.

Mr. FOGARTY. Sometimes, perhaps, it has been the fault of Congress because the appropriation bill had not passed until we were in the first quarter of the next fiscal year. That would not be the fault of the Bureau of the Budget.

But, in other instances, the Department and the Bureau of the Budget have taken a lot of time in making these apportionments. As a result, you lose the amount of the increase that would otherwise be in the first-quarter apportionment.

Dr. FARBER. That I can understand, sir. That has happened.

Mr. FOGARTY. I think maybe Congress has been to blame some times, too, because we acted too late on some of these appropriations.

Mr. CEDERBERG. What do you think of institutional grants for research?

Dr. FARBER. I should have mentioned this. It was merely an oversight not to. The institutional grants represent an opportunity for greater initiative on the part of the medical schools or of research institutes and hospitals to start programs of research which might not be far enough along to request support from the NIH. I think the idea is an excellent one. It is worthwhile trying to see how well it works. It is not a gift to the institution. It should not be restricted to medical schools, but should be awarded to every institution which possesses NIH research grants. I think anything that will increase

the initiative in the institution itself is worthwhile doing, and this seems to be a valuable move in that direction.

Mr. CEDERBERG. There is general agreement among the medical schools. They are in favor of this program.

Mr. FARBER. Yes, and those that understand the management of many research programs will be more in favor of it than investigators who are working only on one program.

Mr. CEDERBERG. Thank you, sir.

Mr. FOGARTY. Do you have anything else you would like to say, Doctor?

Dr. FARBER. I would just like your permission to put material into the record which I did not present today. What I would like to say is: Thank you very much, indeed, Mr. Chairman, and members of the committee.

Mr. FOGARTY. We appreciate your coming down here and giving us your advice. I hope that we can go along with some of it, anyway.

(The added statement of Dr. Farber is as follows:)

ADDED STATEMENT OF DR. SIDNEY FARBER, PROFESSOR OF PATHOLOGY, HARVARD MEDICAL SCHOOL AT THE CHILDREN'S HOSPITAL; SCIENTIFIC DIRECTOR OF THE CHILDREN'S CANCER RESEARCH FOUNDATION, ETC.

Mr. Chairman and members of the committee, with the permission of the chairman, I am inserting this additional statement to accompany my impromptu remarks before the committee. I should like to emphasize my admiration of the administration of the National Institutes of Health under the leadership of Dr. Shannon. From my own investigations of the entire program of the National Institutes of Health, which has been aided this year by an unusual opportunity, I want to state that:

1. The review of grant requests by study sections and councils has been more expert and critical than ever before, despite the greatly increased number of requests which had to be examined. This is explained by the great devotion and expert knowledge of the members of the Division of Research Grants, and the administration of the National Institutes of Health, coupled with the high sense of responsibility and unselfish desire to serve exhibited by the large number of citizens who compose the study sections and councils of the NIH.

2. There has been no evidence that physicians have been taken away from patient care or teaching because of the greater availability of research funds during fiscal 1960. To the contrary the teaching programs have been enriched and patients have been given better care than ever before.

3. The interest of the Federal Government in the support of medical research has stimulated rather than discouraged private giving.

TOTAL COST OF RESEARCH

The attention of the committee is called to one of the greatest threats to research progress in this country. This has to do with the inability of the medical schools, universities and research institutions to find, without tremendous effort, the amount of money called incorrectly indirect costs incident to the carrying out of a research program. Various suggestions have been made and formulas have been studied by the Bureau of the Budget. It has been pointed out to you that when a research contract is given an academic institution the total cost is paid. It seems clear that increased expansion of the badly needed medical research in this country, through the magnificent support given by congressional appropriations through the NIH will grind to a stop unless the total cost of research is included in research grants. The medical schools, universities, and research hospitals are in the throes of a revolution which marks the beginning of a magnificent new era not only of research progress but also of great stimulation to the quality of the teaching and improvement in the physical structure of the research portions of educational institutions. The leaders of educational institutions in which research has increased to such a heartening degree must rise to the occasion and demonstrate vision and professional capacity, sufficient to direct these new and badly needed resources of research support in such a manner as to strengthen their institutions rather than look upon the great opportunities afforded by the

NIH expansion as a threat to carrying on their activities in a manner not consistent with our time. A long and careful study of this question leads to the recommendations:

1. That the total cost of research be included in the amount of a research grant.
2. That the terms "indirect cost" or "overhead" be dropped and that the term "actual cost" be substituted.
3. That only those actual costs be honored which were brought into existence by the onset of the research program and that there not be included any reimbursement of an expense which goes on in that institution if there were no research, or which is not increased by the research. While heat, light, and maintenance would go on if there were no research, the cost of these services will be increased in measurable amount by the added and specialized activity necessitated by the research program. The maintenance of grounds and the salaries of fixed personnel, such as the dean or the director of a research institute, would all go on if there were no added research programs. Such items, therefore, should not be included in a formula. It is to be hoped that the definition of total costs in fair and realistic terms, calculated within the frame of reference to the cost of the research program in question, will act as a solution for a vexatious problem which if left unsolved will stand as an obstruction to the effective utilization of the magnificent opportunities afforded research workers throughout the country by the farsighted recommendations of the congressional Appropriations Committees.

## INTENSIFIED CANCER RESEARCH PROGRAMS—CANCER RESEARCH CENTERS—DIAGNOSTIC AND THERAPEUTIC CANCER CENTERS

*Introduction*

In testimony before the House Subcommittee on Appropriations for HEW in 1959, a recommendation was made on the basis of a suggestion entered in testimony the previous year—that support be given for centers for cancer research with emphasis on diagnostic and therapeutic aspects of the problems of cancer. This represented a logical progression in the philosophy of NIH research support which began with the project grant. That type of grant will always remain a valuable device for the support of research by individuals on specific subjects. The great expansion in research made possible by Federal appropriations brought about the development of larger, more stable grants for longer periods of time concerned with support of whole groups of people working on programs or in specific areas. This expansion, in turn, called for the provision of better and more facilities, and for the training of scientists. Construction and research training grants followed in logical turn.

Two considerations led to the recommendation in last year's testimony of a logical forward step of great magnitude in the Federal support of cancer research. The first has to do with the needs of patients in centers of population for the rapid application of the results of research anywhere in the world, including that in a local or regional institution. The second consideration arose from the experience of both the National Institutes of Health and the cancer research workers throughout the country that full exploitation of the great progress in research of the past 12 to 14 years could be realized only if a number of experts in the various fields of clinical investigation of cancer, supported by scientists in the several laboratory disciplines required for such clinical investigation could conduct research on a truly professional level in adequate facilities and with full support of their efforts.

It was recommended that these cancer research centers be created in independent institutions with programs independent of the National Institutes of Health. It was not intended that such centers be offshoots of the National Cancer Institute in Bethesda, representing nothing more than a series of colonies directed from a central source. Emphasis was placed, too, on the provision of support on the same realistic basis as that given the magnificent program of clinical and laboratory investigation in the National Cancer Institute in Bethesda.

## THE RESEARCH CENTER PLAN IN THE SEVERAL PARTS OF THE NATIONAL INSTITUTES OF HEALTH

It is clear that a plan which represents the attainment of optimal professional research conditions for the first time must be applied to the many areas of responsibility of the National Institutes of Health. What will be said in reference to cancer research centers may be applied in varying form to every one of the categorical areas supported through the National Institutes of Health. In addition, an opportunity already explored in preliminary form through the appropriation

of $3 million in the budget, fiscal 1960, emerges for the support of research in what might be called general clinical research. Here a research ward, a part or all of which might be set up for metabolic studies, can make possible with suitable support the precise clinical investigations of doctors and scientists representing the many disciplines of medicine, surgery, pediatrics, psychiatry, neurology, dermatology, and all of the other disciplines which are to be found in a research-oriented hospital, either independently situated or affiliated with a medical school. These general clinical research centers represent the ideal for which professors of medicine and surgery, and the other clinical disciplines have waited for many years. The research manpower for such centers is ready and waiting, but unable to work to capacity because of the lack of the kind of support which has worked so successfully in the clinical center in Bethesda, or in small private ventures in a few institutions in the country where endowments made possible this kind of clinical research.

From a personal experience gained from visiting a number of institutions which have applied for such general clinical research center support, I can say that no venture ever supported through the NIH by funds appropriated by the Congress has ever been greeted with such enthusiasm and gratitude by doctors and scientists whose major interest is the study of disease in man. I wish to join in strong endorsement of the recommendations for support of these general clinical research centers with the two citizen witnesses, Dr. Handler and Dr. Thomas, who testified yesterday afternoon in behalf of the research appropriation for the Division of General Medical Sciences. At this time, too, I would like to endorse strongly the recommendations of the citizen witnesses who have appeared, or will appear before your committee this week in behalf of the appropriations for each of the categorical institutes of the National Institutes of Health.

### CANCER RESEARCH CENTERS

What is a center? This imperfect name implies the bringing together for the most effective and rapid progress in medical research of experts highly competent in their fields of activity, organized for the attainment of specific goals concerned with medical research, as for example, the prevention or abolition of a dread disease, or the solution of a problem of importance in biology and medicine. This conception includes the provision of adequate physical resources, equipment, and facilities, including support of research beds, with provision for full cost of everything that has to do with the conduct of such research. Flexibility is of paramount importance in this conception so that full use of existing facilities, manpower, and resources may be made while deficiencies are remedied. Such centers may be organized around a specific problem, such as diagnostic and therapeutic aspects of cancer research concerned with the evaluation and development of cancer diagnostic tests; or a program of cancer chemotherapy which may be as inclusive as the synthesis of chemical compounds, studies of their mechanism of action, toxicity, and pharmacological properties, and the effects of these compounds on human beings with disseminated cancer.

A second kind of center may be concerned not with problems of this kind, but rather on the provision of research resources in different parts of the country. Such resource centers may provide necessary experimental animals of the proper kind and in sufficient numbers, or deal with specialized apparatus, such as computers and other technical appliances for the application of mathematics to biological and medical problems. Expensive research instruments of large size and cost might be grouped in special installations to serve many parts of the country.

### LOCATION OF CENTERS

These centers may be located in facilities or organizational units which are a part of universities or medical schools, or they may be placed in institutions which are independent, as for example, in any cancer research institute. These should be located wherever there are research leaders and institutions willing to take responsibility for leadership in research on a professional level. They should be created, if they do not exist, wherever there is a center of population with problems which demand solution as rapidly as possible.

### FINANCING AND ADMINISTRATION

These centers might be supported through the existing grants program, or if in the opinion of the administration of the Congress they could be better handled by the contract mechanism, this should be done. Confidence is expressed in the

ability of the NIH to work out the administrative mechanism to meet the needs of this new opportunity.

### CONCLUDING REMARKS ABOUT CANCER RESEARCH CENTERS

The support of cancer research centers is badly needed. The amount of money available for the support of cancer research has never been great enough to bring out the full research potential of the country, nor have all funds available for cancer research been even remotely commensurate with the human or economic magnitude of the problem of cancer. Cancer research must be regarded as a professional pursuit to be carried on by the most expert scientists and doctors available with long-term support of their research conducted in adequate facilities on apparatus suitable for the purpose. The results of cancer research should be carried to man without delay. This can be done only if there is adequate support for research observations on cancer patients in specialized clinics and research wards, with the aid of laboratories representing the several sciences basic to clinical investigation. The creation of such centers realistically supported and located in many parts of the country will, without question, accelerate greatly progress in cancer research and make possible the shortening of the tragic lag which still obtains between discovery in the laboratory and application to the patient who is dying of cancer.

The creation of the cancer research centers will make for far more rapid progress in the solution of human cancer by making possible the study of humans with cancer. Discovery so made can be studied in the basic science laboratories which will make their contribution in turn to the welfare of the patient on the cancer research ward.

During the past year I have discussed the possibility of these cancer research centers with colleagues in cancer research in many parts of the country. I have heard nothing but enthusiastic endorsement of the conception. The Association of Cancer Institute Directors has officially gone on record in unanimously urging the appropriation of funds for the support of the cancer research centers. The provision, Mr. Chairman and members of the committee, of realistic support of centers throughout the country will bring to people throughout the country for the first time an equal opportunity to receive the benefits of research which has been carried out in those institutions, or in laboratories and clinics throughout the world.

### SUMMARY OF RECOMMENDATIONS CONCERNING CENTERS

1. The research centers supported through the NIH should be characterized by flexibility in design, emphasis on the correction of deficiencies in a given institution (e.g., research, ward, or laboratory construction, personnel support, research equipment, animal facilities, etc.), or creation of facilities in a center of population devoid of such research facilities.

2. The research centers should be oriented toward the categorical areas represented by the several institutes in the National Institutes of Health. There should be centers for cancer, cardiovascular, neurological, or mental disease, and other "dread diseases." The plans should include provision for general clinical research centers which might encompass attacks on the several dread diseases as well as basic study of patients from the point of view of the discipline rather than the categorical disease.

3. The support should represent the total cost of such clinical research and should include, therefore, the cost of research beds, the supporting personnel, and also the cost of the research and equipment in the laboratories of the sciences basic to such clinical investigation.

4. The cancer research centers may be all-inclusive on the basis of knowledge of today, or may be oriented particularly toward the study of cancer in the human, including programs for the development and evaluation of diagnostic tests, the role of immunity, and vaccines in human cancer, and study of the action of anti-cancer agents.

5. Another form of research center may be concerned with resources such as those for the breeding of animals required for research, or for the creation of computer centers.

6. The amount of support should be realistic and commensurate with the size and actual cost of the maintenance and budget of such a center. It should follow in principal the splendid model created in the National Cancer Institute in its activities in the Clinical Center in Bethesda. It should include the cost of new construction, remodeling, equipping, and maintaining facilities adequate for the task. Multiple year appropriations and awards by contract would be beneficial.

The selected institutions, either with medical schools of universities, or in independent research institutions or research hospitals should give evidence of stability and continuation of an environment ideal for the purpose.

ADDED REMARKS CONCERNING THE 1961 FOOD AND DRUG ADMINISTRATION BUDGET

With the permission of the chairman and the committee, I would like to make some comments concerning the budget of the Food and Drug Administration for fiscal 1961. My interest in the Food and Drug Administration is twofold. As a citizen, I am deeply interested in the enormous responsibility of the Food and Drug Administration in monitoring the welfare of this country in the broad areas with which you are so familiar. The special responsibility of the Food and Drug Administration in the cancer chemotherapy national program is an area which has brought me in particular association with the Food and Drug Administration since they have assumed from the beginning of the national chemotherapy program part of the responsibilities for the pharmacological studies in new cancer agents. From this relationship my colleagues and I in the chemotherapy program have developed an appreciation for the quality of their work.

A study of their budget recommended for 1961 shows that they are still short of the goal recommended by the Citizens' Advisory Committee which studied the Food and Drug Administration in 1955, resulting in a recommendation of a three- to four-fold increase in from 5 to 10 years. This recommendation is minimal rather than maximal as the scope of the Food and Drug Administration has become more clearly understood by scientists and physicians outside of Washington. In addition to their budgetary needs to support the actual work of the Food and Drug Administration there is great need for a new building which has been estimated at $23,840,000.

May I speak as a citizen then in strong support for a realistic budget for the Food and Drug Administration and for an appropriation to provide a new headquarters building in Washington? The budget should be commensurate with the great responsibilities of the Food and Drug Administration—responsibilities which have grown enormously during the last 10 years alone. Not the least of these is the added responsibility for determining tolerances or permissible levels of radioactivity in foods, drugs, or cosmetics, and for detecting radioharmful products and removing them from the interstate market. Only an adequately staffed, equipped, and supported agency can possibly cope with the constantly increasing number of additives to food, to cosmetics, and to medicines taken into the human body.

## NEUROLOGICAL RESEARCH

### WITNESSES

**DR. FRANK FORSTER, CHIEF OF NEUROLOGY, UNIVERSITY OF WISCONSIN; FORMERLY DEAN OF GEORGETOWN UNIVERSITY MEDICAL SCHOOL**

**DR. A. B. BAKER, DEPARTMENT OF PSYCHIATRY AND NEUROLOGY, UNIVERSITY OF MINNESOTA, THE MEDICAL SCHOOL, MINNEAPOLIS, MINNESOTA; CHAIRMAN OF NATIONAL COMMITTEE FOR RESEARCH IN NEUROLOGICAL DISORDERS**

Mr. FOGARTY. The committee will be pleased now to hear from Dr. A. B. Baker, Department of Psychiatry and Neurology, University of Minnesota.

Dr. BAKER. Mr. Chairman, I am Dr. A. B. Baker, professor and head of neurology at the University of Minnesota Medical School, and chairman of the National Committee for Research in Neurological Disorders.

Gentlemen, as you know, the National Committee for Research in Neurological Disorders is composed of 15 different organizations devoted to the neurological and sensory disturbances, as well as the two largest national societies of neurology, the American Academy of Neurology and the American Neurological Association.

One of the purposes of the national committee is to survey the research needs and research personnel in our country, and then to try to make recommendations for the development of these programs.

Although I have been chairman of this national committee for almost 9 years now, this is the first opportunity I have had of appearing before you gentlemen. Actually, I have welcomed the opportunity this time for a number of reasons.

First of all, I happen to be a member of one of the many millions of families in this country who have witnessed the suffering caused by these neurological and sensory disturbances. I have had a younger sister who was suddenly destroyed by infection of the nervous system, leaving her young children to be taken care of by the family.

And then also I have had an older sister who has lost her vision because of infection of the eyes. I watched my parents travel throughout this whole country, spend all their money trying to get some help for this girl, futilely.

I have also witnessed, since my parents' death, the suffering and the restrictions produced by this type of an illness.

Secondly, as chairman of the national committee, I feel a deep obligation for the many millions of individuals who belong to these societies who are looking to us to encourage more research as to the cause of their illnesses.

Then, finally, of course, for some 20 years as a neurologist, I have experienced a frustration of telling family after family and patient after patient that we just don't have an answer for their illness, and they just must continue the way they are until some time in the future we might find some answers. It would be very nice to say, for a change, that the future looks more optimistic.

Now, as you have no doubt been told, the neurological and sensory illnesses are a primary cause of crippling. We have at the present time about 20 million of these people in the United States. This is 12 percent of our population. This is more than all other illnesses together, and twice as much as the closest competitor, which is heart.

Now, this is a very formidable number. This number, of course, does not at all indicate the suffering and the restriction that these people go through, because of their illness. This very formidable number does not indicate the hardships people have to go through in taking care of these patients. Of course, I might mention, because this question may be asked as to balancing a budget, this big group of figures we have, this some 20 million does not indicate an economic loss of this country, and what might happen economically if we ever get a breakthrough and find some way of repairing some of these crippling illnesses, because we restore to economic productivity a vast body of our population.

Until 1944, this group of patients was truly the forgotten group in medicine. They were hidden away in the homes. They were shunned, they were stigmatized. They were isolated and they were a burden to themselves and their families.

The tragedy, of course, was that most of these people, a good share of them, had good minds and they could realize their own plight. It was actually in desperation, about at that time, that the families of

these patients formed a group and tried to do something to obtain aid for these individuals. The voluntary health groups, when organized, had a number of immediate problems. The first one they had was the problem of educating the public as to the magnitude of this problem, so that the public would be willing to offer aid and support it.

The second problem was a problem of public information. They had to educate the public as to the nature of these illnesses, so that these people would not be stigmatized, so that they could assume a more active role in society. This is the job we have not accomplished as yet. Many of these neurologically disabled patients are stigmatized and cannot hold jobs in society, even though physically they might be capable of doing so. They have a large job of patient care. These patients are in a home, crippled, and they had the job of trying to develop techniques to make these patients more comfortable in their home and in their environment.

Fourthly, they had a job of helping the families take care of these patients. These families were assuming the entire burden, and it was a difficult burden in many cases. I know the expense involved in trying to take care of some of these people, from personal experience.

Then, of course, finally, they had the problem, the final problem of trying to do something specific about these illnesses. Actually, all these other measures were merely holding-the-line measures. These patients and their families demanded, and had a right to demand, that we go further than merely taking care of the patient; that we find an answer to the illness. This meant institution of formidable research programs as to the cause and treatment of these many illnesses.

Now, the brain is the most complex organ in the human body. Naturally, research as to the defects in the brain is very, very expensive. The volunteer health groups attempted to set up research programs and have given more and more money over the years toward research. But, because of the enormous number of patients and different diseases involved, they just could not assume the entire role of research along with the other responsibilities that they had.

It is for this reason that they organized, about 8 or 9 years ago, as a unit, and attempted to see if they could approach Congress for help. Over the past number of years, you gentlemen have been very sympathetic and very liberal in your support for the research programs in these neurological disorders; and I am sure we have made tremendous strides toward the answer in many of these problems.

I should like to point out, because of the magnitude of this problem, that we have only scratched the surface. I think we must face the fact that we have just begun to approach this fantastically complex and large research problem in the diseases of the neurological and sensory organs. It is going to take a much greater expenditure of funds before we get our final answer.

I should like to take a few moments in projecting some of the key problems which face us, particularly in the field of neurological disorders, with which I am better acquainted. We have one big problem in perinatal damage to the brain at the time of birth. Being born is a natural process. It is necessary for the survival of the race. One

would think this would be a very natural and harmless process. Still, it is one of the most harmful processes to man. The sudden transition of an infant from breathing through the mother to breathing by itself requires a very complex chemical reaction to the human brain, and many babies just cannot make this transition. As a result, a large number of infants are born with a damaged brain, due to what we ordinarily call a normal-birth process.

At the present time, in the country, we have approximately 3 million of these damaged youngsters. They go by many names. Some are called cerebral palsy youngsters; some are called mental retardation; some are called epilepsy. We are adding 15,000 new ones each year.

The National Institute of Neurological Diseases and Blindness has started a very fine program, cooperative program, in an attempt to try to solve this problem. I feel confident, however, that it is going to take a much greater expansion of this program than we have now, most before we get the answer to this important problem.

Now, I come to a problem which to me is probably equally, or maybe more, important; and that is a problem of the aging brain. We have succeeded over the past many years in keeping man alive longer and longer, so that the life expectancy of man has slowly increased. We have not done one single thing about keeping the brain alive longer and longer, so that we have people living longer periods of time, but the brain continues to age as it did 50 years ago. As a result we are having a continually increasing aging population with brain damage, either in the form of strokes or mental deterioration. This is a very important problem.

Unless we do something about this and do it fast, and do it on a large scale, we will be faced with a real economic problem on our hands. We will be faced with an economic problem of developing institutions and areas where we can take care of our constantly aging population who cannot take care of themselves because the brain has aged faster than the body.

This problem, of course, has barely been touched in the entire research program in medicine today.

The final problem which, to me, is the most important, is a problem which is peculiar strictly to the nervous system. The human brain, the nervous system, is different than most tissues in the body. Once it is injured, it never grows back again, so that once a person is crippled with any of the neurological illnesses, he remains a cripple even if you find the cause of the disease and stop it; the patient remains a cripple, primarily because the nervous system does not regenerate.

We must, therefore, plan a research program of magnitude and skill which will investigate the reasons why the nervous system does not regenerate. I am certain that the answer is there. There is no reason why the nervous system should be so different from other tissues of the body. There is no reason why the nervous system should not follow the same type of pattern other tissues of the body follow and I feel certain that somewhere in the research laboratories there is the answer to nervous system regeneration.

If we can solve this, of course, we will be in a position to return these people, millions of crippled individuals back into our environment, and a situation of social and economic independence.

Now, obviously, to attempt to attack all these research problems in the neurological diseases would be impossible at the present time. We do not have either the research facilities or the research personnel to approach this problem. It is much too great.

The National Committee for Neurological Diseases has closely scrutinized the research personnel and the research facilities that we have, and we have put together a budget which we think is realistic and within the means which we have to work.

In other words, we think that any expansion of the program must be done slowly enough so that we can keep up with it, with our personnel. It is for this reason that we have presented the budget which Dr. Forster is going to offer, a budget to which I hope you gentlemen will give favorable consideration.

Mr. FOGARTY. Thank you very much, Doctor.

PERINATAL PROGRAM

Doctor, you mentioned the perinatal program being expanded. I thought we were told that the goal was to examine 40,000 expectant mothers each year.

Dr. BAKER. I think that's right. That is their goal.

Mr. FOGARTY. You think it ought to be expanded?

Dr. BAKER. Before they are through with this, the goal will have to be expanded.

Mr. FOGARTY. It started out as a 5-year program. That was what Dr. Bailey recommended.

Dr. BAKER. That's right. This is a realistic program, to start on a problem of this sort, but I still maintain that this problem is complex enough so that before we are through it is going to have to be expanded beyond this. This is a problem which we must find an answer for. This is the future of the human race, to maintain a birth process which is safe. It is a problem we cannot neglect. It is a problem we had never started until Dr. Bailey first suggested getting this program off the ground as a cooperative project with different skills being brought together to attempt to solve this problem.

I feel certain, however, in my own mind, as I do about many other problems, that the nervous system is so complex that you may start at a certain pace to try to solve a problem, and you may get a few preliminary answers, but before we are through, we are going to have much greater programs, than the starting program which is contemplated.

On the other hand, we must start at a certain pace because, as I pointed out, in our field and in many fields we just don't have the people or the facilities. It is no use starting with a tremendous onslaught without the people to do the job.

Mr. FOGARTY. We were told, I think by Dr. Bailey, 4 or 5 years ago, there was a tremendous shortage of neurologists, certified neurologists. I think he said that in one area of the country there was only one for two or three States.

Dr. BAKER. In the southern part of the country today we have still areas where there is one qualified neurologist per million population, and it is for this reason that the voluntary health groups had to set

up diagnostic clinics where they have qualified neurologists and bring a patient to the doctor, at least getting a diagnosis, because there are no neurologists in the area.

DISCUSSION OF THE BUDGET

Mr. Fogarty. What about the problem we are faced with in increasing this budget, when people tell us that we have to balance the budget, and cannot increase the appropriations this year?

Dr. Baker. Dr. Forster, you said you thought you had a good answer for that.

Mr. Fogarty. What is yours?

Dr. Baker. My answer is a very simple one.

Mr. Fogarty. I will give Dr. Forster a chance to present his.

Dr. Baker. I am a physician. When it comes to patient health, all I would say, if they said that, you should sometimes have to stand in a clinic and see these many cripples come through, and tell them there is nothing we can do for them. Then see what you think about balancing the budget.

Mr. Fogarty. You are a physician, but I am just a layman. I am trying to find the answer that I can use to some of these questions.

Dr. Baker. The answer, if they would listen, if we spend money for research, and can find the answer to crippling, we won't have the problem of balancing the budget because you will turn these people back to useful economic lives.

Mr. Fogarty. What about the fellow who just looks out the window—his mind is made up.

Dr. Baker. If he won't listen, anything you say isn't going to make too much difference. I have never had trouble in getting people to listen to me because in my field primarily everybody has somebody in their family with this illness involved, and they are all anxious to listen.

Mr. Fogarty. 20 million people have some one of these problems. They affect almost every family in the country.

Dr. Baker. I have never had trouble getting someone to listen, because they have experienced these problems, and when you experience a problem, you are interested in it.

Mr. Fogarty. Here we have the Secretary of Health, Education, and Welfare issuing a press release when this budget was released, saying that this is a dynamic program and we are going to continue the progress that we have been making. And then, after we get into the budget, we find it is not a progressive program at all; in many areas it is going backwards.

Do you agree that this budget that we have before us is a forward-looking budget?

Dr. Baker. I cannot agree with it at all. I think as far as the overall training and research program is concerned, I think this must go forward for many years at a rapid rate, and I still feel that the expenditures we are now incurring are nothing compared to what we are going to have to expend in many years in the future.

Mr. Fogarty. Someone mentioned the fact yesterday that if we don't find the answers to some of these problems that confront us today, we couldn't build enough medical schools and graduate enough doctors to take care of the population 40 years from now.

Dr. BAKER. I think it is probably true that if we don't find some of these answers in the near future——

Mr. FOGARTY. With the population growing older and increasing as it is, unless we find the answers, in 40 years we couldn't produce enough doctors to take care of people.

Dr. BAKER. We have another problem. If we don't spend more money for research now, we will be faced in a few years with the fact that we will have to retrench even further because we will be spending all these additional sums of money to build institutions to take care of the damaged little ones and the chronically ill. It is better to get some of the answers now, even at the risk of sacrificing in some other area, so that in the future we won't be forced into a situation where we are spending money merely to take custodial care of people in increasing numbers.

STATEMENT OF DR. FRANK FORSTER

Mr. FOGARTY. All right, Dr. Forster, go ahead. We are glad to see you back here again. We don't know why you left Washington, though. Go right ahead.

Dr. FORSTER. First of all, sir, I want to echo again what Dr. Farber said regarding the Institutes of Health and the graciousness and farsightedness of your committee and the Congress in their appropriations.

Also, the Institute has done a tremendous job in fostering research and training and has worked well with the neurologists and the scientists in the neurological field throughout the country. The NINDB has developed important and good public relations, and working relationships. Working with the citizens committee, we have reviewed the budget of NINDB and studied the needs, as Dr. Baker has pointed out. We have prepared a realistic budget which we feel properly reflects the needs.

This proposed budget of $61 million includes funds in the grant areas for development of broad programs in certain neglected areas of research. Dr. Baker has already spoken of the aged and chronically ill, and how these are in large part neglected.

The area of research in mental deficiency has barely been tapped. Cerebral vascular disease is becoming increasingly important with the increasing age of our citizens.

With the developments that have come about, there are more and more drugs available for the neurological patients, particularly in epilepsy and Parkinsonism, and we feel that these areas must be scrutinized from the aspect of clinical research.

The budget also includes funds for intramural research and collaborative projects. Dr. Baker has discussed this intramural program which is obviously a good program, and deserves adequate support. Therefore we recommend an increase of $600,000 to further strengthen this staff for this is a very complex and tremendous program.

Now, the citizens have become aware that the National Institute of Neurological Diseases and Blindness which was one of the last ones to be formed at Bethesda, has suffered increasingly from shortage of space in its operational activities. As a matter of fact, it is even

difficult to reach somebody by telephone, because they are caught traveling between Silver Spring and Bethesda. It must be exceedingly difficult for them to carry out their activities. We strongly urge that funds be appropriated now for the planning of a single, unified research facility at Bethesda for the important activities of the Institute, where they could be efficiently centered. We asked for an increase in intramural funds for perinatal research laboratory in connection with the primate colonies, where monkeys are developed.

Mr. FOGARTY. Have you been doing work there?

Dr. FORSTER. I have not visited, no, sir. I know about it, and I was there before the NINDB took it over, but I haven't visited it since. I have read the reports.

Mr. FOGARTY. We were there a year ago, and we were quite impressed.

Dr. BAKER. I have been there, yes.

Dr. FORSTER. Actually, I feel very strongly about further support for this. I have the great privilege of chairing the exchange mission to the Soviet last year, and in Sukhumi they have the equivalent of a tropical climate, on the Black Sea. Here they have a primate colony with sufficient budget there that scientists from all over the Soviet—off the record.

(Discussion off the record.)

Dr. FORSTER. If they get bureaucratic approval and so forth, they may go there. Here they have cubicles and facilities for the scientists to work and carry out and complete their researches.

I think with our colony at Puerto Rico, it would be in our best interests if we had facilities like this, where scientists working in the perinatal and other fields and in fundamental research, that concerns the primates, particularly the newborn primate, had a place and opportunity to do this kind of work.

We are primarily concerned with the measures required to strengthen the total national research effort, and we need more development of broad multisidiciplinary programs and the cooperation of nonmedical and medical groups. This, I think, applies particularly in the field that I am most interested in, that of epilepsy.

Of course you all know how many patients there are, about 5,000 in every million of population, and for example about 20,000 in our State of Wisconsin. There is no permanent cure available at this time, but the development of drugs has gone a long way toward this, and the support of the Institute has helped very much in fundamental research in this area.

We can completely control the seizures in about half the patients with epilepsy and decrease in another 25 to 30 percent. We are not satisfied, because our goal is no seizures for anybody and this, of course, we hope to achieve.

Part of the problem is that with the development of more and more drugs, the means of determining the effectiveness has grown in a rather haphazard manner. The drug is put in the hands of a single or a few investigators and there is not always the same standard classification of the disease, or of the different types of seizures, nor are the criteria for improvement exactly the same; nor are the control procedures

always put into the study, so that often the results presented by one group of scientists cannot be superimposed upon those of another.

Now, for this reason, we are having a symposium on the University of Wisconsin campus in Madison this May; not only for the field of epilepsy, but in the neurological diseases and blindness. Here we will bring together scientists who are working in this field. We hope we will have participation from industry. The pharmaceutical houses will have their research scientists there also, and the Food and Drug Administration will be represented as will pharmacologists, and biostatisticians.

We hope that criteria can be set up so that the results of drug testing in treatment obtained by one investigator will be applicable to those of another, and, more than this, we hope that out of this will come a stimulation for the development of new treatments and newer drugs, along with a better line of communication between all the people interested.

Mr. FOGARTY. Are they using drugs in Parkinsonism?

Dr. FORSTER. Yes. These drugs are successful to a certain degree. They do not cure it, but they do help.

Mr. FOGARTY. What about that operation?

Dr. FORSTER. This, I think, we still consider as in an experimental stage. It has its place in certain selected cases, but it is not yet at the point of being a routine procedure. There have been about five shifts in the type of operation, which I think spells out that it is not yet specific.

### CLINICAL RESEARCH OF CENTERS

One of the things we are particularly interested in would be the development of centers elsewhere. Dr. Farber also referred to this in his testimony.

I believe there should be centers for epilepsy, aging, and so on. There are gathered around the country in different places nuclei of scientists. Congressman, you asked why I went to Wisconsin. At Wisconsin there are chemists interested in epilepsy. The neurophysiologists there are interested in the field of epilepsy. The neurosurgeons are well known in this field and I am primarily interested in it from the neurological viewpoint.

We tend to gravitate in the academic world to join colleagues interested in similar fields. All of us are primarily oriented toward medical schools, and so the nucleus of institutes like this are available. We are working somewhat piecemeal without complete numbers in personnel and equipment.

We can increase the yield of research and I think come close to solving many of these problems in the programs, and hit a breakthrough at an earlier point.

I have another reason why I feel so strongly about this also. The Soviets have set up a number of institutes like this, and centers, in different cities. We can do this and do it better, because we would not have the restrictions and the complications that exist in Soviet science. In our American system this would work more effectively, far more effectively.

I am certainly very dedicated to American principles; even if it were not so, I would think that a month over there would have been enough to convince me. But the point is, I am interested that

you do not think I am too favorable to their point of view, but it bothers me to see a potential better than ours scientifically; and for this reason I think the centers here would help us to stay ahead of the Soviets, as we are at the present time, in medical research.

Mr. LAIRD. Were you here in Washington for some time?

Dr. FORSTER. Yes, sir.

Mr. FOGARTY. At Georgetown University.

Mr. LAIRD. How long have you been in Wisconsin?

Dr. FORSTER. A year and a half.

I noticed a reference in Dr. Masland's testimony to the importance of eliciting the active participation of certain nonmedical, industrial, and technical groups in the development of equipment and instruments for medical research. This is highly important. We oftentimes get along on almost an accidental basis depending upon a scientist hearing of a piece of equipment. He is riding on a plane and talks to an industrial manufacturer.

I rode in yesterday with a man who is making something that was analyzing metals, so I spent the whole flight between Madison and Milwaukee trying to find out what this apparatus is, whether it is any good for medicine, and could we use it. It turned out that we couldn't. We must miss many opportunities. If we coordinate efforts and have equipment programs for the development of equipment, better tools will be placed in the hands of investigators.

Now, all that I have said here has dealt with neurology, and particularly certain phases of this.

I wish to point out that the eye and sensory diseases of course are also included in our budget.

I am anxious to see their part of the program supported.

Mr. FOGARTY. We had a good hearing yesterday morning on the subject of blindness. We had four or five witnesses, and I think they did a very good job. Dr. Van Slyke was here, of course, and helped out.

I think they established a pretty good record.

Have you concluded?

Dr. FORSTER. I have finished.

Mr. FOGARTY. Doctor, you sat here when I asked these other doctors about some of the problems we have on this side of the table. I went over some of these areas where the budget has cut below the current level, that I think we ought to restore. It adds up to about $180 million.

I feel that we have to restore that $180 million before we can add anything to these programs that you are talking about, but when we talk to Members of Congress and the committee, and our constituents, some of them say, "Well, we can't increase this or we can't restore that because we have to balance the budget." What is the best answer?

Dr. FORSTER. Each of these gentlemen, of course, have their own constituents to think about. I think any one of their constituents who had a very careful budget, with so much for food, shelter, light, telephone, and so on, but who developed pneumonia, would not fail to buy $10 worth of penicillin because it wasn't in his budget. He would raise the money somehow.

Looking forward, we are trying to develop the future penicillins. It makes equally good sense to borrow or to obtain the money to develop the drugs that will save the life of the person and return him to work again.

Mr. LAIRD. What about paying taxes for it?

Dr. FORSTER. This is the alternative to borrowing. One either has to increase the income or the indebtedness for it; increasing income makes more sense because you are trying to keep the budget balanced. So the raising of taxes is logical.

I hesitate to get into this, because this is not my field.

Mr. LAIRD. Just your opinion.

Dr. FORSTER. I think this is important enough that money needs to be raised, sir.

Mr. FOGARTY. Another problem I have been interested in is the problem of mental retardation. I have always heard from parents of these children that no one knows what it is unless you have one of your own; isn't that true?

Dr. FORSTER. Yes, sir.

Mr. FOGARTY. I am sure that those people who are affected, the 20 million in this field of neurology, would do anything in order to find some of the answers to these problems. Is that a fair statement?

Dr. FORSTER. Yes, sir.

Mr. LAIRD. I have no questions, Mr. Chairman.

I certainly appreciate the doctor coming here and appearing before the committee. He has made a very fine contribution.

Mr. FOGARTY. Thank you very much, Doctor.

AFTERNOON SESSION

WEDNESDAY, MARCH 2, 1960.

## MENTAL ILLNESS

### WITNESSES

**MIKE GORMAN, EXECUTIVE DIRECTOR, NATIONAL COMMITTEE AGAINST MENTAL ILLNESS**

**DR. NATHAN S. KLINE, DIRECTOR, ROCKLAND STATE HOSPITAL, ORANGEBURG, N.Y.**

**DR. CECIL L. WITTSON, PROFESSOR AND CHAIRMAN, DEPARTMENT NEUROLOGY AND PSYCHIATRY OF THE UNIVERSITY OF NEBRASKA, COLLEGE OF MEDICINE; DIRECTOR, NEBRASKA PSYCHIATRIC INSTITUTE; CONSULTANT, NEUROPSYCHIATRIC RESEARCH, TO THE SURGEON OF U.S. NAVY; MEMBER OF THE COMMITTEE OF CONSULTANTS ON MEDICAL RESEARCH TO THE SUBCOMMITTEE ON LABOR AND DEPARTMENT OF HEALTH, EDUCATION AND WELFARE OF THE APPROPRIATIONS COMMITTEE OF THE U.S. SENATE.**

Mr. FOGARTY. The committee will come to order.

We have Mr. Mike Gorman with us this afternoon and he will introduce the other witnesses on mental health.

Mr. GORMAN. Mr. Chairman, I have a prepared statement. I won't read it. I'll just submit it to the clerk and make just a few highlights.

Mr. FOGARTY. All right. Fine.
(The statement referred to follows:)

THE BUREAU OF THE BUDGET AND THE MENTAL PATIENT: A STUDY IN VALUES

Testimony before House Appropriations Subcommittee on Labor and Department of Health, Education and Welfare on fiscal 1961 budget for National Institute of Mental Health by Mike Gorman, Washington, D.C., Executive Director, National Committee Against Mental Illness

Mr. Chairman and members of the committee, a full discussion of the numerous inadequacies in the administration's fiscal 1961 budget for the National Institute of Mental Health is, indeed, a most disheartening process.

In the face of overwhelming evidence to the effect that increased investments in psychiatric research and training are continuing to pay off in the return of thousands of additional mental patients to their homes and their loved ones over the past few years, the administration has cut the Institute budget below last year's appropriation. Furthermore, it has initiated this cut with full knowledge that, in the current year, scores of applications approved on the basis of scientific merit and high priority of need by the Institute's advisory council in the fields of research, training, research fellowships, title V, and general practitioner indoctrination have been turned down because of insufficient funds.

Facts and figures cannot adequately portray the impact of this uneconomic and inhumane policy upon the one in every five American families which sooner or later must seek psychiatric help for an afflicted member. Let me therefore quote, from a letter which came across my desk some weeks ago, a plea representative of the hundreds upon hundreds which pour into our committee office each year:

"Psychiatry is mediocre or poor because the doctors are overburdened. Rehabilitation and research hardly manage to crawl at snail's pace. Room and board diversions have improved but the alleviation of human misery, particularly of mind, heart, and spirit, shows no appreciable gains. Daily environment and routine after a year causes each day to seem the same, regardless of any diversions. Time seems to stand still, drag interminably, or take flight. Either way it causes a feeling of irretrievable loss. One realizes he is aging, and the older he becomes while in the institution the more difficult, if not impossible, it will be, if he is fortunate enough to obtain release, to secure a livelihood and adjust to the rapidly changing times of a critical era in our country's history. Many patients have to stay in a mental hospital for the remainder of their lives because they are outcasts, rejected, poor, aged, forsaken and forgotten, and without any means or kin whatever.

"One sees an elderly patient drop dead upon the floor amid the stench and din of a roach-ridden ward, or die gradually after weeks, months, or years of debilitating ailments, and one can't help asking himself, 'Will that be me?' In the dead or dying patient, he sees himself after the passage of several years or decades."

Can the horror be mitigated? Can this great democracy, with all its material wealth, mount a successful offensive against this raging epidemic of mental illness? The administration, with its defeatist budget, answers in the negative, but our letterwriter has faith in a people who conquered a continent and once fired the shot heard 'round the world:

"In the war against mental illness, it is a grievous disservice to our God, humanity, and our country, this generation and future generations, to be apathetic and reluctant to make the necessary economic sacrifices in order to provide the funds required to combat and overcome one of the most humiliating and disruptive plagues of all. It will be a shameful blot on the sense, decency, and honor of Federal and State Governments and the public if they fail to rouse from their lethargic halfway and wait-and-see attitude.

"Is it a case of too much money? It will be protested that buildings, roads, bridges, and other projects are needed now. Are these things more important than human beings? These can wait. The health of the people has precedence as succeeding generations will testify."

Who is this bold letterwriter who has the temerity to attack the "sound" fiscal policies of the present administration? Let him describe himself:

"I am ugly, of meager education, poor voice, no home, wife and family, rejected by kin, have little money, no livelihood, no freedom and independence, no normal life. I am nothing—except in the eyes of God. I must make do with what I have—an able mind and the knowledge of suffering. Whatever I can do to help others and bring happiness I do, and I consider myself rich.

"I can see that my bleak plight here is rendering my efforts futile. Daily my lot becomes more lonely and desperate. I can only hope my suffering will not be in vain—but will mean courage, solace, help, and hope for others.

"The bitter cry of anguish you hear is not mine alone, but that of all who are stranded and abandoned."

Mr. Chairman, the writer of the letter from which I have quoted is a patient at one of the oldest and most distinguished mental hospitals in this country. Possessed of a fine mind and an extraordinary ability to communicate, he is consigned to the scrap heap of our democracy because we have not given our psychiatrists and allied personnel the tools with which to return him to productive living.

Over the past 4 years, given but a small increase in research and training moneys, workers in the mental health field have convinced practically everybody except the present administration that intensive psychiatric treatment programs can save thousands of doomed lives, not to mention hundreds of millions of dollars in mental hospital construction and maintenance costs.

Let us look at the irrefutable evidence. On January 20, 1960, the National Institute of Mental Health reported that for the fourth consecutive year there was a significant drop in the number of patients in State mental hospitals. Over the past 4 years, this unprecedented drop of 16,000 patients has proven beyond a shadow of a doubt that we are well on our way toward the eventual conquest of the problem of mental illness. It is important to note, too, that this dramatic reduction in mental hospital populations continues to take place in the face of ever-rising admissions to all of our mental hospitals.

In State after State, this magnificent revolution has inaugurated a new era of hope and optimism.

In New York State, which has the largest mental hospital system in the world, the reduction of 5,000 patients over the past 5 years has fired that State with a new enthusiasm leading to the investment of millions of dollars in additional intensive treatment programs.

In nearby Maryland, the State mental health commissioner recently reported to the Governor that the number of patients discharged from mental hospitals has almost tripled during the past decade, despite a doubling of admissions in the same period of time. The commissioner noted that "Maryland's mental hospitals would be overwhelmed by the present rate of admissions if they had their discharge rate of 10 years ago."

The Mental Health Commissioner of Arkansas recently wrote me that although 10,000 new patients have been admitted to the Little Rock Hospital since 1956, the mental hospital population has dropped by about 200 because of a 45-percent increase in the rate of discharge. Here are his own words:

"Had we not improved our release rate and had we experienced the same increase in admissions, we would have had about 2,500 additional patients which, at the old per diem rate, would have cost us 50 percent more in operating costs and about $15 million in buildings to accommodate the additional patients."

Because the new drugs, increased psychiatric personnel, and new community mental health facilities are paying off, every State of which I have direct knowledge has increased its mental health appropriations this year appreciably over last year's figures. Put very simply, everybody is investing increased moneys in psychiatric research and training except the administration—which persists in its hold-the-line philosophy. Mr. Chairman, in the field of mental illness the hold-the-line philosophy means holding thousands of patients in mental hospitals who could be released and returned to a productive, taxpaying status in their communities.

Let me document briefly the impact of this unimaginative, uneconomic administration budget upon the major programs of the National Institute of Mental Health:

RESEARCH GRANTS

The administration allows only $14,690,000 for the research grant programs of the Institute. This is an increase of about $2 million over last year's program level. Theoretically, this will allow the magnificent sum of $2,800,000 for new research projects to be doled out among hundreds of eager investigators throughout the country. However, there is currently a backlog of about $2 million in research projects already approved by the Advisory Council, but not supported because of insufficient funds. You understand, Mr. Chairman, that I am reluctant to mention this backlog since Secretary Flemming sent up a series of alarms last summer about the Congress appropriating more money than could properly be spent in this area.

I wonder if Mr. Flemming is now willing to eat some uncontaminated crow?

This research backlog is causing considerable bitterness among research workers in all parts of the country. They are getting sick and tired of receiving the following uninspired communication from the National Institute of Mental Health:

"I very much regret to inform you that although the National Advisory Mental Health Council on November 16–18, 1959, recommended approval of your research grant application, we are unable to make an award because of the lack of sufficient funds in the present fiscal year. We are, therefore, inactivating your research grant application at this time. If you wish to submit another application to compete for funds which will be made available for fiscal year 1961, it would be best that you submit such a request proir to March 1, 1960."

The lack of sufficient research funds is even impeding the continuation of important research projects. I have a recent communication from Harvard University which protests bitterly the fact that a 3-year research project costing $90,000 has been approved for 2 more years and completion by the Advisory Council, but cannot be carried through because, according to a letter from the National Institute of Mental Health, "their appropriation is not sufficient to make the recommended grant to support the continuation of the project."

Since the $2 million in rejected research grant applications will undoubtedly be renewed, this really leaves only about $800,000 for new research projects. If you figure the research grant program on a 25 percent overhead basis, and if you further reduce the research project amount by the sums needed to finance the new institutional grants proposed by the Secretary, you find yourself in a situation in which you are several million dollars short of financing existing grants. In that situation, I hope that Harvard University, which has been so actively lobbying for the 25 percent overhead figure these last few years, will apply equal energy to increasing the research grant appropriation so that all of the research projects on which it is supposedly losing money will not be discontinued.

There is one further point which needs emphasis. The Mental Health Advisory Council has the reputation of being the toughest of all the Institute Councils in reviewing applications. It approves only one in three research applications, a singularly low percentage. After reviewing a number of the rejected applications, I am absolutely convinced that many of them are rejected because the approval level must fit into a designated budget figure.

The National Committee Against Mental Illness is therefore recommending $24,690,000 for the regular research grant programs of the Institute during fiscal 1961. This sum is predicated upon a 15-percent overhead cost; if the 25-percent figure is adopted, several more million dollars will be needed for the immediate relief of Harvard and other mendicant institutions.

### RESEARCH ON AGING

We want to make a particular plea for increased research into the physiology of aging.

The American Psychiatric Association recently released a report which disclosed that 30 percent of the patients in State mental hospitals today are over 65. This comes to the staggering total of 175,000 mental patients in our State institutions who are 65 or older. Furthermore, 65,000 of these are 75 years or older.

While a large percentage of these patients die within the first or second year of admission, an increasing number live on because of the remarkable advances made possible by medical research. It is estimated, for example, that more than 20 percent of these elderly mental patients stay in these institutions 11 years or more.

And this problem is just beginning to expand. Last year, 27 percent of all admissions to mental hospitals were patients over 65. Furthermore, 90 percent of these first admissions over 65 years of age had senile or arteriosclerotic brain damage. This is a fantastic increase over the comparable admission figures for elderly patients just several decades ago.

In his testimony a year ago before this committee Dr. Felix, discussing the 4-year trend toward a reduction in mental hospital populations, caught the full impact of this issue when he remarked that "more patients who are good risks are getting out sooner, and the poor risks are not getting out. This means that there is beginning to be a pileup of poor physical risks as far as life expectancy is concerned, and of older people also. * * * The older people are not going out of the hospital much, if any more, rapidly than they were before. Since the younger people are going out more rapidly, on any one day the hospital contains a greater proportion of older people than formerly."

It is our contention that this low rate of discharge of elderly people need not necessarily be. Preliminary figures from New York State, which has created

several intensive research and treatment units for elderly patients, indicate that 25 percent of these patients can be discharged as against the national average of about 6 percent.

Research on the physiology of aging is probably the most exciting frontier in psychiatry today. The small handful of investigators devoting their time to this problem are turning up increasing evidence to the effect that the major debilities of aging are diagnosable and reversible.

For example, at the Galesburg State Research Hospital in Illinois, Drs. Harold and Willimina Himwich are engaged in a 10-year project to develop a chemical map of the brain as it ages. Hundreds of elderly mental patients, formerly neglected in the back wards of the Illinois State mental hospitals, have been brought to Galesburg for physiological studies which will eventually encompass several decades.

We have a great number of exciting leads in the physiology of aging. We know that deficits of blood, oxygen, solid fats, and proteins play a significant role in depriving the aging brain of its needed nutrition. A few scientists are devoting themselves to the great mystery of the aging of brain cells. There is increasing support for the theory that the decline in brain function in the elderly is due to the death of individual cells in the brain. Unlike the cells in other parts of our body, brain cells are not replaced. The physiological why and wherefore of this offers a staggering challenge to a host of young researchers.

The old pessimism about the inevitability of physiological deterioration accompanying aging has gone by the boards. Cerebral arteriosclerosis, which affects the great majority of elderly mental patients, has been successfully controlled in many cases through the administration of anticoagulants. Furthermore, several groups in different parts of the country have proved that the administration of sex hormones has prevented further arteriosclerotic degeneration.

In the superb Council of State Governments publication, "The States and Their Older Citizens," the major recommendation of that lengthy and thoughtful study is stated as follows:

"Basic research on aging holds the brightest promise for the future happiness and welfare of older persons. Success in the medical sciences in reducing or stamping out such diseases as diphtheria, pneumonia, smallpox, syphilis, tuberculosis, and yellow fever developed from fundamental discoveries followed by new means of treatment and prevention. Similar results can be expected in attacking the diseases of old age through basic research into the nature and causes of the aging process."

Mr. Chairman, the National Institute of Mental Health is currently spending only about $1 million on both research and training programs in the field of aging. Contrast this with the more than $250 million that is required just to maintain the aged in our State mental hospitals, plus the several hundred million dollars expended by the Veterans' Administration in this area.

As a small beginning, we recommend a minimum of $2 million for physiological research upon aging during the coming year.

PSYCHOPHARMACOLOGY

There is increasing evidence that the enormous interest in psychopharmacology is far outstripping the present meager resources of the Psychopharmacology Service Center at Bethesda. When we first testified for the creation of such a center 5 years ago, we predicted that the drug revolution in psychiatry would eventually necessitate a large research and evaluation program similar to the magnificant effort in the field of cancer chemotherapy.

Research questions in the area of psychopharmacology have multiplied fantastically over the past 5 years. In addition to the continuing flood of tranquilizing drugs, the last several years has witnessed the introduction of a number of chemical compounds effective against depressions. Beyond the immediate problem of the clinical evaluation of these many new compounds, there are the related and enormously difficult problems of effective animal screening of the drugs and basic and desperately needed research on the metabolic mode of action of these drugs.

The Psychopharmacology Service Center cannot be commended too highly for its realization of the need for support in all of the areas outlined above. However, the administration allocation of $7,200,000 for the work of the Center during fiscal 1961 would only make possible the support of a small number of the new research applications which are pouring into the Center. We therefore recommend a minimum allocation of $10,200,000 for the Psychopharmacology Service Center during the coming year merely to keep it abreast of the flood of new research and evaluation applications.

DRUG SCREENING CENTERS

A year ago, we testified for the support of a number of drug screening centers designed solely for the screening of promising new compounds against mental illness. At that time, we warned that drug screening programs presently superimposed upon the enormous clinical burdens of State mental hospitals and university teaching hospitals put far too much pressure upon individual investigators. Although the Psychopharmacology Service Center has supported a number of these screening and evaluation programs at both State hospitals and university centers over the past year, I think there is a general consensus among officials of the National Institute of Mental Health that a real need has been demonstrated for the development of soundly financed drug screening centers of top professional quality. Rather than a host of hurried drug evaluations done under the firce competition of competing clinical demands, we need a number of adequately staffed centers which can concentrate all their energies upon the most difficult task of evaluating new compounds.

For these drug screening centers, we recommend an initial allocation of $2 million for the coming year. Dr. Nathan Kline will speak to the details of this proposal.

CLINICAL RESEARCH UNITS

As in other categories of illness, there is a great need in the field of mental illness for the creation of regional research units which can bring the most intensive research and clinical knowledge to bear upon the problem of mental disease. We are recommending $3 million as a modest start for these units, and Dr. Cecil Wittson will outline their functions in some detail.

TITLE V

The title V program, which deals primarily with new and experimental ways of handling mental illness, continues to excite enormous interest around the country. Its support of pilot projects in the control of juvenile delinquency, care of the aged outside of the hospitals, and emergency psychiatric services in the community have attracted nationwide attention.

The administration is allowing only $4,300,000 for these programs, an increase of but $500,000 over last year's level. Including support of a number of excellent projects in the field of juvenile delinquency, it is estimated that the title V program could use several million dollars more right now in support of current applications. We therefore recommend a minimum of $6 million for the title V program during the coming year.

RESEARCH FELLOWSHIPS

For some inexplicable reason, the administration continues to neglect this vital program dedicated to training research workers so despearately needed in all parts of the country.

Over the past 3 years, the Congress has raised the level of this program from the starvation sum of $600,000 to the present level of approximately $2 million. Each year, the administration moans about a shortage of psychiatric research workers; each year the Congress raises the number of research fellowships to close the gap, and each year a new backlog of approved but unpaid fellowships is accumulated.

It is also important to note that the present regular research fellowship stipend for psychiatrists is ridiculously low. A psychiatrist who has completed four years of medical school, 1 to 2 years of internship, 3 years of psychiatric residency, and 2 years of military service is offered $5,500 a year, plus $500 for each dependent, if he desires to embark upon a research career. For this reason, of the 282 research fellowships awarded by the National Institute of Mental Health in 1959, only a handful went to psychiatrists. It is true that there are some career investigator stipends available, but they are few in number and are awarded to investigators who have already demonstrated some promise in research.

I receive scores of communications each year protesting the starvation level of psychiatric research stipends at the present time. Typical is a recent communication from Dr. Max Fink, director of the department of experimental psychiatry of Hillside Hospital on Long Island. Dr. Fink writes:

"The present research program into the causes of mental illness is handicapped by an insufficient number of trained psychiatric personnel. * * * I would urge that Congress reconsider the present level of stipends for medical trainees in psychiatric research. Since the Nation is desirous of expanding its research

into medical problems, it is time that the young physician not be placed in the unfortunate position of participating in research training at a significant financial handicap to his family."

We therefore recommend an increase of a million dollars in the research fellowship program. With this additional money, we would hope for both a lifting of the stipend level and a considerable expansion of the number of fellowships.

FULL-TIME RESEARCH POSITIONS

In addition to adequate support for beginning research workers, there is a demonstrable need for the support of research teaching positions, primarily at medical schools and at non-profit psychiatric installations. It makes no sense to train a psychiatric research worker and then abandon him with no opportunity to transmit this knowledge when he has completed his training. Full-time research positions are a rarity today, and unless we establish a number of these positions we will not be able to train the increasing number of young investigators now applying for careers in the psychiatric research field.

As a start, we propose the modest sum of $1 million for these positions. Each of these positions would run about $20,000 to $30,000 annually, including both salary and related research costs.

TRAINING

On April 21, 1959, Secretary Flemming said: "The great need today is for more professionally trained personnel in all fields of mental health."

The conversation is always fine, but the money never accompanies it. Mr. Flemming proposes $22,356,000 for training during the coming year, a cut of approximately $4 million under last year's level. Since a $6 million backlog in training funds has accumulated during the current year, it would take a minimum of $10 million over the administration figure merely to keep up with the existing rate of applications.

Mr. Chairman, two important reports were released last year which documented, in very sorry detail, the essential point that we have now reached a critical period in the supply of psychiatric personnel in this country.

In December 1959, the American Psychiatric Association released a report on trends in psychiatric training. The report noted that although there had been a 30 percent increase in psychiatric residents between 1956 and 1958, more than half of the increase was accounted for by students trained in foreign medical schools. In 1958, these foreign residents comprised about 40 percent of the total number of psychiatric residents as against 33 percent in 1956. Furthermore, in 1958, 60 percent of the psychiatric residents in State mental hospitals were graduates of foreign medical schools.

These statistics tell a very painful story. We are obviously not offering training stipends of sufficient quality or quantity to attract more of our young doctors into the field of psychiatry. And the administration's answer to this problem is a further cut in training stipends.

1959 also saw the publication of "Manpower Trends in the Mental Health Professions," a report of the Joint Commission on Mental Illness and Health to the Congress.

I respectfully commend the depressing statistics in this notable study to Secretary Flemming. If he had merely read the conclusions of this meticulous professional study, I don't see how he could have done anything but recommend a sizable expansion in the training programs of the National Institute of Mental Health.

For example, the study notes that of approximately 3,000 available positions for physicians in State and county hospitals, one-quarter are unfilled today. A similar proportion of positions for psychologists went unfilled, and so on down the line through the various psychiatric disciplines. Even if all these budgeted positions were filled, the study notes, our mental hospitals would still be far below the minimum personnel staffing standards set by the American Psychiatric Association.

Due to the rapid increase in this country's population, these personnel shortages will intensify in the next 10 to 15 years. Discussing the present inadequate levels of psychiatric manpower training in relation to future needs, the report somberly warns:

"We must conclude this survey with a prediction that our country will continue to be faced with serious personnel shortages in all fields related to mental illness and mental health for many years to come. * * * Everyone agrees that our professional personnel prospects are grim and promise to get worse. * * * Our mental hospitals will continue to be overcrowded and our mental patients will receive little treatment."

Considering the above facts, is it not shocking that 50 percent of the approved applications for trainee stipends in fiscal 1960 were turned down because of insufficient funds? Here we have the anomaly of qualified students seeking training opportunities in these areas of critical shortage, but being told by this wealthy democracy that it cannot afford to train them.

I wish Mr. Flemming could spare some time from his extensive public speaking on the need for more trained professionals in the mental health field to read some of the communications I receive each week from clinics, community mental health boards, mental hospitals, schools, etc., pleading for a lone psychiatrist or psychologist or social worker.

The monthly newsletter of the American psychiatric Association is loaded down with advertisements for psychiatric personnel.

Here is a typical communication sent to me from a mental health clinic in Decatur, Ill.:

"For nearly a year we have been looking for a psychiatrist to join our staff as medical director, but without success. * * * We are writing to you for suggestions to help fill this position. We have been advertising in the American Psychiatric Association Mail Pouch."

Mr. Chairman, we are recommending approximately $28 million for the regular training programs of the Institute during fiscal 1961. Actually, this increase of about $10 million over the administration budget will only dry up the backlog and provide a small increase in new traineeships during the coming year.

### GENERAL PRACTITIONER TRAINING

The administration proposes $2,300,000 for the training of general practitioners in psychiatric skills during the coming year. This is exactly the amount allocated for the current year.

In many ways, this is the most inexplicable of all the administration proposals. During the current year, the Institute has been forced to turn down at least 50 approved applications from general practitioners willing to make the financial sacrifice entailed in taking the full 3-year residency leading to certification as psychiatrists. Furthermore, it is important to note that the institutions capable of training these general practitioners have adopted a very tough screening process which approves only one out of every five applicants.

Because the administration allocation this year is the same as last year's, it is impossible to start any new general practitioner trainees. In other words, despite the fact that this program has caught on in a really sensational manner, the administration in effect tells the general practitioners of this country that it will not allow any money for a natural expansion of this program.

This type of budget squeezing, in the face of critical psychiatric manpower shortages in all mental health facilities in every part of the country, amounts to little short of callous indifference to the mental health needs of this Nation.

### TRAINING IN PSYCHOPHARMACOLOGY

In February 1960, the National Institute of Mental Health reported that "the shortage of qualified research workers in this area is acute."

Mr. Flemming, who seems to pay very little attention to information gathered by this Institute which he supposedly supervises, proposes the paltry sum of $300,000 for this program, exactly the same as last year's figure. Although this program is running a backlog conservatively estimated at about a million dollars, and although mental institutions in all parts of the country are begging for pharmacologists to carry on vitally important clinical and research work on the new drugs, Mr. Flemming again proposes that we stand still and make progress.

### MULTIDISCIPLINARY RESEARCH TRAINING

In 1957, this program was begun to provide a broad education in the biological and social sciences for potential research workers. This program has never received the funds to really get it off the ground. For example, broad spectrum training in the biological sciences is still confined to two institutions training less than 100 students between them.

A number of institutions would like to participate in this program, and Institute officials are most eager to expand it. However, it is the same weary story over again—the administration proposes the same sum this year as it did last year.

Mr. Chairman, the National Committee Against Mental Illness, therefore, proposes $105,486,000 for the ramified activities of the National Institute of Mental Health during the coming year. This is far from what is really needed; a truly adequate budget would include another $20 million in training moneys and comparable increases all along the line.

Can this great Nation of ours afford this sum of money to bring about the eventual control of an illness which today afflicts 17 million Americans and fills every other hospital bed in this Nation?

When I look at the moneys being proposed for the conquest of space, I feel like a piker. In testimony a few weeks ago before the House Space Committee, officials of the National Aeronautics and Space Administration unveiled a 10-year space program which will cost $20 billion at the rate of about $2 billion a year.

For the coming year, the administration proposed in excess of $800 million for this space program. However, less than 3 weeks after its original budget submission, the administration requested another $130 million in supplemental funds for the Saturn booster project. This one little supplemental is far more than we are asking for the entire program of the National Institute of Mental Health.

I am troubled by the sense of values demonstrated here. I read that the average cost of some of this Buck Rogers spacecraft will run about $5,000 a pound. That starts me to thinking. The average daily cost for caring for a mental patient in an institution is about $4 a day. That runs between 2 and 3 cents a pound, figured on the basis of average body weight.

Furthermore, it is always permissible to bring in nice 5- and 10-year plans for the conquest of space or the development of new missiles, but the cries are horrendous when we ask the administration to do comparable long-term planning for the welfare of human beings. We are told that to hold last year's budget line in outer space means falling back, but holding last year's budget line in relation to millions of Americans still residing in inner space is somehow "fiscal responsibility."

Mr. Chairman, we don't want to forfeit the jurisdiction of this distinguished committee, but if the National Institute of Mental Health was somehow orbited into outer space, is there not general agreement that it would have very little trouble getting a sharp increase in its budget?

*National Institute of Mental Health*

| | President's budget | Citizens request, fiscal 1961 |
|---|---|---|
| Research grants: | | |
| Regular programs | $14,690,000 | $24,690,000 |
| Psychopharmacology | 7,200,000 | 10,200,000 |
| Drug screening centers | | 2,000,000 |
| Clinical research units | 500,000 | 3,000,000 |
| Title V | 4,300,000 | 6,000,000 |
| Total, research grants | 26,690,000 | 45,890,000 |
| Research fellowships | 1,996,000 | 2,996,000 |
| Full-time research positions | | 1,000,000 |
| Training grants: | | |
| Regular programs | 18,832,000 | 28,000,000 |
| General practitioner | 2,300,000 | 5,300,000 |
| Psychopharmacology | 300,000 | 1,300,000 |
| Multidisciplinary training | 924,000 | 2,000,000 |
| Total, training grants | 22,356,000 | 36,600,000 |
| State control programs | 5,000,000 | 6,000,000 |
| Direct operations, Bethesda | 11,521,000 | 13,000,000 |
| Total request, fiscal 1961 | 67,563,000 | 105,486,000 |

Mr. GORMAN. One of the major points, Mr. Chairman, that we are prepared to make here today is the savings as a result of the investment in research and training.

Mr. FOGARTY. Off the record.

(Discussion off the record.)

EFFECT OF INCREASES FOR RESEARCH AND TRAINING

Mr. GORMAN. In spite of the overwhelming progress over the past 4 years achieved by the research and training increases, it has convinced practically everybody except the present administration that it can save thousands of human lives, not to mention hundreds of millions of dollars in hospital construction and maintenance costs.

I point out that on January 20, 1960, the National Institute of Mental Health reported for the fourth consecutive year that there was a significant drop in the number of patients in State mental hospitals.

Over the past 4 years, this unprecedented drop of 16,000 patients has proven beyond a shadow of a doubt that we are well on our way toward the eventual conquest of the problem of mental illness.

Then I have reports from a lot of different States. I'll just highlight them and I think Dr. Kline will talk to this point. New York has had the biggest reduction. I understand that that State has a Republican Governor. It has had a reduction of 5,000 patients over the past 5 years and that very fact has meant that they haven't had to build thousands of additional beds and it has fired the State with a new enthusiasm leading to the investment of millions of dollars in additional intensive treatment programs, and they have them in 18 of the hospitals now. As a result they are quadrupling their discharge rate.

So if you put a little money in this thing, we think that you can return people to productivity.

In nearby Maryland, the State mental health commissioner recently reported to the Governor that the number of patients discharged from mental hospitals has almost tripled during the past decade, despite a doubling of admissions in the same period. So in other words, you have a tripling in discharges although you have increased admissions and the commissioner noted, and I quote him:

> Maryland's mental hospitals would be overwhelmed by the present rate of admissions if they had their discharge rate of 10 years ago.

If they didn't have this push due to drugs, research, and training, they would be pretty well licked by now.

Now the mental health commissioner of Arkansas recently wrote me that although 10,000 new patients have been admitted to the Little Rock Hospital, just that one hospital, since 1956, the mental hospital population has dropped by 200 at that hospital because of a 45-percent increase in the rate of discharge.

Here are his own words:

> Had we not improved our release rate and had we experienced the same increase in admissions, we would have had about 2,500 additional patients which, at the old per diem rate, would have cost us 50 percent more in operating costs and about $15 million in buildings to accommodate the additional patients.

Now, I have a lot of——

Mr. FOGARTY. Off the record.

(Discussion off the record.)

Mr. GORMAN. Michigan, for instance, has a 73-percent increase in discharge rates over the last 10 years. Pennsylvania has a drop of 3,000 patients between 1955 and 1960. So it is reflected in all the States.

Mr. FOGARTY. How about Rhode Island and Indiana?

Mr. GORMAN. I should have some figures on those States. I will get them.

Do you have some figures on that, Dr. Wittson?

Dr. WITTSON. Yes.

Mr. FOGARTY. Can you supply them for the record? I think it would be well to have those figures for all the States.

Mr. GORMAN. Yes.

(The information follows:)

*Patients residing in public mental hospitals at end of year, exclusive of Veterans' Administration*

| | 1959 | 1955 | 1959–55 |
|---|---|---|---|
| Total | 542,721 | 558,922 | −16,201 |
| 1. Alabama | 7,400 | 7,197 | +203 |
| 2. Alaska [1] | | | |
| 3. Arizona | 1,670 | 1,690 | −20 |
| 4. Arkansas | 4,948 | 5,086 | −138 |
| 5. California | 37,274 | 37,277 | −3 |
| 6. Colorado | 5,943 | 5,786 | +157 |
| 7. Connecticut | 8,602 | 8,668 | −66 |
| 8. Delaware | 1,474 | 1,694 | −220 |
| 9. District of Columbia | 6,980 | 7,318 | −338 |
| 10. Florida | 9,164 | 8,026 | [2]+1,138 |
| 11. Georgia | 11,922 | 11,701 | +221 |
| 12. Hawaii [1] | | | |
| 13. Idaho | 970 | 1,221 | −251 |
| 14. Illinois | 35,835 | 37,883 | −2,048 |
| 15. Indiana | 10,943 | 11,342 | −399 |
| 16. Iowa | 4,490 | 5,374 | −884 |
| 17. Kansas | 3,798 | 4,420 | −622 |
| 18. Kentucky | 6,914 | 7,700 | −786 |
| 19. Louisiana | 8,548 | 8,271 | +277 |
| 20. Maine | 2,920 | 2,996 | −76 |
| 21. Maryland | 8,875 | 9,273 | −398 |
| 22. Massachusetts | 22,200 | 23,302 | −1,102 |
| 23. Michigan | 21,762 | 21,798 | −36 |
| 24. Minnesota | 10,648 | 11,449 | −801 |
| 25. Mississippi | 5,216 | 5,295 | −79 |
| 26. Missouri | 11,748 | 12,021 | −273 |
| 27. Montana | 1,673 | 1,919 | −246 |
| 28. Nebraska | 4,228 | 4,826 | −598 |
| 29. Nevada | 553 | 440 | +113 |
| 30. New Hampshire | 2,578 | 2,733 | −155 |
| 31. New Jersey | 21,457 | 22,262 | −805 |
| 32. New Mexico | 898 | 950 | −52 |
| 33. New York | 92,650 | 96,729 | −4,079 |
| 34. North Carolina | 9,727 | 9,960 | −233 |
| 35. North Dakota | 1,696 | 1,993 | −297 |
| 36. Ohio | 28,671 | 28,663 | +8 |
| 37. Oklahoma | 7,376 | 8,014 | −638 |
| 38. Oregon | 5,017 | 4,886 | +131 |
| 39. Pennsylvania | 39,035 | 40,920 | −1,885 |
| 40. Rhode Island | 3,419 | 3,442 | −23 |
| 41. South Carolina | 6,509 | 6,042 | +467 |
| 42. South Dakota | 1,694 | 1,603 | +91 |
| 43. Tennessee | 8,404 | 7,730 | +674 |
| 44. Texas | 15,857 | 16,445 | −588 |
| 45. Utah | 1,128 | 1,337 | −209 |
| 46. Vermont | 1,133 | 1,294 | −161 |
| 47. Virginia | 11,095 | 11,303 | −208 |
| 48. Washington | 6,677 | 7,361 | −684 |
| 49. West Virginia | 5,458 | 5,619 | −161 |
| 50. Wisconsin | 14,896 | 15,008 | −112 |
| 51. Wyoming | 648 | 655 | −7 |
| 52. Puerto Rico [1] | | | |
| 53. Virgin Islands [1] | | | |
| 54. Guam [1] | | | |

[1] No complete data collected.
[2] New hospital in Hollywood, Fla.

Sources: 1955 Patients in Mental Institutions, part II, tables 1 and 2; table 2, provisional patient movement personnel and financial data by States: United States, 1959.

PHYSIOLOGY OF THE AGING

Mr. GORMAN. I'll skip over some of the detailed budget presentations. I do want to make one brief plea for some increased research into the physiology of aging. I think it is very important.

The American Psychiatric Association recently disclosed in a report that 30 percent of the patients in State mental hospitals are over 65 and that means 175,000 mental patients. That's a lot of mental patients over 65, and 65,000 of those are 75 years of age or older.

While a large percentage of these patients die within the first or second year of admission, an increasing number live on because of the remarkable advances made possible by research. It is estimated, for example, that more than 20 percent of these elderly mental patients stay in these institutions 11 years or more and this, in many cases, is a very hopeless situation and this problem is going on because 27 percent of all admissions to mental hospitals last year were patients over 65.

Now it is our contention that the low rate of discharge of elderly people need not be. Preliminary figures from New York State, which has created several intensive research and treatment units for elderly patients, indicate that 25 percent can be discharged as against the national average of about 6 percent.

So we think that we can do a lot more research into the physiology of aging. Some of it is going on which I have mentioned. There is interesting work in Illinois and elsewhere; many important leads that should be followed up and we note that the National Institute of Mental Health provides about $1 million on both research and training programs in the field of aging. We don't feel that is a great deal of money, compared to the $250 million that is required just to maintain the aged in State mental hospitals, plus that expended by the Veterans' Administration in this area.

In other words, we feel there is very little, Mr. Chairman, being spent on aging, on the physiology of aging. We really don't want more and better rocking chairs. We do want reversing of some of these physiological debilitations of the aging.

We think there is more need now for expanded psychopharmacology. I think they are doing a very good job at Bethesda. They got off to a very slow start but they are now doing very well; they need a lot more money because of the drug applications which are pouring in.

Now on drug screening centers, Dr. Kline will speak on that. Dr. Wittson will speak to the clinical research units or whatever they are called.

Mr. FOGARTY. Research centers.

Mr. GORMAN. Research centers. We make a plea for more research fellowships because, for some inexplicable reason, the administration continues to neglect this program so desperately needed in all parts of the country and this committee and the comparable committee in the Senate each year have to raise the administration budget. It started 3 years ago, if you remember, Mr. Chairman.

The research fellowship program then was only $600,000. It has been raised up to $2 million and still each year the administration

moans about a shortage of psychiatric research workers; each year the Congress raises the number of research fellowships to close the gap, but the unpaid fellowships have accumulated and that is the experience in fiscal 1958, 1959, and 1960. Now, we think the research stipends are a little low at present and we are therefore asking for more research fellowships and full-time research positions.

Now, I presume that you have heard, Mr. Chairman, a great deal on the training business because we think that is still a great area of shortage. To quote the distinguished Secretary of Health, Education, and Welfare, on April 21, 1959——

Mr. FOGARTY. He doesn't think much of it, judging by the budgets that he sent up.

Mr. GORMAN. Well, he thinks very low, because he actually cut the budget by better than $4 million this year in the face of a $6 million backlog in training applications.

He said a year ago that—

> The great need today is for more professionally trained personnel in all fields of mental health.

Of course, the budget doesn't seem to implement what he says.

Mr. FOGARTY. Well, not only in this institute but in practically every other institute, they are holding the line or going back.

I just could not understand it and told him so when he was here.

Mr. GORMAN. Well, I think one thing, without going into detail on this thing, I might point out the American Psychiatric Association recently released a report on trends in psychiatric training, and they noted that there had been a 30-percent increase in psychiatric residents between 1956 and 1958 and more than half of the increase was made up of students trained in foreign medical schools.

In 1958, 60 percent of the psychiatric residents in State mental hospitals were graduates of foreign medical schools. This doesn't seem to argue very well, Mr. Chairman, for any success in trying to use our own doctors in the field. We are not doing the job. We are not offering the training opportunities when 60 percent of the residents in the State mental hospitals are foreigners.

And then we also have other reports that I am sure the Secretary should peruse, if he hasn't, indicating that there are vacancies in State mental hospitals in all parts of the country and we think it is rather shocking that 50 percent of the approved applications for trainee stipends in fiscal 1960 were turned down because of insufficient funds.

Mr. FOGARTY. But you would never know that from Secretary Flemming's press releases about this budget. He said that this was a forward-looking budget and we want to keep it going along the same dynamic path that we have been following.

Mr. GORMAN. Well, it seems to me that these figures are incontrovertible. It is either—we know that there is a 50 percent turndown of approved applications; we know that there are these vacancies all over the country and I note here in the statement, Mr. Chairman, that I wish Mr. Flemming could spare some time from his extensive public speaking on the need for more trained professionals in the mental health field to read some of the communications I receive each week from clinics, community mental health boards, mental hospitals,

schools, et cetera, pleading for a lone psychiatrist or psychologist, just one, or one social worker, and you cannot get them by reading the speeches of the Secretary of Health, Education, and Welfare.

So we are recommending an increase of about $10 million in the regular training programs and the other area that we stress is the general practitioner training program—we are awfully interested in it and the administration keeps it at the same level, $2,300,000, as last year.

Mr. FOGARTY. Well, this was one of your projects a couple of years ago; was it not?

Mr. GORMAN. That is right.

Mr. FOGARTY. And we understood last year it took a little time to catch on but it has become very popular.

Mr. GORMAN. Yes.

Mr. FOGARTY. The doctors like it and it is doing a tremendous amount of good. Do you still think it is a good thing?

Mr. GORMAN. I think it is the most popular single program right now in the National Institute of Mental Health and I am awfully disturbed, Mr. Chairman, that at least 50 approved applications from general practitioners willing to make the financial sacrifice entailed in taking the full 3-year residency leading to certification as psychiatrists have been turned down.

In other words, these have been approved by training institutions and they have a very tough screening process. They only accept one out of every five applicants. All they will get is about $10,000 a year and this is considerably less than they were making in private practice. I think it is awfully shortsighted for the Secretary to do this—it is not a forward-looking budget and it is the same amount of money as last year for general practitioner training. So you cannot start any new general practitioner trainees. If that is progress, I think it is two steps backwards.

Mr. FOGARTY. It is progress in reverse.

Mr. GORMAN. Well, if you are going to turn down 50 general practitioner applications and call it progress, I think we are going to have to do a new job on Webster's dictionary.

Training in psychopharmacology: Dr. Kline knows something about this and my friend from Nebraska, too, and they will talk to that.

## DISCUSSION OF THE BUDGET

In the budget summary we are asking for $105,486,000 and I have it broken down on the last page of the submission by category. Of course, at this point there might be some argument as to the fact that this is a great sum of money and I would just like to put into the record a poll taken by Elmer Roper and this poll was taken, I believe, in the spring of this year. He asked a cross-section of the Nation this question: "Here are a list of things that are paid for by tax money. Would you be willing to see taxes raised so that more money could be allotted to the following?" Public schools came out first, 36 percent, but the interesting thing is that mental institutions came out second at 32 percent; social security benefits, 24 percent; unemployment compensation 17; public streets and highways 13 percent and so on, and Roper makes a very interesting comment and he says this:

That public schools came out first in the poll is perhaps not very surprising. The number two item is more surprising.

The frequent mention of mental institutions is dramatic testimony to the effectiveness of the recent public campaigns on the need for adequate treatment of the mentally ill.

and I don't think we could have said that 5 years or so ago, Mr. Chairman. I could not have said it 10 years ago because there was no interest in this program. You just put these patients out in the woods and they were hopeless and you stacked them up; however, the people are very alert to the fact today that you can treat these people and you can return these people to society and you can make them productive and I wish Mr. Flemming had the same confidence that the American people seem to have in the mental institutions. They seem to feel that they are treatment institutions.

All the rest of this $105 million budget is for the implementation of the research and training programs to get new knowledge and apply it and to continue the tax savings which we have already attained over the past 5 years.

In other words, the reduction of 16,000 patients which has benefited practically every State in the country and cut down enormously on hospital construction. It has also cut down on thousands of beds in the VA. I do not know what more proof we have to bring to show that a small investment of moneys can bring a rather large return.

That is about it.

Mr. FOGARTY. Well, I happen to think you are right but in 1960 we appropriated $68,090,000 and this year the Administration is asking for $67,563,000. So the problems are still here and they are cutting back on this appropriation.

It is something that I just cannot understand.

Mr. GORMAN. Yes. As I point out in my statement, I do get around to most of the States in the course of each year, Mr. Chairman, and most State Governors, Republican and Democrat, have increased their budgets appreciably in the fields of research and training and drugs. They know it pays off.

This has paid off at the State level remarkably and I do not see why the Department of Health, Education, and Welfare is not equally convinced with the rest of the country that this is a very sound economic measure. But let's forget about the humanitarian measurement——

Mr. FOGARTY. Well, economically, it is sound to invest in this kind of thing. The last figure that I have, it cost the taxpayer, local, State, and Federal, over a billion dollars a year.

Mr. DENTON. Yes; $1.8 billion.

Mr. FOGARTY. A billion eight.

Mr. GORMAN. Yes; well, the maintenance of the State hospitals alone cost in excess of $800 million a year, you see, and in the Veterans' Administration, the cost of mental illness was $550 million last year alone.

So if you start adding up some of the gross figures on the cost of this problem you will get something that has to be attacked with strong measures.

Well, Mr. Chairman, that concludes my submission.

I wonder if Dr. Nathan Kline of Rockland State Hospital in New York, who has been before this committee before, may talk a little bit about psychiatry elsewhere in the world and about these drug screening centers.

Mr. FOGARTY. Go right ahead. We are glad to have you back again, Dr. Kline.

STATEMENT OF DR. NATHAN S. KLINE

Dr. KLINE. I am delighted to be back.

Medicine is not only an art and a science but also an expression of our national and international attitudes. What we know is determined to a large extent by the nature and extent of the research we support. How this knowledge is applied is a measure of both our intelligence and our intentions.

Now personally we are influenced by the experiences which we have and my own opinions about the direction, extent, and applications of medical research have been conditioned by what has happened to me since I last had the privilege of appearing before this committee.

During the summer I was in Pakistan for consultation with officials of their Ministry of Social Welfare as to the psychiatric needs of that country and only 10 days ago I returned from a trip to the Republic of Liberia where I had been invited by President Tubman to advise on the establishment of a system of care for psychiatric patients.

The successful operation of the clinic which we established for the Republic of Haiti led to these inquiries from other parts of the world. And in the course of my assignments since last being here, I was also able to investigate quite thoroughly the psychiatric resources of Nigeria, Ghana, and to visit some of the leading research installations again in Switzerland, France, and Italy.

Finally, which is quite important, I spent almost 6 weeks in the Soviet Union visiting many of their major centers of neuropsychiatric investigation and treatment.

The present state and the organization of psychiatric care and psychiatric research in the Soviet Union was presented at considerable length last November before the New York Academy of Sciences. A monograph of more than a hundred pages on this will be in print by the end of the month.

One of the most relevant points in the monograph is, first, that the organization and application of psychiatric services in the Soviet Union is superior to our own in a number of important respects.

Second, although our physicians are very much better trained, we have far too few. The number of doctors per population in the United States today is less than there were 10 years ago and the situation is daily becoming worse.

In contrast, the Soviet Union already has about 50 percent more physicians, including neuropsychiatrists, and the ratio per population is increasing. At the present time, they are turning out more than three times as many medical graduates per year as we are.

Last year, we turned out about 7,500 medical graduates; and in the Soviet Union, it was over 24,000 physicians graduated.

In view of the desperate need for medical assistance in many of the African and Asian and South American countries, it will be difficult for them to continue to refuse the assistance which the Soviet Union urges on them unless the United States and its allies are prepared to offer some adequate substitute in the foreseeable future.

The acceptance of nonmilitary humanitarian personnel appears completely safe whereas in fact the missionaries have long ago taught

us that there is no more potent technique for proselytizing and propaganda than such medical care where it did not previously exist.

Thirdly, throughout the world our medical research is admired, respected, and real gratitude expressed for its accomplishments. The average person in any country may or may not be interested in technological progress but he is passionately concerned with medical discoveries and treatments which apply to himself or his family.

Even as a single researcher, I often receive 5 to 10 letters a day describing the illness of a patient or a family member and asking for help and sometimes just asking for hope. During the year dozens of such letters come from abroad and some from the most unlikely places. You wonder where they found my name or anyone else's name to write to.

When illness strikes and available treatment is ineffective, the urgency or the demand for any scrap of useful knowledge transcends ordinary political and geographic limitations. In our long struggle for the allegiance and the imagination of mankind what we can do to help counts more than what we can do to hurt.

Fourthly, our priority in research which does now exist is not automatically guaranteed. They are a number of reasons to expect rapid progress in Soviet medicine. One of these is that the Soviet Union is just moving into a time segment when their labor force will be minus an estimated 12 million as a consequence of the population deficit resulting from the Second World War.

Since this is occurring at a time when there is need for an expanding labor force it is evident that much more attention will be paid to the health problem in order to guarantee maximum efficiency from the workers who are available.

Secondly, there is the high priority placed on research of all types in recognition of the fact that discovery of new knowledge is the only protection and compensation for obsolescence and discard.

And thirdly, the prestige and propaganda value accruing from any major medical advances is difficult to overrate.

Fifth, the Soviet system is so established that the greatest social and economic advantages go to the researcher. In terms of real income after taxes, the Soviet researcher earns approximately nine times the average for the general population. Here in the United States, the ratio is barely twice that of the general population average. Income of top level investigators in the United States to be comparable to the Soviet Union would have to be in the $60,000 to $80,000 a year range with very top drawer research personnel in the $100,000 class or better. Mr. Greenawalt, the president of Dupont, in his book "The Uncommon Man," has calculated his real salary to be approximately that of a first-rate Russian professor.

Since it is the researchers who earn the highest salaries and benefits, the great concentration of intelligence and ambition in this area is to be expected. With the increasing emphasis on medical problems we may expect a replication of the grand strides which occurred in the area of physics and space travel. Let no one say in shocked surprise that, a few years from now, we were not warned, that this was going to happen.

All of the foregoing would be secondary and unimportant if there did not exist such a desperate need for new methods of treatment and

for more widespread information as to techniques of applying medical knowledge already available.

The budget recommendations which follow are not fanciful estimates or projections from statistical tables but are the outgrowth of more than 15 years as a working investigator in the field and I know my own needs as well as those of my colleagues. Based on this information and experience I ask consideration for the specific requests which follow.

There now exist a very sizable number of excellent research projects which await only adequate financing.

As a former member of one of the NIMH study sections I can personally attest to the detailed and rigorous screening given to every project. Whatever errors may have been made were undoutedly on the side of failing to support good work rather than foolish support of unworthy investigations.

To have projects approved by such a fine-tooth-comb screening and then not have the funds to support them would be laughable if it were not so tragic. Months of planning and review go into the creation of a research proposal and its review by the study section and the advisory council. If after all this it is deemed worthy of support, the absence of funds to then do the work makes a mockery of the whole procedure.

Although I know the mechanism which creates this situation I am still endlessly confused personally to receive a notification that one of our research grant requests has been approved, but that there are unfortunately no funds to support it but that if I wish to, I can repeat the whole procedure, thank you.

The result is not only confusion but often discouragement. The implementation of a project of major importance may thus be lost for years or forever. It is frequently the borderline or debatable proposal which is not acceptable to everyone on the committee because it contains a new and different idea or technique.

Unless there are adequate funds to support work of this type there is little likelihood of breakthroughs; that is, sudden and rapid major progress by reason of a novel and unorthodox approach. Our great research strength in recent years has been that we have given sufficient funds to investigate not only the obvious but also the not-so-obvious.

Presently, as the whole field expands, we are in danger of drying up one of the wellsprings of inspiration. It is for this reason that I urge as strongly as I am capable that the amount appropriated for research grants be raised from the $26,690,000 proposed by the administration to the $45 million which is the most conservative estimate of what is needed here and now.

The inadequacy of screening facilities for new drugs is also costing us far too much by both economic and humanitarian measures. Poor screening of new preparations has probably led to the rejection of useful pharmaceuticals. For instance—and again I quote from experience—it was our persistence at Rockland State Hospital and that of a few other places in the face of considerable opposition that demonstrated the value of at least two preparations, which are now in widespread use, an acknowledged benefit.

52692—60——22

In a third case, a preparation of considerable value has even now been almost discarded because of unreliable reports of toxicity, while in a fourth case a drug of little or no merit was widely used because faulty screening unfortunately made it appear quite effective, and as I discussed a while back with——

Mr. FOGARTY. Off the record.

(Discussion off the record.)

Mr. FOGARTY. Back on the record.

Dr. KLINE. It is sad indeed that we are only now at the moment beginning to work with a new promising preparation when, with adequate facilities, we could have started a year ago. It was available then. By now, we would have already determined the value; if it is as great as we anticipate, why, many thousands of dollars have been lost and much suffering taken place in the meantime; I would interject here the same comments that Mr. Gorman stressed, that this committee and its counterpart in the Senate were tremendously instrumental in getting drug therapy going and it is hard for you gentlemen sitting here to realize the impetus given the whole field of psychopharmacology, by reason of the fact funds were designated for this specific purpose, and I am sure that you have speeded up this field. One might say, eventually it would have caught on anyhow if it were good, but there isn't the slightest doubt in my mind that the approbation given by this committee by reason of appropriating funds advanced the thing by at least 5 years and the savings effected in this matter, as already pointed out, run up into literally the tens of millions in money alone.

I feel also—I'll read the testimony. It says concisely, above and beyond all of this I have not the slightest doubt that other preparations are already in existence which would enable thousands of people to be discharged from mental hospitals and prevent tens of thousands more from being admitted if only adequate facilities existed to determine their value.

There is an acute need and one which would pay high immediate dividends for the establishment of adequate screening centers for new psychopharmaceuticals. Not only would these screening centers be able to test the usefulness of dozens of preparations but they would also establish methods and techniques of evaluation that could then be used on a broad scale throughout the country in virtually every mental hospital.

The designation of $2 million for the establishment of about half a dozen such centers is modest indeed in terms of the anticipated return. We submitted such a proposal and I am sure one of the reasons that it was turned down was the astringent statement that the project would cost about a half million dollars a year and because you cannot draw personnel from other parts of the hospital and expect to get this type of thing done. I think part of the reluctance, at least at the National Institute, to support this was because they thought it would be drawing away from other research funds which are so desperately needed.

They are now over $2 million behind in grants that have been approved for which there are no funds available and it is going to be more than double that within another year at the present rate of increment.

So I think they are reluctant to put considerable sums into screening centers when they are so desperately needed for research grants

and I think in addition to increasing the funds for research grants, the designation of $2 million specifically for this purpose would relieve them of the decision-making necessity which gets pulled hither and thither.

If the committee were to designate the funds for this purpose, it would solve their problem for them and just as the original $2 million appropriation for psychopharmacology itself has probably been one of the most brilliant investments ever made, I think that similarly a setup that would enable us to screen rapidly drugs and get the good ones on the market and keep the bad ones off would do a great deal.

A similar opportunity exists in clinical research units of other types and Dr. Wittson will go into that. He is broadening that item very justifiably and I just wanted to emphasize that I am talking about something quite different than he is.

I am talking about simple machinery for screening new drugs rapidly, a purely mechanical sort of thing.

The other field where major increase is needed is in respect to training grants and fellowships and Mr. Gorman has already spoken to that end. As a result of insufficient funds at present we are losing a whole cordon of research talent. Again, I know these things personally because there are men on my staff and people from other countries who want to come on our staff and the present situation in applications for fellowships—they will not even receive an application until March of 1961.

We cannot even offer the people the opportunity of submitting a request until another year has passed which seems a completely aidiculous situation for a country that is attempting even to maintain e research position, and funds should also be made available for the establishment of full-time research positions; there must be some kind of relationship between the training and effort demanded and the compensations which the same man could achieve by turning to private practice.

I cannot help but go back to the example, the Russians are going to offer a tremendous threat in the sense that their researchers earn easily four to five times, on a relative basis, what ours do and have all the prestige of being top members of society.

Care must be taken not to distort the function of the university and as pointed out by Kidd in his recent book "American Universities and Federal Research" it must not be done by reducing teaching functions.

Mr. FOGARTY. Who is that?

Dr. KLINE. This is Charles Kidd of the Public Health Service. He has written an extremely interesting book on the effect of Federal research in American universities and he has raised some question about the fact that universities may have distorted their intended purpose because of their great need of funds and simply accept research in order to keep things going.

There may be a diversion of people from teaching to research but both activities are essential. My own feeling would be that the establishment of something of the type that Dr. Wittson has in mind as research centers which certainly can be university affiliated or related but the two functions are something quite different.

Incidentally, I was again referring back to the Soviet Union. Most of their research is done in a research institute and not in universities per se and certainly not in medical schools and the few examples we have in this country of institutes of that type such as the Rockefeller Institute, The Sloan-Kettering, Fels Institute and so on are the most, I think, successful places for producing successful results.

So that, not that we have to emulate or imitate the Russians by any means, but we have had longer experience at it actually than they have and it has been highly successful but we simply, as unfortunately is the case, haven't taken advantage of what was obvious.

I have seen with my own eyes and heard with my own ears some of the end products resulting from the funds recommended by this committee and voted by the Congress. The direct benefits to tens of thousands of patients in the United States and inevitably to other tens of thousands in other countries, in addition to the ones that I have visited recently, cannot be measured in terms of economic savings alone and the concern with humanity and the courage which actually this committee is taking in sometimes venturing where the more conservative parties fear to tread has been a tremendous boost and cannot be valued in terms of money alone and I think it has made possible a great deal of good works which have done more to help the United States abroad than almost all of the military assistance.

Mr. FOGARTY. You would not think so from this budget we have before us.

Dr. KLINE. No; I am startled quite frankly, Mr. Chairman. Every year when I look at this budget and then realize the—I come in and plead for what is almost a pitiable amount in terms of what we should be spending.

The money devoted for medical welfare, I think, is disproportionately minuscule compared with what even the Congress should be concerned with since it is charged with the care of the general welfare and general welfare to me means not only putting up radar screens and giving military aid to people but, maybe it is because of my training, general welfare sounds to me a lot more like providing necessary medical research, if you take care of their health.

Mr. GORMAN. Mr. Chairman, the final witness is Dr. Cecil Wittson. He wears about 8 or 10 hats. Out in Nebraska he is the director of the Nebraska Psychiatric Institute and professor in charge of the department of neurology and psychiatry of the University of Nebraska.

He is a native of South Carolina.

STATEMENT OF DR. CECIL G. WITTSON

Dr. WITTSON. Mr. Chairman, as has been indicated, I will direct my remarks primarily toward the need and opportunity for regional clinical research centers focused primarily on psychiatric research.

First I would like to tell a little bit about what has happened in my own State in Nebraska as a result of an active program, a statewide program, and call your attention to the exact reduction in the patient population in the State institutions.

This graph shows how the number was increasing from 1950 and on through 1955 and at this point we began a reduction and we had over 4,700 patients at that time.

In July of 1959, we had 4,200 and on January 1 of this year, we were down to 4,003 patients which is quite a significant reduction. Now had this curve continued as it was and if we had not been able to establish a program which was largely stimulated—significantly stimulated rather by help from the Federal Government, we would have had about 5,500 patients. So there has really been almost a 1,500 patient reduction in the residents at State hospitals.

During this 5-year period, there was a 19 percent increase in the number of admissions; there was a 61 percent increase in the number of discharges.

Mr. Gorman spoke somewhat on the problem of aging. We are very apt to take an entirely pessimistic view. This view is not entirely justified. In Nebraska in 1955 and 1959, we had almost the same number of admissions at State hospitals over the age of 65, and in 1959 as compared with 1955, we had doubled the number of discharges of patients over 65 and our readmission rate dropped at the same time which would indidate that we had not been sending patients out of the hospital before they were ready to leave.

So with an active program something can be done for the problem of the aging that have to be committed to mental hospitals and significant reduction can be obtained in the number of patients who are hospitalized in State mental hospitals.

Last year and I assume again this year, witnesses will emphasize to you the need for regionally located facilities for clinical investigation for some of the other diseases. Last year, I think, it was felt these research centers were needed for furthering the development and to facilitate the application of new discoveries.

In the field of mental health, we are faced with the same problem of obtaining the briefest and most economical development and application of new methods of prevention, treatment, and rehabilitation.

We have a very serious lag between medical discovery and the application of the discovery. This lag is costly both to the individual patient and to the Nation's economy. The proposed centers would provide an immediate, practical, and economic means of accelerating progress in the prevention and treatment of mental illness.

These regional centers for controlled clinical investigation would be developed in existing community psychiatric facilities. No new construction would be involved. They would function in many respects like the psychiatric division of the Clinical Center at Bethesda.

Unlike the Clinical Center at Bethesda, however, the cost of the regional centers would not be borne entirely by the Federal Government since these centers would be located in, and integrated with, existing university medical centers in various parts of the country.

In the operation of these regional centers, various university departments and disciplines within and without their schools of medicine would participate and the local resources that are now channeled into their operations would continue to be available.

This would obviate the necessity to duplicate personnel and equipment and would undoubtedly provide for research in depth in an economic way. Some 16 universities have on their campuses psychiatric institutes, and various of these psychiatric institutes are integrated with the State mental hospital of the region and in some instances, as in my own, with the overall State mental health program.

The ideal goal of psychiatric research would be the prevention and cure of all mental illness. The thousands of mentally ill now hospitalized and the thousands that will be hospitalized pressures us to a more realistic goal; that is, simultaneously seeking better understanding of the causes of neuropsychiatric disorders and the development of the improved methods of diagnosis and treatment.

Mental disorders, as you know, seldom arise from a single cause, but are rather the result of the interplay of physiological, psychological and sociocultural factors. We can't anticipate a single form of treatment, nor can we anticipate that future psychiatric research be carried out in a restrictive, categorical framework.

To carry out psychiatric research today we need a whole spectrum of scientists—psychiatrists, neurologists, psychologists, biochemists, geneticists, sociologists, anthropologists and others.

Again, no single setting is sufficient. Psychiatric research must extend beyond the laboratory and the ward and even the clinic into the community. Only some aspects of basic research can be laboratory bound.

In the development phase of research, we need a relatively small number of patients but we do need extensive personnel because many observations have to be made, repeated tests are carried out and findings carefully checked and rechecked. After this has been accomplished, clinical application requires availability of large groups of patients and good communication between the investigators and the practicing physicians.

As Surgeon General Burney and many others have stated, there is a serious lag today between medical discoveries and their application to sick patients.

Dr. Richard Masland, Director of the National Institute of Neurological Diseases and Blindness, in a very comprehensive study of the problem of mental retardation said:

> Our first suggestion is that an appropriate setting be found in one of the major research centers of the United States for the establishment of a fully staffed research unit to investigate the problems of mental subnormality through the full range of its medical, biochemical, physiological, social, and other aspects.
>
> Such a center can provide the leadership and focus essential to the proper development of a research program which is starting almost from fundamentals and can, at the same time, attract the high quality trainees who will assure its continuation.

I think the statement of Dr. Masland's on mental retardation was equally applicable to the entire problem of neuropsychiatric disorders.

In these centers, it is anticipated that some important basic investigations and discoveries will be made. However, they are most needed for research development and application. As I have already indicated, they would be a part of the university complex and the facilities common to a university would be available providing resources difficult and most expensive to duplicate.

Further, the unfortunate circumstance by which thousands of individuals, mentally sick, are hospitalized in large State mental hospitals provides a unique opportunity for clinical research in the psychiatric field.

These centers would work very closely with their associated State hospitals. There would be an interchange of patients between the State hospitals and the centers and research units would be established in State hospitals for directed or collaborative research.

In the Midwest, we have already done that and my own university has four laboratories, small research units, in four different State institutions.

Mr. FOGARTY. Does that help to bring this knowledge to the local physician?

Dr. WITTSON. Very much so, sir. Yes, sir; but they are working directly with the investigators and they are able to communicate person-to-person.

Mr. GORMAN. How about the surrounding States? Why don't you tell them about television, what you do in surrounding States?

Dr. WITTSON. For 3 years we have had an interstate program in psychiatric training. From this method of communication, we have been able to carry a part of our training program from the university to four institutions in Nebraska, the medical college, 2-year school in South Dakota; the State hospital in South Dakota; State hospital in North Dakota which is further away than Chicago—something over 500 miles away—and three Iowa institutions.

Since this matter has been brought up, one of our great needs is this: Improved communications, and we should make use of the marked advances in the technology of communication. I think it can be done with very good results.

At the present time we are using television to carry our research to remote, off-campus institutions.

As I have already indicated, the clinical investigation requires very careful observation, both for the safety of the patient and for the assessment of the procedures of the staff. Some of the psychiatric institutions, like my own, have small, specially designed and staffed research wards. We have 10 beds for this purpose. The psychiatric part of the clinical program at Bethesda has 73. The total number of beds in the United States available for control of clinical research probably numbers not more than 250; it's simply not enough to get the job done. The personnel of each unit has to be very carefully selected and has to be assigned to the research program, otherwise they will be diverted to meet the service demands and demands in other parts of the institution.

Furthermore, not all doctors and nurses are able to carry out the requirements for research investigation.

Few, if any, of the existing psychiatric institutes today could expand their clinical investigations and possibly would not be able to obtain sufficient local funds. Similarly, we know that the local authorities at the State and county level will not underwrite the extra costs for care of indigent cases, and it would be quite unfair to impose on the sick individual and his family the extra financial burden this would entail and the extra tests and examinations necessary for the purposes of careful clinical investigation.

A significant part of the support of the existing institutes comes from project grants made to individuals by Federal agencies and private foundations. This type of support, usually given for a limited period and for specific purposes poses serious problems of integration and continuity. Frequently it is some months, or even a year, as Dr. Kline pointed out, between the time a need is recognized and the time that a project grant can be obtained, if it is obtained. This lag, necessary for the administration of project grants, often prevents a desirable and effective use of facilities.

In addition to the primary goal of accelerating and enhancing psychiatric research per se, there would accrue, from the establishment of these centers, secondary gains of considerable significance. Since clinical investigation requires the best possible medical care, individual patients in the regions would benefit. It has been a constant observation, as we discussed a few minutes ago, that research in a hospital tends to improve its clinical services. The same benefits usually spread to the surrounding medical community. I think perhaps the most important secondary gain would be the stimulation of interest of both the graduate and undergraduate level of these universities in medical sciences. The gradual establishment of such centers throughout the country beyond the large metropolitan areas would tend to encourage, too, a better distribution of psychiatrists, nationwide, whereas they are now so highly concentrated in a few major metropolitan areas.

The application of findings to clinical practice would be greatly facilitated. The busy practitioner, whether he be in the public psychiatric practice or general practice, can make only occasional trips to the remote research centers, and then at best he will make only a very casual and nonrecurring acquaintanceship with the investigators. Regional distribution would facilitate a closer and continuing relationship between the practicing doctor and the investigator. Then there would be established an intimate and cooperative relationship between the investigator and the State hospital and this would tend to upgrade the professional climate of these State hospitals which would assist them in the recruitment and retention of well trained doctors.

Again, another benefit would be that it would encourage participation and support by local government and industry and private philanthropy. As you know, generally individuals would rather make small gifts to national programs, and the larger gifts tend to stay at home.

To be conservative, it is estimated that at least six of the existing university psychiatric institutes would easily be able to phase in an enlarged program of clinical investigation without impairing teaching and training responsibilities. Here I would like to differ a little bit with my colleague, Dr. Kline. I have been connected now for some years with the university and it has been my experience that research, on the campus of a medical college, enhances the teaching; it does not reflect on the teaching, and I would not propose to follow the Russian system. I think it has been the experience of most universities that if a medical college was actively engaged in research that the quality of its teaching goes up.

I have personally communicated with the directors of psychiatric institutes in various parts of the country, in fact from the east coast to the west coast, and they have confirmed my opinion that a minimum of six would be ready to phase in such a program in the fiscal year of 1961, and this is a conservative estimate. In the case of my own university, readiness to establish a center has been demonstrated by the submission of an application to the National Institutes of Health. Since we have necessarily studied the projected facilities, administration and budgetary requirements of one such center, I would be glad to try to answer any specific questions the committee might have with regard to the facility, the staffing, the budget that would be needed.

Mr. FOGARTY. Tbank you, Doctor. You are asking for $105 million this year; is that right?

Dr. WITTSON. That's right, Mr. Chairman.

Mr. FOGARTY. Do you think that is enough?

Dr. WITTSON. No, sir; I say in the closing budget summary I would like another $20 million for training, but I would just have to be a little cautious, I guess. I am caught by the infectious caution of the administration in asking for $105 million.

Mr. FOGARTY. Yesterday we had the National Association for Mental Health in——

Dr. WITTSON. Yes, sir.

Mr. FOGARTY (continuing). And they arrived at almost the same figure you did, $104,857,000, but there were two or three places where they are emphasizing more than you, and vice versa. I was wondering why. For instance, "Total research grants," you are asking for $45,890,000 and they were suggesting $36,890,000.

Dr. WITTSON. Yes, sir.

Mr. FOGARTY. Then the other large one is "Training grants" where you are asking $36 million and they are asking for $46 million.

Dr. WITTSON. Yes.

Mr. FOGARTY. What is the reason for that difference? You are asking more for research than they are, and they are asking more for training than you are. What is the reason?

Mr. GORMAN. Actually, Mr. Chairman, in the basic training request we are asking for more outside of this forward funding.

I didn't include the forward financing. I feel it is rather a complicated problem and I think it is necessary, but I did not think we knew enough about the complications of budgetrary procedures to project 12 months in advance. In the research area, Mr. Chairman, very clearly we are asking for quite a few things, several things that they are not asking for: the drug screening centers that Dr. Kline spoke to, the clinical centers mentioned by Dr. Wittson and the increase in psychopharmacology of $3 million, and I think a larger boost——

Mr. FOGARTY. They asked for $8,500,000 and you are asking for $10,200,000.

Mr. GORMAN. That's right. In the regular programs of research I think we are asking for more than they are, a $10 million increase because of the backlog at present just in the regular grant program, but if we included the forward financing in this thing, Mr. Chairman, it would be up another $16 million right off the bat, but I did not want to fool around with that, because I would be likely to be caught in the budget coils, you know how that works.

Mr. FOGARTY. Is there anything else you would like to say?

Dr. WITTSON. Only that I would like to confirm what Mr. Gorman said about the amount of the clinical centers as would be directed to mental illness, his recommendation of the $3 million would be enough for us to start a program in approximately six institutes. I think it would take about a half a million dollars per institute to start the program; after that, we believe the amount needed would vary as to the number of beds that could be delegated to this purpose by the institute. somewhere around a million to a million and a half per center, we believe would be the amount needed.

Mr. Fogarty. There seems to be a lot of enthusiasm for this program all over the country.

Dr. Wittson. I feel, sir, that perhaps we are now at the point where this could be the most important single step that we could take.

Mr. Fogarty. Is there anything else you would like to say, Dr. Kline?

Dr. Kline. No. I would concur with Dr. Wittson and again ride my own hobby horse momentarily, that I would agree that this is probably one of the most productive steps, the one that would pay the highest returns immediately, in any event, to find out what drugs are available and use them. So that I think that both of these are actually very small amounts in terms of what the final dividends, the immediate and the final dividends would be.

Mr. Fogarty. Thank you.

Dr. Wittson. I would too like to concur in what Dr. Kline has said, that there is a need for control screening of the drugs. We have to have centers where we can have well-controlled screening.

Mr. Fogarty. It makes a lot of sense to me.

Dr. Wittson. So that we could eliminate those that are useless and, being useless, if they are administered, they can do a great deal of harm because they deny the patient of something that might be helpful.

Mr. Fogarty. I think you made that point very well. I don't think we had heard that side of the story before.

Dr. Kline. No; and unfortunately there are specific examples. This is not a theoretical postulation; it's a sad fact.

Mr. Gorman. Thank you very much, Mr. Chairman.

---

Wednesday, March 2, 1960.

## Heart Program

**DR. PAUL DUDLEY WHITE, SPECIALIST IN THE FIELD OF HEART DISEASE, GRADUATE OF HARVARD MEDICAL SCHOOL, CONSULTANT IN MEDICINE AT MASSACHUSETTS GENERAL HOSPITAL, EMERITUS CLINICAL PROFESSOR OF MEDICINE AT HARVARD, PAST PRESIDENT OF THE AMERICAN HEART ASSOCIATION, CONSULTANT FOR THE NATIONAL HEART INSTITUTE, AND PRESIDENT OF RESEARCH COMMITTEE OF THE INTERNATIONAL SOCIETY OF CARDIOLOGY**

**DR. MICHAEL DeBAKEY, PROFESSOR OF SURGERY, BAYLOR UNIVERSITY, COLLEGE OF MEDICINE, HOUSTON, TEX.**

Mr. Fogarty. I was pleasantly surprised with your letter of a couple weeks ago, Doctor. From reading that letter I understand you have really been getting around this country the last month and doing a lot of things.

Dr. White. I have been doing them for several reasons, partly for this purpose and partly for the American Heart Association and the good of mankind. To identify myself——

Mr. Fogarty. Also, you were on a nationwide television broadcast which I missed, I am sorry to say, but my wife saw it and she thought it was very well done.

Dr. WHITE. She approved.

Mr. FOGARTY. And also many people have remarked to me about the amount of money that you suggested might be appropriated this year, and they asked me what I thought. I said, "I have known Dr. White for quite a while now and he is not, in my opinion, a spendthrift."

Dr. WHITE. I am still a New Englander.

Mr. FOGARTY. I tell them that your are a conservative New Englander, and I am sure you would not be advocating the expenditure of funds like this unless you were positive we were going to get a lot back in return. Is that a fair statement?

Dr. WHITE. That is a fair statement. I think it is a fair statement.

Mr. FOGARTY. You do not mind being called a conservative New Englander, do you?

Dr. WHITE. No; not at all. Dr. DeBakey and I are here, both from the south, Texas and New England together, and we are in agreement about it.

To identify myself, I am Dr. Paul Dudley White of Boston, formerly clinical professor of medicine at Harvard University and physician to the Massachusetts General Hospital, past president of the American Heart Association, formerly executive director of the National Advisory Heart Council, and past president of the International Society of Cardiology. I am at present an active practitioner in the field of heart diseases, consultant in medicine to the Massachusetts General Hospital, president of the International Society of Cardiology Foundation, and vitally interested in the circulatory problems of my community, my State, the United States of America nationally, and the world at large.

Now, having made that introduction, may I express my appreciation for this opportunity to come back to you after 3 years and testify again.

I appeared first before this committee on February 15, 1949, a few months after the passage of the National Heart Act and the initiation of the National Heart Institute and the National Advisory Heart Council. My last appearance before this committee was on February 27, 1957.

It is always important, it seems to me, to present a historic background for our present activities and future plans and I would like to do that. Dr. DeBakey will tell more about the future plans, but I will say a word or two about them.

Mr. FOGARTY. All right.

Dr. WHITE. As I said, before the year 1507 heart disease was not recognized as such. In fact, it was thought that if the heart were affected death would come at once. Then autopsies, post mortem examinations began to be made as perhaps the first scientific evidence that many diseases could exist and that life could go on. This was as a result of post mortem examinations. In 1706 a notable Roman physician named Lancisi was requested by Pope Clement XI to carry out post mortem examinations in individuals dying suddenly in Rome that winter, following an epidemic of sudden deaths which had alarmed the populace. Not only were these autopsies performed but they were described in a volume entitled "De Subitaneis Mortibus," which means "On Sudden Death," written by Lancisi and dedicated to the Pope. Because of the great historical importance

of this volume and clear proof of the chronicity of some of the diseases that cause sudden death, as well as the great uncertainty of the causes of these diseases, I would like to quote briefly from Lancisi himself. I am referring to a book published in 1707 written by Lancisi, physician for Pope Clement XI in Rome, as a result of an epidemic of sudden deaths during that whole winter of 1705–6, and in the preface of that book, which is being translated at the request of Bishop John Wright and me—Bishop Wright is now in Pittsburgh; he used to be in Worcester. We hope to have it published before very long. It is a remarkable book and has historical material of pertinent interest today.

Let me read you from the preface:

At Rome, in the summer, autumn, and winter of 1705 down to the spring equinox of 1706, were many sudden deaths. The populace, as they do in a panic, invented a number of explanations: the poor quality of the tobacco; exhalations from the earth after recent earthquakes; inferior chocolate; a mysterious poison (virus) in the air.

That sounds absolutely modern. This is just what we are wondering today, you see, 252 years later.

Pope Clement XI turned, as he ought, to spiritual remedies and a special liturgy, but uniting prudence and piety, appointed in January 1706 a committee of investigation—

this was done way back there 250 years ago—he prayed, but he also appointed a committee of investigation—

and ordered the head physician of the Medical College at Rome to have some of the bodies dissected. Lancisi was appointed head of the committee to report to His Holiness; Cardinal Pallavicini, the Governor of Rome, gave all possible assistance and the experiments—

that is, the dissections—

were made in a public theater. By means of such dissections and other observations which Lancisi now publishes he arrived at certain conclusions.

The report of the autopsies, what they found.

Then, to go on to the findings:

Was the cause simple (not complicated) and universal, or particular and mixed? First, was the cause particular in individual cases? We know that in certain years or seasons, death comes to men, yes and to animals such as cattle and goats, from a pestilential condition of the air or a taint in air or water—

this is the time of cholera, plague, and typhoid, all these diseases were current and were in epidemic form, but here was an epidemic of sudden deaths, you see—

or from a scarcity or defect in their pasture, and that it rages without warning.

But I consider it more likely that the cause of the sudden deaths at Rome was not single and absolutely common to all, but that in the majority of cases there was a special cause for each case.

These were the chronic cases, they weren't incidents of the epidemic or plague.

I conclude this from the external symptoms, and my conviction was only strengthened by autopsies. For it will be shown in the following pages that the peculiar and principal cause of premature death in each case was the presence of certain seeds, which were produced gradually and were finally called into action on a sudden; as Hippocrates says: "Diseases do not come to men suddenly but are collected and pile up little by little." No need to blame the tobacco; since some whose nostrils were never defiled by that dust died suddenly. Or exhalations from earthquakes, since many who escaped death lived where there had been most earthquakes. Nor was the chocolate to blame, for men like Dr.

Placentius, an octogenarian, or myself, accustomed to drink it as much as twice a day for 30 years escaped. On the other hand, many who never tasted it died suddenly. Nor was it a case of undetected poison in the air, for when like augurs we inspected the entrails, we found clear and well-known causes for the disease.

Before the Pope ordered us to dissect, there was evidence for the theory that the cause of death was particular and not universal; in some cases there were symptoms of rupture of the blood carrying canal—

that is the aorta—

which had been weakened by the varix or an aneurism in the chest or abdomen. Many died of violent apoplexy due to stoppage or effusion of blood in the brain; others of a violent spasm of the heart or paralysis or obstruction of the passages of the heart and of the large arteries—

this is atherosclerosis.

Thus was hindered the passage of the blood from the heart into the lungs and the brain, and so the vital and reciprocal communication of those organs was suddenly cut off. But I must repeat again and again, that so far as I know, every one of those who died suddenly had long suffered from some disease of the fluids—

that is the blood—

the intestines, or *at least of the blood vessels.*

I emphasize that, that was very interesting.

* * * Therefore, to the best of my belief, these sudden deaths did not come to the healthy, but nearly always to those who had long suffered from poor health. For them this was a sort of foaming over of human nature, or an unfavorable crisis arose, with men who had long been either openly or secretly—

that is, unknown to themselves—

in poor health.

If that book had only been studied or adequately appreciated many years ago—I mean, 250 years ago, when it was written—we wouldn't be so far behind now. But a hundred years went by before they began to pay attention to the fact that you might have angina pectoris and it could be due to coronary heart disease; that was published in 1799 in a letter by Jenner to Perry, and then another hundred-odd years went by before James Herrick, of Chicago, described coronary thrombosis; 200 years between Lancisi who really pointed it out and Herrick who put it on the map, 200 years.

Mr. Fogarty. In what year did you start research?

Dr. White. Well, I am coming to that.

Next I would bring in the year 1920, 40 years ago, when a few of us who were fortunate enough to have been born still in the dark ages of medicine were bold enough to initiate the specialty of cardiovascular disease. It was frowned upon at that time. Cardiology wasn't a good word. At that time we were chided by many of our associates and teachers who thought that heart disease was too small a field and too narrow for us to work at.

In medical school prior to that time and in the hospital as an interne—this was in the teens, about the First World War—I had never heard the words coronary thrombosis used in the school and used in the hospital, although now it is the most popular of all our diseases and a common cause of death, both sudden and less sudden. It was only in the 1920's that we became conscious of this disease responsible for the common heart attack which had been first described by James Herrick, of Chicago, in 1912, 200 years after Lancisi, so slowly did the wheels of progress turn then.

Due to this specialization from 1920 on, the tempo has increased progressively, not in a straight line, but in a curve, in all fields of medicine, including that of heart disease. I am sure that much more has been learned about heart disease and much more has been done for it in the last 40 years than in all the centuries before and I would add the same thing about the last decade in contrast to the three previous decades in the 40 years. It has been a most thrilling experience to have lived through these times and to have seen the dawn of such progress, in large part through the devoted labors of investigators in the study of the various heart diseases, in the discovery of ways to prognosticate and to treat them, and, not last, not least—last but not least, you see—in the support of this progress both moral and material by such enlightened legislators as members of this committee, and I say that with strong feeling. However, less has been done about prevention of heart diseases which should claim first priority than about diagnosis and treatment, important as they are. Most of the advances have been made in diagnosis and treatment and these are superb advances.

In the first edition of my book which was published in 1931, nearly 30 years ago, I had an appendix with a long series of questions—this was 30 years ago—many of which now have been answered, some in the last 10 years. I ought to add a little booklet, really. I haven't published the fifth edition yet, the fourth edition was 1951, but I ought to republish that list of questions again, because it was fascinating.

Let me proceed, now, to my first testimony before your House committee in February 1949, 11 years ago. I would like to quote just briefly from that testimony. It was an auspicious beginning, but as we see now a very small one. We are still growing. We are only part way along in our teenage, not even a teenager, only 11, 12 years, and we haven't even reached the teens yet. Maturity will be established when we have conquered these diseases, not only through their adequate diagnosis and treatment, medical and surgical, but also through their prevention. I am sure that that can be accomplished, at least in our young and middle-aged, and while there may be difficulty because of the resultant long life, I personally think that, as I have said recently, middle age should continue to age 80. There is no reason at all why three score and 10 should be the limit of our life. We have already extended the expectation of life from the forties, 45 of a hundred years ago, to 70 now, and if we can lick this atherosclerosis in the early years of adult males, young and middle aged, there is no reason at all why we should not survive not only as far as 80, but well after 80. In other words, 80 is a perfectly rational time of beginning old age. As I approach 80 I may change my mind; maybe as it draws nearer I will think it ought to be 90, but that's true.

A few years later—Well, I will read the first paragraph of that, the testimony I gave in 1949.

My presence before you—I said, after identifying myself—is the result of my conviction that this Government has a great role to play in the future in the control of heart disease which, more than any other hazard threatens the lives of all of us. This conviction of mine is based on more than 25 years of experience—now that is extended more, of course—close to 40—in the practice of medicine itself, in teaching medical students and doctors, and in conducting personally research in heart disease.

The old saying, "An ounce of prevention is worth a pound of cure," is my text. Our goal is fundamental: to prevent and not merely to diagnose and treat heart disease.

About 90 percent of deaths from heart ailments can be traced to coronary arterial disease, high blood pressure, and rheumatic fever.

Now, we have extended this. Dr. DeBakey will enlarge on that. It isn't heart disease now or brain disease or diseases of the legs or the kidneys that should be our chief interests but disease of the inner wall of the arteries that supply the heart and the brain and the kidneys and the legs. And here is a book which I might show you now called "The Arterial Wall" just published under the editorship of Lansing, a small book, which mostly tells about our ignorance concerning the arterial wall. We talk a lot about cholesterol, you see, about the blood and very little attention has been paid to the arterial wall which is the crux of the whole situation. Oh, the blood pressure is too, but the arterial wall has been studied astonishingly little. So it is arterial disease that is more important than heart disease or the brain disease or kidney disease or diseases of the legs. It is the artery wall that has been neglected, so it is the vascular part of cardiovascular disease that is looming up now much more important than heart disease per se, although the heart still has fundamental diseases, rheumatic or occasionally rare cases of diphtheria and so on.

A few years later, on April 16, 1953, I appeared—I appeared yearly through those years—and I presented before the Senate subcommittee a patient to illustrate in a clearcut, decisive way some of the advances which had occurred. This is the testimony at that time in which I presented this patient. This is from the record, and it had occurred in the previous few years. Most of these advances illustrated by this one patient were supported by research funds, both allocated by Congress and collected in the annual heart drives of the American Heart Association. This patient I would now like to present to you gentlemen of the House committee 7 years later. This was in 1953 that I presented him for the Senate and now he is here to be presented to you today. With your permission I would like to show him to you now, because he has remained in good health after marvelous recoveries from conditions which would have been fatal 10 or 15 years ago.

I would like to read a brief statement of his case and present him to you. Robert Giblin. Mr. Giblin, right here; here is Mr. Giblin, who is the gentleman the summary of whose case I have here and I will pass it out to the subcommittee. It was passed out to the Senate subcommittee 7 years ago, and I have added an addendum for the years that have occurred since 1953.

I saw him first when he was 14 years old, in August 1940, and he had high blood pressure. There was no treatment. We were just beginning to recognize a certain congenital defect of the aorta which could produce high blood pressure. That was discovered in the 1930's, late 1930's. So we were able to recognize that he did not have high blood pressure from a kidney disease primarily or an obscure type of heart disease; he had a definite narrowing of his aorta which produced the high blood pressure.

He was 15—and I saw him once a year, 1940, 1941, 1942, 1943, 1944, when he was 14, 15, 16, 17, 18 years of age. No treatment. We simply advised him not to play so much football because we knew if

there was an increased pressure it might be a strain on his aorta, but he felt perfectly well.

Then Dr. Gross and Dr. Crafoord independently—Dr. Robert E. Gross in Boston and Dr. Clarence Crafoord in Sweden, in Stockholm—independently discovered or invented this operation of the partition of the aorta. I would very much like to have Dr. DeBakey speak on that, interrupting me, after I have finished this brief review.

I referred him in 1945 to Dr. Gross, but Dr. Gross—his experience was very limited then and Giblin was so well that he felt he had better not risk him and he said wait for a few years until I am more expert with this rather than working on a healthy boy. So we waited and meanwhile his father had been ill, Bob's father, and we had general advice in 1947, 1948, in December of 1948. Then in December of 1949 he had an infection. We thought it was rheumatic fever at first. He had had a tooth out in November with penicillin and he seemed to be better in January, but in February he began to be sick again. In March we made a diagnosis of probable subacute bacterial endarteritis, an infection of the aorta. The germ had gotten in probably through the gums and had decided to grow in this defective part of the aorta and we had an awful time controlling it. Penicillin didn't work and we finally gave him chloromycetin and he finally recovered but his weight went down to about 116, from 150 or so, and he was pretty sick.

I even suggested that Dr. Gross operate on him while infected, take out this aorta and save his life, but fortunately we did not need to do it then and he recovered.

In 1950 I sent him again to Dr. Gross and in November of 1950 Dr. Gross operated upon him and found a condition of his aorta, and I will pass this picture around. That is the body open [distributing drawing]. There is a very narrow, long strip of aorta, a big aneurysm (swelling) below it which was too difficult to operate upon, so we closed him up. This was in 1950, before they had the blood vessel banks. You see, they didn't have a long enough piece of aorta to put in there, so every month through 1951 we got in touch with Dr. Gross to see if he had gotten a piece of aorta long enough to put in to take the place of this, you see. Finally in January of 1952 Dr. Gross called him in. He got a piece of aorta and called him in and operated on him. It took 10½ hours to replace 14 centimeters of aorta, and this picture shows—these are drawings by Dr. Gross' artist—after he put in the graft, you see.

Mr. Denton. Was it a tube?

Dr. White. No, it is a blood vessel from somebody else, you see, but now we have other techniques which are also very good, and better perhaps.

This was 1952, and each year I have examined him and he has been in good health: 1952, 1953, 1954, 1955, and he was married in 1955, and he has a family now. In 1956 as a result of his examination he was told he could play golf. In 1957 he had a sore throat but he looked in good condition. In 1959—I missed him in 1958—in good health, blood pressure normal and I examined him this morning before coming from Boston to appear here and he is in good health now. If you want he can show you his scar, but he is a very healthy man.

This, you see, shows the value in one patient, it shows five important advances. First in his case was the diagnosis which was difficult to

make until we began to concentrate on the field and began to have special workers and money to make these studies, then came the cure of what had been, before 1944, 99 percent fatal. In this infection we used to hesitate and hated to make the diagnosis because only one in a hundred, I don't believe one in a hundred, survived, and then came the operative relief, this magnificent surgical procedure by a pioneer in the field. Fourthly came his complete rehabilitation which is also an important development in the last decade or so. The President's rehabilitation has been very dramatic, but it is routine now, as I have said sometimes. A person, after all, who is just run of the mill, thousands of others like him, we expected him to make an excellent recovery.

Finally, Giblin illustrates the value of the long followup, the long followup with patients is often neglected.

Mr. FOGARTY. The President is a pretty good example, though, with all that he has on his mind and all the work he has.

Dr. WHITE. Yes, he's excellent. He's some patient, I might add, too.

Mr. FOGARTY. Does he follow orders?

Dr. WHITE. Oh, yes. It's time that you did, too, probably.

Mr. FOGARTY. You are right.

Do you think I ought to play golf?

Dr. WHITE. Oh, yes. It's important for you to play golf and also important to come up and get a checkup and probably also do a little something about your weight.

Would you like to ask Mr. Giblin any questions? We would certainly be glad to answer them.

Mr. FOGARTY. Off the record.

(Discussion off the record.)

Dr. WHITE. I might simply add he demonstrates the importance of further followup as one of our techniques, because he is here essentially 8 years later sustaining his good improvement with the replacement of a large section of his aorta. Such a triumph even raises the possibility in the remote future of heart as well as blood vessel and kidney banks or of artificial devices to maintain the circulation in critical cases. I mean, this would have been unheard of 20 years ago.

Then I said, let me come to my last appearance. Do you want to ask anything about him now? Do you want to see Bob's scar?

Mr. FOGARTY. I remember him.

Dr. WHITE. He's got a nice looking scar.

Mr. FOGARTY. And you took your shirt off when you were here before.

Mr. GIBLIN. Yes.

Dr. WHITE. I guess I have shown him to both committees.

Then my last appearance was 3 years ago and I have that testimony here. I don't think I need to do more than say it is a privilege to supplement the testimony of Dr. Andrus who preceded me. I have four brief but important observations to make.

In the first place, I cannot emphasize enough the contrast that has come in my own lifetime between the fatalism, pessimism, and ignorance about heart disease a generation ago and that of today, best illustrated by reading the first chapter of Ecclesiastes written in 200 B.C., when he said: "Is there anything new under the sun?" "There

is nothing new under the sun." But he was a pessimistic philosopher and he wrote very well, but he was very discouraging.

Then I contrasted that with the report of Dr. Lillehei of Minneapolis whom I saw the other day in Ohio, barnstorming as I was for the American Heart Drive.

Secondly, although it is true that with increasing length of life of our population today, there is bound to be more heart disease, nevertheless a large percentage of deaths from cardiovascular disease in the United States is in our young people. It isn't just because we are getting older that we have heart disease. There is a great deal in our middle aged and young men, especially, and they live shorter lives by 6 years than the women. So there are an infinite number of more widows than widowers in the United States today, and this is a condition we should correct. I mean improving the rate in men by advising not the widows, but the wives to do something about saving of their husbands. They can do it by strong support of the research programs that are going on and probably by giving advice about diet and exercise and a few simple things, even before we have all our proof.

Thirdly, the increased moneys that have been spent for cardiovascular research in the last few years have been extremely helpful. Much has been accomplished in particular in the fields of basic and physiological research, rheumatic heart disease, hypertension and coronary heart disease.

Finally, the challenge of the future is great, beyond our expectations, and we must accelerate our progress in order to get the answers sooner to some of these serious problems that remain. It isn't a matter of convenience. Is it convenient to increase by some millions of dollars our research? Is that inconvenient? It's a matter of life and death. It's much more important then just convenience or the budget. We must amplify our basic research including biophysics as well as biochemistry and genetics as well as physiology and our investigation of the relationship of the ways of life.

For example, there are very few geneticists in this country today or in any country. Our ignorance about heredity in man is appalling. We must study the host as well as the disease. We should not expect to be able to recommend programs for ways of life for all persons equally. We must make recommendations to suit the individual.

It would be silly to treat 100 percent of the people for something for which only 5 percent are candidates. This is a waste of money, of time and energy. If 100 individuals have streptococcus sore throat, only 5 of the 100 on the average would come down 2 weeks later with rheumatic fever, and the 95 would escape. Why then have a program that treats 100 percent of the people when only 5 percent need the protection? We must do so now, because we cannot recognize the 5 percent who are susceptible. We must "fail same." We need to know how to recognize the susceptible. It's true all across the field of disease, not just individual heart disease. When this can be done our treatment is effective and true prevention possible.

And I said, in conclusion—this is my last statement last time: In conclusion, as a result of my experience during the years in which I have appeared before you, I wish to pay tribute to your patience and to your recognition of the needs of medical research and training today. Thank you for your invitation to come back after these 3

years, because what has happened in the last 3 years has been tremendous and very stimulating. The progress has been not on a plateau. I remember once being asked years ago, Haven't you reached the plateau yet? The question was asked, you know, of some investigators, and sometimes they would say, "Well, almost." But then we began to realize that at least we must keep on growing, we must continue to invest in increasing amounts of profitable research until we have these answers and then we can settle back.

This brings me to today and I welcome this opportunity once more, as I said, to speak to you because of what has happened in the last 3 years. The pace has quickened. Operations unheard of a decade ago, even a few years ago are now being done to restore life to the brain as well as to the legs, the kidneys, and now even to the heart. I have brought along a device which really—Dr. DeBakey might show you [exhibiting device]. I will pass this around. This is a special catheter that an associate and colleague of mine, Dr. David Littman, has constructed. There are different kinds—each one invents his own. He constructed it to obtain beautiful X-ray pictures of the coronary circulation. We obtain pictures of circulation in the little coronary arteries by introduction of this catheter in a leg artery. The catheter goes up the aorta to its valve and then inject fluid of contrast material. By X-ray at that time you get an outline of the coronary arteries and you can see where they are obstructed. So we now can make a definitive diagnosis by this technique, the new technique, and Dr. Littman obtained 69 such pictures in 69 cases, with little difficulty, but no danger. The other day Dr. Lillihei, whom you may know told me that he has carried out such diagnostic technic in 150 cases. You will probably do more than that without any harmful results (to Dr. DeBakey). In a few of these patients a localized block in the artery has been removed. If it is a general block, it is very difficult to advise cutting a lot of arteries to clean them out. Recently the Massachusetts General Hospital had one patient who was treated in an emergency. He was taken sick and dropped dead in the corridor in the hospital. He was just visiting there, and his chest was opened, the heart massaged. He was taken to the operating room and there was an ischemic area, the bloodless area and above it the embolism in the coronary artery. The artery was opened and the embolism this clot was removed. The pale spot on the heart immediately flushed up and there was blood again, you see. However, the patient lived only 2 days when there were other things that happened to him. But this is a sort of forecast of what we may some day be able to do, and this is brand new.

What have been some specific accomplishments in the last few years? In the first place, we may say that these highly developed diagnostic technics and therapeutic measures have been brought even into remote parts of the country so that many cities and towns now have developed their own centers for cardiovascular diagnosis and treatment. Ten or twelve years ago, before this program started, we could count such diagnostic centers and pioneer surgeons—like Dr. Gross and Dr. DeBakey—on the fingers of both hands, only 6 or 8 or 10 of them, I suppose, and now there are scores throughout the country, indeed probably a few hundred. There are various estimates as to whether there might be 200 or 250 such centers with well trained expert surgeons available all over the country now, and each

surgeon represents just one member of the team. Here we have a team that can deal with a cardiac catheterization. It is just wonderful to go through the country now, as I did the other day, in Cincinnati and Dayton and other places like that, Des Moines, and find all of this going on, which didn't exist a few years ago. I visited them and I have talked with their people. This is, in itself clear evidence of the value of the funds already expended. It takes a lot of money to start these centers. Wherever good research is being done—and I notice that my predecessors spoke of this—medical teaching is improved, and wherever medical teaching is improved the level of the health and of the medical and surgical care of that community is improved. Therefore, the initiation of good research in any part of the country or any part of the world brings with it eventually a much improved state of health; it's axiomatic.

I have asked many of these colleagues of mine in this country and abroad within the last 2 weeks to send me a statement of their needs including the number of dollars that are really essential for adequate programs, and I won't take time to read these—we don't have time—but I have a great flock of reports from people like Dr. Stamler in Chicago, who is a tremendously energetic and able worker in the field. He used to be with Dr. Louis Katz. I know him quite well now. He has tremendous programs started and it will cost a great deal more money than he has available, studying atherosclerosis, studying people who live different ways of life right there in Chicago, a checking clues in his laboratory with animals. I will just read one paragraph:

In 1958 we were able—through the cooperation with the venereal disease control program here—to collect 1,600 bloods, door to door, in the low income areas of predominantly Negro residence. These were bloods on male and female Negroes, aged 25 to 64. The sera sat in the deep freeze for 1 year, until last summer, because no technician was available to analyze them for cholesterol. When the data were finally obtained, they revealed a significant difference between Negro and white males in mean level of cholesterolemia. The level for the Negro males, aged 40 to 59, was 207 milligrams percent; for the white males, 239 milligrams percent. This may be an important lead clarifying comparative patterns of coronary disease in middle-aged Negro and white men. It needs to be vigorously followed up, among other things * * * in the area of rheumatic fever * * * and studied.

As you know, one of our most important undertakings is the coronary prevention evaluation program * * *

This, of course, is the great problem in atherosclerosis which involves not only the coronary circulation but the same disease as the blood vessels in the neck, the kidneys, the legs and so when you protect against one area, you protect the heart and you are protecting the brain too. When you protect one and prevent these strokes, you are protecting the other parts of the body.

* * * a research effort assessing the ability to achieve primary prevention of coronary disease in high-risk, middle-aged men at present free of any clinical evidence of this disease. In the attempt to achieve prophylaxis we are utilizing chiefly nutritional and hygienic means to correct defects making for high-risk, e.g. hypercholesterolemia and obesity. This work is proceeding all too slowly with the help of a $13,750 grant from the American Heart Association and part of our grants from the Chicago Heart Association and the National Heart Institute.

Some money has already been given to them.

Our consultant statistician tells us that we need a minimum of 500 men in the study group (apart from controls) and preferably 1,000, to get a statistically clean answer, setting the minimum medical objective at havling the incidence

rate of coronary disease in these highrisk men. With our present resources, we are able to accrue an average of two new participants per week, since the work-up and indoctrination, medical and nutritional, is extensive, time consuming, and expensive. Obviously, at this pace it will take several years to gather together the necessary study population.

And it is an expensive procedure.

* * * Our estimate is that it would cost about $50,000 per group per year—

this is on a comparative study throughout the country—

plus $50,000 per year for the coordinating group responsible for overall statistical, laboratory and other work. Thus, for about $500,000 per year over a 6-year period we could reasonably anti cipate a clearcut answer to the crucial question confronting medicine and public health in our country today: How much can be accomplished—based on recent research advances—in the prevention of coronary disease? This seems to me to be a worthwhile investment, reasonable in amount and potenti ally incalculable in value. It is analogous to the mass polio inoculation field trial.

That is just one example. I have one here from Cincinnati, Benjamin Miller, who has done some very fundamental work in the disease of the arterial wall itself. The problem isn't wholly the cholesterol in the blood, or the cholesterol in the arteries; there are other problems, other changes in the artery wall that haven't been added to the study. There is a letter from Keys with whom I am working on studies in other countries as well as in this country, and he says:

Well-organized teams having investigators—

this is a summary—

and continuing contacts with the men being studied are assured for all the areas and groups mentioned abo ve to carry on the work and to analyze the followup results will require a period of about 70 years at an annual cost of $150,000 aside from funds pro vided within each of the foreign countries—

for the studies to be made in these different foreign countries, and not including the funds provided directly from the University of Minnesota.

And then there is one from a member of the Public Health School at Harvard University in Boston. It is again an appeal for an amount of money. A letter from Italy from the executive secretary general of the International Society of Cardiology telling about the need in the 38 countries' 10 programs would cost $6 million for an adequate study, beginning study, and that money is not available.

Then a cablegram from Geneva, WHO; they only have one cardiologist in all the WHO.

Mr. FOGARTY. That is all?

Dr. WHITE. And they are appealing to the International Society of Cardiology and some of the rest of us to help.

This cable is from the combination of the International Society of Cardiology and WHO, a cablegram from India, from New Delhi, and I will just read this one, as an example:

From personal experience of myself and colleagues—this is a very able woman whom we know quite well, a member of the international society doing research in India on this problem of heart—11 affiliated countries, Asian Pacific Society Cardiovascular Disease, very important cause of death and serious sickness. Pattern of heart disease shows marked ethnic variations. Besides coronary disease, cerebral vascular disease, and hypertension, cor pulmonale and rheumatic fever serious public health problems. Abundant material for epidemiologic studies which will help solve etiology heart disease.

And give them a start out there in that part of the world.

Research lasting several years absolutely essential but withheld due lack of funds. Money necessary, statistical studies training research workers and public health education. At least $1½ million necessary per year for 10 years.

That is just an example of the need.

Another cable from Chavez who is the leader of the Latin American cardiology throughout the South and Central America and the islands and he figures that it would be—he said:

Re your letter February 19. Necessities of this institute for cardiovascular research are many and great. In accordance with the technical staff we have $1 mill on a year. This would be a moderate amount. There are great programs awaiting like epidemiology of cardiac diseases in Mexico, the experimental campaign against rheumatic heart disease studies on the effects of our altitude in cardiovascular patients, etc., if we add the requirements of other medical research institutions the amount would increase two or three times.

Several million dollars, just as an illustration, not of what we must do entirely but what is to be done, and we can coordinate our work with them, because what we learn abroad may be as helpful for our own citizens as probably a study in this country.

Then a letter from Sweden, similarly, and from Czechoslovakia, then to end up my testimony, I will show you one other book. "The Chemistry of Heredity," and what I have said about this is as follows:

It may be possible some day in the remote future or not so remote future, so to alter our chemical constitution that we may be able to counteract the effects of body inheritance, that is, the inheritance of inadequate hearts and blood vessels. In other words, this is just beginning to open up. We may be able to blame our ancestry after all——

Mr. FOGARTY. And correct it?

Dr. WHITE. And correct it by determining the defective enzymes in our genes and then chemically correcting them. This has been recognized now, the faulty enzyme of the disease called sickle cell anemia, it's been identified and it opens up possibilities.

Finally, to illustrate some of the reasons for the requests for much more money than has been allocated in the President's budget, let me mention the natural growth of the activity of all these centers—it's a natural growth; it isn't just a straight line up, it's a line that goes this way [indicating]—medical and surgical, working on new techniques of diagnosis and of treatment, the need of training many new workers in the fields I have just mentioned, especially genetics, and the establishment of researches therein, the utilization of such a resource as an adequate monkey colony which we lack and which is badly needed. We are envious of the Russians for that, not much else, but badly needed, which, incidentally, was one of the important advances found in Russia, medically, over our own resources. The $63 million, especially with the dollar at its present value, is much too little to support this growing program. It's a matter of life and death, this hazard of atherosclerosis to all of us, especially young and middle-aged males in this country today. It is not a matter of convenience. We must do something about this but we cannot do it intelligently until we have more proof of the correct answers. Lord knows we have questions enough but we still need the answers. Dr. DeBakey will be able to give you more details not only about surgical diagnostic and operating techniques but about details of the budget itself.

Finally, thank you very much for listening to me, and I very much hope that the recommendation of the citizens' budget will be accepted as a perfectly rational need in our work today, local, national, and to cover some of our obligations internationally, or opportunities, rather than obligations. I should add simply that what we can learn in research from countries outside of the United States may not only be of help but even more instructive in the development of our knowledge as to how best to preserve the health of our own citizens in the United States. Is prosperity to blame for the current epidemic of serious atherosclerosis in this country today and in the prosperous minorities in many other countries? If so, what factors of prosperity are to blame and can't we be prosperous and at the same time keep healthy?

Thank you.

Mr. FOGARTY. Thank you, Doctor; that was a very good statement. It is good to have you back with us again. We missed you for the past 3 years.

CITIZENS BUDGET

What is the total of the citizens' budget?

Dr. DEBAKEY. $115,250,000.

Mr. FOGARTY. $115 million; that is compared with $63 million in the budget before us.

We have a budget that we think is lacking in many areas. There is a cutback this year in hospital construction of some $60 million which the majority of the committee do not think should be allowed to stand. There is a cut of $80 million in the aid to schools in federally impacted areas, and $2 million in vocational education and $5 million in grants for medical research facilities. There is a cut of $25 million in the water pollution program where we are trying to clean up our streams, and—well, all of these cuts that are made amount to about $180 million. So we are faced with the prospect of restoring these cuts of about $180 million before we can talk about increases in these areas that you are interested in.

Then, at the same time, of course—you have heard this question before so I know it is not unexpected—we have men in Congress who do not believe in research, period. They think more of balancing the budget than they do of following out some of the leads that you have talked about today that might save lives and extend life expectancy. What is the best answer for them, what is the best answer for me to give if I am confronted with that statement on the floor of the House and the committee?

Dr. WHITE. One answer I think would be, What is a life worth? What is Bob Giblin's life worth; what is it worth? You see? It has been worth much more, I am sure, than the funds that were put into the researches that saved his life. That is true of many leaders in Government and business and the professions today who are, as you read in the newspapers, being either crippled or killed at the age of 40, 45, 50, 55. The average age of patients that have coronaries are 52 and that is too young. These people are valuable and it is the height of their value. What are they worth? They must be worth millions and millions, aside from the increase of our knowledge which is going to save many people who are not so important as leaders in the present day. So I think it is a matter of really life and death but not of convenience from the standpoint of budget or lack of time to

consider it and so forth. I think this is critical when this is the most exciting time in all medical history. We've got these opportunities and they are accomplishing a great deal; we see it every day.

Mr. FOGARTY. It would be a terrible blow, would it not, just to level off these programs in view of what you have in front of you?

Dr. WHITE. Yes, our experience as to what has happened in the last 10 years shows this. It has been wonderful. We are just in the middle of it. We haven't reached even the teenage.

Mr. FOGARTY. That is a good point that you make.

Thank you, Doctor. Dr. DeBakey, I have had the pleasure of meeting you on several occasions, but I think this is your first appearance before this committee.

Dr. DEBAKEY. Yes, sir; it is.

Mr. FOGARTY. We are very pleased to have you here. You may proceed.

STATEMENT OF DR. MICHAEL E. DE BAKEY

Dr. DEBAKEY. Thank you, sir. My name is Michael E. DeBakey. I am a professor of surgery and chairman of the Department of Surgery at Baylor University College of Medicine. For many years I have been a teacher of surgery as well as a practicing surgeon, and my interest in clinical and investigative surgery has been intensified by my close association with advisory groups to national agencies concerned with cardiovascular surgery. I am familiar with the research and educational programs in this field and am aware of their many needs and their potential for development, particularly at this time. I should, therefore, like to make some remarks in support of an increase in appropriations for the National Heart Institute as proposed in the citizens' recommendations for fiscal 1961, as attached, in the statement which I would like to submit for the record.

Mr. FOGARTY. All right, we will be glad to have it.

*National Heart Institute appropriations*

| | Fiscal 1960 appropriations | Fiscal 1961 citizens' recommendations |
|---|---|---|
| Grants: | | |
| Research projects | $36,468,000 | [1] $74,000,000 |
| Research fellowships | 2,663,000 | 4,000,000 |
| Training | 8,679,000 | 15,800,000 |
| State control programs | 3,125,000 | 6,000,000 |
| Total, grants | 50,935,000 | 99,800,000 |
| Direct operations: | | |
| Research | 8,036,000 | 10,000,000 |
| Review and approval | 1,121,000 | 2,000,000 |
| Training activities | 185,000 | 200,000 |
| Professional and technical assistance | 1,726,000 | 3,000,000 |
| Administration | 234,000 | 250,000 |
| Total, direct operation | 11,302,000 | 15,450,000 |
| Total | 62,237,000 | 115,250,000 |

[1] Includes $15,000,000 for establishment of research centers and $11,000,000 for primate colonies.

Dr. DEBAKEY. The figure that has been proposed, and with which I concur wholeheartedly, is $115,250,000, of which $15 million would be included in research centers and $11 million for primate colonies.

In this century of medical renaissance, progress would be almost inevitable even without such aid, but as in so many other fields, a concentration of funds and energies can produce results much more rapidly and of a magnitude and scope that are almost inconceivable. Expenditures made now for these purposes can provide the impetus and the means for bolder attacks on the major diseases and for fuller inquiries into basic biochemical and physiologic problems. Research in the major diseases, and especially in cardiovascular disease, has been greatly increased, but there is urgent need for more precise, more concentrated, more effective—and more expensive—investigations.

Accordingly and in support of this proposed budget, certain considerations deserve emphasis. First among these is the need to maintain and further strengthen the programs of research and training which have contributed so much to the advancement of our knowledge in the attack upon diseases of the heart and blood vessels. This is well reflected by the impressive progress that has taken place in recent years both in terms of the greatly increased number of highly skilled and competent research workers and exciting new developments derived from these research endeavors. Indeed the advancements made during the past decade alone far surpass all previous efforts in this field of endeavor. It is my firm conviction that this has been largely due to the great impetus given to research activities during this period through basic support provided through the National Heart Institute's research and training program.

The impressive progress that has been made during this time may be illustrated by some of the advancements in the surgical treatment of diseases of the heart and blood vessels with which I am most familiar. The major etiologic factor responsible for the development of these cardiovascular disturbances is arteriosclerosis or atherosclerosis. Although the cause of this disease remains a baffling problem, intensive research and clinical investigations, during the past decade particularly, have provided a much better understanding of the nature of the lesions produced by the disease and, as a consequence, have led to the development of highly effective methods of surgical treatment. In general, the pathologic lesions resulting from this underlying disease tend to assume two broad patterns. On the one hand, the disease may cause a weakening or loss of integrity of the vessel wall with progressive dilatation and aneurysmal formation, which ultimately produces serious and even lethal complications from rupture or thrombosis. On the other hand, the atherosclerotic process may progressively enlarge and encroach upon the lumen of the vessel and thus ultimately lead to its complete occulsion. Owing to its predilection to involve and block such vital arteries as the aorta and those that supply blood to the brain, heart, kidneys, and lower extremities, as well as its tendency to develop progressively with increasing age, it constitutes the most frequent cause of death and disability in this country, accounting for more deaths than all other diseases combined. Highly effective methods of treatment for these grave lesions have become available only within recent years.

Aneurysms of the aorta, for example, have challenged physicians for centuries, having been recognized as a deadly condition since earliest times. Various methods of treatment were devised and employed, but until recently—indeed, up to 1952—none proved effective. Within the past decade, however, curative treatment has been accomplished by development of the surgical principle of removal of the diseased segment of blood vessel and its replacement with a substitute blood vessel to restore normal function. Successful application of this method of treatment is dependent upon a number of factors, among the most important of which are the principles of blood vessel suture and arterial graft replacement. The development and refinement of these principles were brought to full clinical function in the research laboratory, thus providing an impressive example of the great importance of fundamental investigation in the attack upon these clinical problems. More recently, and as a result of these basic studies, the problem of replacement of diseased arteries has been effectively solved through the development of substitute blood vessels made of such plastic materials as dacron and teflon. So rapid and effective have been these research developments during the past few years that these plastic blood vessel substitutes have now become as readily available in the operating room as suture material.

Thus, within the past decade, curative treatment of aneurysmal disease has become a complete reality with widespread application. The centuries-old challenge has been successfully met. These deadly lesions, which were formerly considered hopeless, are now amenable to curative treatment. Even the most extensive forms of aneurysms involving such vital segments of the aorta as that adjacent to the heart and that supplying the brain, liver, gastrointestinal tract, and kidneys can be successfully treated by this means. Moreover, with increasing experience and further surgical refinements, the results of operation have been steadily improved, as illustrated by a recent analysis of approximately 900 cases of aneurysms of the abdominal aorta in which the rate of success following this form of treatment has now been increased to more than 95 percent. In addition, followup studies extending over 5 years have clearly demonstrated that the survival rate in these patients has been increased more than sixfold.

Especially striking has been the progress made in the surgical treatment of occlusive forms of arteriosclerotic disease. Here again, intensive research and clinical investigations during the past decade have established an important concept of the disease which has led to the development of highly effective methods of surgical treatment. Thus, it has been found that in many forms of this disease, the atherosclerotic lesion is well localized and segmental in nature with relatively normal arteries proximal and distal to the diseased vessel. This tendency of the arteriosclerotic process to assume a pattern of localized or segmental involvement constitutes a most important observation for it provides the basis for effective surgical treatment even in the presence of fairly extensive disease involving arteries in different parts of the body. The serious and even lethal manifestations produced by these lesions are due to the fact that they also tend to involve the major arteries supplying blood to such vital organs as the heart, brain, and kidneys. By thus blocking circulation to these vital organs they are responsible for the occurrence of strokes, heart attacks, gangrene of the lower extremities, and, in some instances, hypertension.

Only in recent years, and through knowledge gained from investigative studies, precise diagnostic as well as effective therapeutic methods have been developed. The precise location and extent of these occlusive lesions may now be visualized roentgenographically, and in accordance with these findings several methods of surgical treatment may be employed consisting of removal of the occlusive lesion or its replacement with a substitute artery to restore normal circulation. The efficacy of these methods of treatment is well demonstrated by a recent analysis of more than 1,500 cases of this type in which successful results were obtained in approximately 95 percent. Thus, a large number of patients who formerly would have died or would have been seriously disabled from these occlusive forms of atherosclerotic disease which produce gangrene of the lower extremities, strokes, and high blood pressure may now be completely relieved.

It is thus apparent that much gratifying progress has been made both in terms of therapy and in a better understanding of the underlying pathologic features of these grave diseases. In this connection, it is worthy of mention that much of the research support leading to these developments has been derived from the National Heart Institute. In many respects, however, the knowledge gained from these studies has emphasized the need for greater and more intensive research and clinical investigations. There are a great many aspects of this problem that remain obscure or poorly understood, including particularly pathogenesis, circulatory hemodynamics, underlying pathologic features, extent and type of atherosclerotic involvement, metabolic disturbances in cholesterol and lipid components, and even the clinical and surgical therapeutic approaches.

Particularly important are studies relating to the dynamic aspects of lipid deposition by means of recently developed methods of gas-phase chromatography which may provide a better understanding of the pathogenesis of the disease and thus ultimately lead to effective methods of prevention. Only during the past year has it become possible to employ these precise methods of investigation to determine cholesterol metabolism and lipid composition in these patients. On the basis of information which has already become available, it is now believed that vital information can be gained from studying patients with atherosclerotic lesions in regard to the accumulation of cholesterol deposits to ascertain the source of cholesterol and to determine whether it is deposited from the bloodstream or synthesized within the arteries in response to stress or injury. These basic and fundamental questions cannot yet be fully answered, and such basic metabolic studies are an essential part of our overall program of cardiovascular research. Despite the gratifying progress that has been made recently in the surgical approach to some of these conditions, there remain many forms of the disease in which these surgical procedures have not been sufficiently refined to permit successful application, particularly those involving smaller vital arteries such as the coronary and intracranial arteries. These and other fundamental problems deserve much more intensive investigation. The cost is high, but the results are inestimable in terms of scientific knowledge that may be gained to permit a more effective attack upon these serious conditions.

The establishment of primate colonies is another proposal that I consider tremendously significant to research on atherosclerosis as well as to other important diseases. Very few laboratories have been in a position to use primates for research in heart disease, but it is obvious that these animals, so closely related physiologically to man, must simulate closely the reactions of the human being to disease. Some of them have even been found to develop atherosclerosis naturally. The matter of the primate colony has been brought before the committee previously, and I am sure you are familiar with its merits.

Finally, I should like to submit for your consideration what I consider to be the most impressive concept for actuating a concentrated attack on disease and thus accelerating our entire research effort. This concept is concerned with the establishment of research centers which would provide a broad and stable organizational framework in a proper intellectual and scientific environment to facilitate integration of effort in diverse scientific disciplines upon an identifiable goal. As the research programs of NIH have expanded and evolved, it has become clear that the entire system for awarding research grants should be adjusted to the changing needs of scientists and organizations. Unlimited potentialities lie in the concept of research centers, and the advantage of the flexibility of such a program of unidirectional but broadly defined research cannot be overemphasized. A whole new impetus can be afforded by this broad and farsighted approach to research.

Such centers as these might be directed toward a single disease or biological phenomenon or toward provision of physical, mechanical, or animal resources for specialized methods of research in support of other centers. The pattern has already been established of awarding research grants within certain institutions to various departments working on aspects of the same problem, and the mechanism already exists for accomplishing this purpose. In our own school, for instance, a number of separate grants have been awarded various departments for research in atherosclerosis. Flexibility in the granting of these funds will permit resources of brains, ideas, and equipment from an entire institution to be more effectively utilized.

Although some money was appropriated last year for this purpose so that the initial phase of the activity could be started, the concept is already well developed. Enthusiam for the idea, however, has been much greater at this time than the extent of its implementation. I have had occasion to discuss the matter with a number of research workers from institutions all over the country, and I know well their high regard for this proposal and the tremendous frontiers that they know it can open for research.

The organizations and institutions that are selected as centers will probably already have an excellent working nucleus of scientists and facilities, but a concentration of funds will provide for a more diverse group of scientists to work toward a selected goal with all available clinical and laboratory facilities to support them. It can bring together the best of our scientific researchers in a stimulating intellectual

group wherein their ideas may have an opportunity to cross-fertilize and germinate in the warmth of a creative environment. Large numbers of the most dedicated and able scientists will be attracted to such an academic environment, offering an opportunity for intensive and long-range research. In the framework of a medical school which is already concerned with education, patient care, and investigation, students, residents, and faculty can combine with patients to provide a stimulating approach to research from both a clinical and an investigative point of view. The training of young investigators would be greatly enhanced not only through this stimulating environment but also through the close association with the diverse scientific disciplines involved in the center. Furthermore, and extremely important, such centers established throughout the country can, along with medical schools, by their very presence provide higher motivations and standards in the practice of medicine and thus enrich the medical scientific community of the entire country.

Diversity would more than ever be a prime characteristic of these research center grants. More than one center might be established in connection with a given institution. Such centers associated with medical schools could incorporte existing research and training grants in an overall organization. Research adjuncts, such as data-processing equipment, primate colonies, and biometrical departments, could be developed either within individual centers in which this sort of extension would be justified or separately for the use of several centers. Funds for construction of additional buildings should be provided in some cases. Problems of the functions essential to the working of each individual research center should be determined on an individual basis.

Most important of all, the atmosphere of common purpose, within a research environment of sufficient size to give adequate scope and freedom to individual investigators, can provide an integrating force centered around specific problems. New focuses of research can be activated, and a more intense and direct attack on research problems can be launched with a greater degree of aggressiveness and rapidity. New developments and new ideas can thus be quickly pursued in accordance with the greater degree of flexibility of a research center having funds that will permit this kind of rapid change in approach to produce more fruitful results. To be sure, the cost of establishing these centers at the outset would require substantial funds, but in the aggregate and over a period of time it should not exceed the cost of setting up individual projects with their inevitable duplications. Indeed, there are reasons to believe that it would provide greater economy in the long-range support of research. In this connection it is desirable to emphasize again the fact that this concept of research centers provides a mechanism of supplementing but not supplanting the individual research grant project type of support.

In closing, I believe that this concept represents a truly great step toward the realization of the goals of this Nation in medical research. It has been a pleasure for me to appear before this committee and I should like to express my deep appreciation for the understanding and good will that you had other Members of Congress have displayed on so many occasions. I am seized with a feeling of confidence and a hopeful outlook in the knowledge that our Government program is under the direction of a group of astute, informed, and dedicated legislators. I am certain that the advances that have been made in

the past decade will eventually seem inconsequential to us when compared with the discoveries that we can already envision for the years ahead. Your role in these developments may actually be among the most important of all because you hold the key that can open the door to an era free of cardiovascular disease.

Now, if I may, I would like to speak extemporaneously about this whole area.

Mr. Fogarty. Go right ahead.

Dr. DeBakey. Dr. White has already presented to you a background of the development in a very fine way and very entertaining way.

### PROGRESS FROM RESEARCH THROUGH NATIONAL HEART INSTITUTE

I would like to first very briefly, if I may, indicate to you some of the progress that is being made in this field which I attribute almost directly to the support of the research through the National Heart Institute which you gentlemen have provided.

I believe that in the past decade alone there have been more real advantages in our knowledges and understanding of cardiovascular diseases, particularly in our means of doing something about it both diagnostically and therapeutically than there has been in all previous time, and this may be well illustrated by certain fields of surgery with which I am more familiar.

For example, in the field of aneurysmal disease, to which Dr. White referred quite briefly, a condition which may be of congential origin, but which now-a-days particularly is most commonly due to arteriosclerosis. I might say that arteriosclerosis produces two patterns of pathological condition, one in which the diseased wall becomes badly damaged and then becomes unable to withhold the pressure within and dilates. This is an aneurysm. This may be due, as I say, to a congenital condition such as the one Mr. Giblin had. The danger of course is that ultimately it ruptures and produces death.

Mr. Denton. Is that in the aorta?

Dr. DeBakey. It may be in any artery but it is most common and the most dangerous site is in the aorta. There is a small number of these in proportion to the total number that occur in the vessels of the brain. These conditions have pared away some of our most eminent people: Albert Einstein, for example, died of a ruptured aneurysm of the aorta. This has been a challenge to physicians for centuries; this has been well described and well known, and various forms of treatment have been described, but only in 1952 did we develop an effective form of treatment by which it became possible to remove this lesion and to replace it with a blood vessel. First we used the homografts, such as was used in Mr. Giblin. This treatment came directly from the research laboratories. The methods which we now have to substitute blood vessels, such as the various plastic substitutes of arterial vessels which we now use just as commonly as we use arterial sutures in operating rooms; this is available now. Even 4 years ago they were not available. Today they are available and used in operations very, very readily. The manufacturers put them on your shelves and you can use them whenever

you want to. You can use them for any length. We can put them in now from one end of the aorta to the other.

Mr. DENTON. With the plastic tubes?

Dr. DEBAKEY. Yes. They are made out of teflon and dacron and they are better than the homografts, because they retain their strength. You see, the body encases them in tissue that allows the blood to flow through quite satisfactorily. This is just one example. Here we had a condition——

Dr. WHITE. May I interrupt and ask if Giblin should later show the need of repair of the homograft, would it be all right to put in one of the newer plastic types?

Dr. DEBAKEY. Oh, most assuredly, we have done that. We have actually treated patients who have had his condition in which the homograft has subsequently developed the same disease. We have removed the homograft and put in the plastic tube, so this can definitely be done. Here is a condition that can now be cured, removed and cured. It is an example of what has come out of research, intensive research and our plea is that we further intensify this research, that we accelerate the pace so that knowledge will become available to us, not within 5 or 10 years, but within the next 2 or 3 years. This is really what we are asking. We want to accelerate the pace of research by these additional funds.

Now the other pattern of atherosclerosis is just the opposite. The wall thickens and grows and gradually consumes the lumen of the blood vessel and then completely blocks it. This is the most common cause of death and disability. This accounts for more deaths and disability than any other condition, or all other conditions combined.

Dr. WHITE. May I interrupt just a moment. That is what Lancisi said 250 years ago.

Dr. DEBAKEY. Yes, that is exactly right. This is cause of heart attacks, this is a cause for strokes, this is a cause for certain forms of hypertension when it involves the renal arteries, this is a cause for gangrene in the extremities, disability, inability to walk, for example, walking only for short periods and having to stop, ultimately gangrene. This is the cause for the most common disorders we have today in our middle and older age groups of people, because people develop these diseases over a period of time. If you live long enough, you will—if you have the tendency to develop arteriosclerosis, this is what occurs. It occurs in certain patterns, which we are only now beginning to understand better. Why? Because we have means for studying, and this little device that Dr. White presented to you is a means for providing arteriography, we call it angiography, which is to inject material into the blood vessels which shows up on the X-ray, and then we can visualize the exact patterns of the arterial system, where lesions are, where they tend to begin and end. This ability to see has added one of the really important concepts that has come from investigative work in this field. Incidentally a start was given to us by a Portuguese research worker. I went on one of my trips to Europe to the hospital where he did the first one, now more than two decades ago.

Dr. WHITE. What was his name?

Dr. DEBAKEY. Del Santos.

Now this concept, you see, provides us then with the understanding that a lesion may be extremely well localized and may have well defined limitations proximal and distal in the vessel wall. What Dr.

White was talking about a moment ago was our interest now in the vessel wall. This is the cause of heart attack; it's not the heart itself primarily, it's the vessels of the heart, the coronary arteries. The same way with the strokes; it's not the brain, it's the vessels supplying blood to the brain, and in hypertension, high blood pressure, in a certain proportion of the patients with high blood pressure we know as a result of very recent work it is not the kidney, it's the blood vessel to the kidney, which becomes partially blocked by this same arteriosclerotic lesion. The lesion diminishes blood flow to the kidney and triggers off the mechanism for the production of hypertension. As a result of our understanding of the nature of this lesion we can now apply surgical treatment to restore normal circulation either by removing this localized lesion and replacing it completely or by bypassing it. Bypassing is one of the very common procedures we employ. We attach a substitute above and below a lesion and bypass the whole thing. Actually we shunt blood around the block to restore normal circulation. We can cure a certain proportion of cases of stroke, we can cure a certain proportion of patients with lack of blood to the extremities, with hypertension, with lesions that involve other vessels that may produce gastrointestinal disturbances and with lesions in the blood vessels to the heart.

Dr. White. May I interrupt just a moment by saying Dr. BeDakey himself has done some very magnificent pioneering in this very field.

Dr. DeBakey. Thank you.

Dr. White. I have been sending patients to Houston often in the old days.

Mr. Fogarty. I see.

Dr. DeBakey. The point I am trying to make is this is progress. These are real advances in our knowledge and our understanding of these conditions and the application of our knowledge to the benefit of sick people. This comes through more intensified research and over the period of the last 10 or 12 years during which the Heart Institute has been investigating and training new investigators. We have developed a large group of young investigators now in this country that provide the most intensive and active endeavors in research in this field anywhere in the world, and these people are becoming very skilled and competent in research methodology.

Here again is an example of the importance of research and development of methods to study these diseases. Very recently, during the past year alone there has developed a method for the study of lipin metabolism using gas phase chromatography. We can now study how this material actually metabolizes, why is it put down in the vessel, and how is it done, where does it come from? These are the things you have got to understand before you can really develop truly effective methods of prevention, which is our objective, as Dr. White has said.

## CLINICAL RESEARCH CENTERS

There are two other things that I want to emphasize because I have referred to them in my testimony to the Senate Appropriations Subcommittee last year these are the primate colony centers and the research centers. During the past year the interest and enthusiasm of these centers has been very, very impressive to me. I have traveled around and seen the institutions and talked to investigators and I

have been greatly impressed with their interest and enthusiasm and their understanding of the really great emphasis that these things would provide. For this reason, I have particularly emphasized in my statement, here, the importance of these activities, particularly the research centers which I think may constitute almost a revolution in our approach to the research in the cardiovascular field, as well as others.

Mr. FOGARTY. Do you agree with others who have appeared, Doctor, that this would be a way of getting the new knowledge out to the field?

Dr. DEBAKEY. By all means. It would be a very effective way. You see, you are bringing it closer to the people. You are bringing these research activities in closer touch with the local regional area, with the medical profession and the people who will be in there.

As I said in my testimony, I think that this is an extremely important thing, that such centers are established throughout the country and along with medical schools, through their presence provide higher motivations and standards in the practice of medicine and thus enrich the medical scientific community of the entire country.

I think they will act as focusss, nuclei for this purpose.

Mr. FOGARTY. That is one of the big problems, is it not, getting the knowledge to the local physician?

Dr. WHITE. It's magnificent now, because they don't have to go long distances anymore. The center is not far away from almost any community in any State.

Dr. DEBAKEY. I have indicated in here some of the concepts of the centers and the characteristics they would have, some of the advantages they would have, and I am sure you have heard a lot of testimony about this already, so I won't go into it in detail. You will find in this statement some of my own thoughts about centers that are really gleaned from discussions all over the country with investigators who have already gotten this idea and already begun to apply for centers and already have given time to thinking about the planning of the centers.

The question sometimes has been raised: Aren't these centers expensive? Yes; they are going to be expensive, and I think the initial cost will be substantial, but I think as time goes on much of this cost will be the same, if not less, than the cost of similar research carried out by individual research practice. In other words, I think this is a means of supplementing the mechanism we now have, not supplanting it, and I think in time it will provide greater economy and a much more effective way for both research and training, and this is what I think would be the very important aspect of the ultimate development of these centers.

Dr. WHITE. May I add just one point and that is this rivalry, this hearty and interesting and friendly rivalry between the various centers. One investigator finds a little improvement in the technique and the others come around to see it and another one, someone else has a little improvement on that. It's wonderful.

Dr. DEBAKEY. Speaking from the surgical aspects, we have in our place on the average of I would say five to seven, eight, surgeons with us constantly who are visiting with us from all over the country and all over the world who are anxious to observe the latest technical developments. The progress in this field is so rapid now that it

actually is way ahead of the publications. There is a lag between the time the development is made and the publication is out, so that one of the fastest ways of learning about these developments is to visit these places and actually see what is going on, and this we ought to do now.

Dr. White. I have a letter from Prochazka, a Czech heart surgeon just wrote me expressing tremendous appreciation. He was in this country to see what was going on.

Dr. DeBakey. Mr. Chairman, I want to say, finally, that I think it's a great privilege and opportunity to be here before this committee and I want to express my gratefulness, my deep appreciation and, not only for this privilege but also the understanding and good will, the truly informed and dedicated way in which this committee has carried out its role in these developments

Mr. Fogarty. What do you think of the present budget before us for $63 million?

Dr. DeBakey. In my opinion, Mr. Chairman, it is completely inadequate to do the job I think needs to be done and can be done. I am convinced on the basis of what I know about the research potential of this country that the only means by which we can meet this research potential and accelerate our research developments and in that sense gain the knowledge that we need to fulfill our objectives in terms of the welfare of our people is by a much greater increased budget. I therefore think a minimal increase with which I am in accord is the Citizens' Committee recommendation of $115,250,000, total.

Dr. White. It is an emergency.

Dr. DeBakey. It is a vital need, because here we are on the edge of learning how to protect our young and middle-aged men from this one disease of atherosclerosis and we will be able to. I am sure we will be able to; but the longer we delay in getting enough people on the job, the slower we will be and the more people will succumb to it.

Mr. Fogarty. Dr. Katz was carrying on an experiment with chickens. Is he still?

Dr. White. Yes; but Stamler, whose letter I read off, was one of his men and now he is working on his own, but we need monkeys rather than chickens.

Mr. Fogarty. There is a big need for monkeys?

Dr. DeBakey. I think so; very definitely. Man is more closely similar to the monkey.

Dr. White. It is expensive.

Dr. DeBakey. This is expensive. I think what has happened in many areas is that lack of funds has forced us to translate some of our experiments in our lower animals to man too quickly. We are dealing with a complicated disease. We must have the facilities to proceed from simple animal forms in our studies to the higher forms of animals, including ourselves and monkeys.

Mr. Fogarty. We have made extensive progress in the control of hypertension, have we not?

Dr. White. Oh yes; it's wonderful, really wonderful.

Mr. Fogarty. Is that not a good example?

Dr. WHITE. But we don't know the cause yet. We have made great improvements. Of course the infectious types of heart disease are well controlled. Syphilis is practically out in any civilized community now, cardiovascular syphilis, which used to be 25 percent of all our cases in the South, and it is less than 1 percent probably, and rheumatic heart disease is going right down with control of the streptococcus. Those things are under pretty good control.

Dr. DEBAKEY. I would like to mention one of the exciting developments just in the past year. In fact, we just presented our own paper to the society at the University of Minneapolis. We have now a large series of cases of hypertension treated surgically in which the hypertension was due to the particular location of arteriosclerosis involving the artery leading to the kidney. Restoring the normal blood flow to the kidney by means of the blood vessel grafts, we cured this hypertension. Hypertension was cured in a patient who was unable to read the newspaper because of eye lesions. He had the eye changes that went with high blood pressure but within 10 days from the operation, by the time he was out of the hospital, he was able to read a newspaper again. His blood pressure was perfectly normal. the lesions which he had in his eyes had virtually disappeared just in that short period of time.

Dr. WHITE. You can do the same thing with a neck operation.

Dr. DEBAKEY. That's right. We have had people with strokes wake up.

Mr. FOGARTY. That is recent?

Dr. DEBAKEY. That's recent. I had the father of a doctor as a patient who had a stroke while he was in the hospital. We were able to operate upon him within 2 hours after the appearance of the stroke. He was completely unconscious and paralyzed on one side. We operated on him. This operation, usually a very simple one, is done under a local anaesthetic. We took out the blocked blood vessel and restored normal circulation. Before the incision was closed he woke up.

Mr. DENTON. That is what they did to a friend of ours.

Dr. DEBAKEY. That's right. Sometimes we do have to go to the chest because the blood vessels start in the chest.

Dr. WHITE. About 40 years ago we were just beginning to study the coronary arteries; we didn't pay any attention to the carotid. Only 10 years ago we began to pay attention to the carotid.

Mr. FOGARTY. We do not know, or we cannot predict ahead of time, whether a person is going to have a stroke?

Dr. DEBAKEY. Yes, but to some extent we believe we can learn how. We are just beginning now to have a program supported by the National Heart Institute and units working together in cooperative groups scattered around the country. There are about 20 of them, geographically dispersed, consisting of individuals with a common interest in this field including neurological, medical, and surgical workers. These neurologists are studying patients from various standpoints and trying to connect their findings with earlier findings. We are moving more and more into the earlier stages where we can detect symptoms that we formerly would not have detected. We are beginning to learn how to detect disease earlier. This knowledge isn't generally available yet. There is a lag. This is one of the advantages the centers would provide, making knowledge available to the practic-

ing physician in a much shorter period of time. This, in a sense, brings the research laboratory right to the operator, to the hospital, to the clinics, and to the practicing men.

Mr. FOGARTY. Any questions?

(No response.)

Thank you very much, Dr. DeBakey. We appreciate your thinking and Dr. White, we appreciate your coming down from Boston again.

Mr. DENTON. Let me ask you, if somebody has already had a stroke and is partially paralyzed, can you operate on him at all?

Dr. DEBAKEY. Oh, yes, we can. We have had patients up to 3 weeks after the occurrence of the stroke on which we have been able to operate and restore circulation. After that while it is slower, the recovery is much more rapid than it would have been if circulation had not been restored.

Mr. DENTON. If it has been several months ago, could you do anything now?

Dr. DEBAKEY. Several months is probably too long. There is one thing that is important in that regard. If we learn that a patient has had one stroke we think he is likely to have another. So we have investigated the possibilities of another stroke in such a person by looking for other vessels. You see there are four major arteries to the brain and we check the others. If any of them show disease we remove the possibility of another stroke by operating on the diseased vessel. In about 50 percent this is what we have found; they do have disease in other vessels.

Mr. FOGARTY. It is very interesting. Thank you very much.

Dr. WHITE. I want to thank Bob Giblin for coming.

Mr. FOGARTY. Oh, yes, we thank you, Mr. Giblin, for coming down as a living example of what research has accomplished.

---

THURSDAY, MARCH 3, 1960.

## DENTAL HEALTH PROGRAM

### WITNESSES

**DR. RAYMOND J. NAGLE, MEMBER OF THE COUNCIL ON DENTAL EDUCATION OF THE AMERICAN DENTAL ASSOCIATION; DEAN, COLLEGE OF DENTISTRY, NEW YORK UNIVERSITY; PRESIDENT-ELECT, AMERICAN ASSOCIATION OF DENTAL SCHOOLS**

**DR. ALFRED E. SMITH, MEMBER, COUNCIL ON LEGISLATION, AMERICAN DENTAL ASSOCIATION**

**HAL M. CHRISTENSEN, ASSISTANT SECRETARY, COUNCIL ON LEGISLATION, AMERICAN DENTAL ASSOCIATION**

Mr. FOGARTY. The committee will come to order.

We have before us today the representatives of the American Dental Association. Dr. Smith, we will be glad to hear your statement.

Dr. SMITH. Mr. Chairman, members of the committee, I am Dr. Alfred E. Smith of New Orleans, La., a member of the American Dental Association's Council on Legislation. I am accompanied by Dr. Raymond J. Nagle, Dean of the College of Dentistry of New York University, and Mr. Hal M. Christensen, assistant secretary of the association's council on legislation. Dr. C. W. Camalier, assistant

secretary of the American Dental Association, cannot be with us this morning. He was unexpectedly called away.

We are here today to present the American Dental Association's views and recommendations on fiscal 1961 appropriations for the dental health activities of the U.S. Public Health Service.

Despite the outstanding advances in the development of new technics and methods in the treatment and cure of dental disease, a reasonable measure of control over thisn ear-universal affliction is still a far-distant possibility.

It would take the dental practitioners in this country 5 to 10 years merely to eliminate the backlog of dental ailments now afflicting the population. The out-of-pocket cost for such an undertaking would be from $10 to $20 billion not taking into account the value of the directly related losses in working time and productivity. By adding to this the pain and suffering involved in thousands of cumulative years of rampant tooth decay, periodontal disease and other oral afflictions, one can gain some idea of the dimensions of the dental disease problem in this country.

Obviously, the solution to the problem does not lie in the direction of conventional treatment of existing disease since neither sufficient manpower nor facilities are available; the solution lies in the discovery new and dramatic means of prevention through research.

Bold and imaginative research planning and the tapping of additional new research resources are necessary.

The association is prepared to offer to the committee certain recommendations for expanding the dental research program to bring it more closley in line with the problem we are facing.

The association's principal witness is Dr. Raymond J. Nagle, dean of the College of Dentistry of New York University. Dr. Nagle is a member of the association's council on dental education and is president-elect of the American Association of Dental Schools. Dr. Nagle is especially qualified to speak on the subject of dental research both from direct experience as director and administrator of a large program at his own school and from his wide experience with dental research on a national basis.

Mr. Fogarty. Go right ahead, Dr. Nagle.

STATEMENT OF DR. RAYMOND J. NAGLE

Dr. Nagle. Mr. Chairman and members of the committee, I represent the American Dental Association and the American Association of Dental Schools.

Reference has been made to the unfortunate but well-established fact that the dental disease problem is growing at a much faster rate than our ability to arrest it through even the most modern treatment technics.

We are faced with a progressively widening gap in the ratio of dentists to population and, even assuming the establishment of several additional schools of dentistry, the rate at which dental practitioners can be educated and graduated will not approximate the projected rate of population growth. Thus, unless new methods of preventing dental disease can be found and unless existing dental manpower and facilities can be used on a broader and more efficient basis, there will be a constant increase in the amount of untreated dental disease and

a steady decrease in the availability of dental treatment and care over many years to come.

The American Dental Association and the American Association of Dental Schools believe strongly that in order to do something effective about this problem, both long and short term, the total dental research effort must be expanded and accelerated significantly.

As previously pointed out, there can be no reasonable disagreement over the fact that in relation to the magnitude of the dental disease problem, the public and private expenditures for dental research are woefully small. The yearly bill for dental care in this country is about $2 billion which is only a fraction of the total economic loss involved and represents treatment and care for less than half the people who need it.

Despite the huge financial losses, the pain and suffering involved, and the deleterious effect on the general health and well-being of the public, funds available for research into the nature and causes of dental diseases are not readily obtainable. This results in part from the fact that in the minds of many people, dental disease is a minor problem involving only an occasional toothache or other temporary discomfort; the dramatic characteristics that bring forth public and private philanthropy for diseases such as cancer, heart disease, and mental illness are not present. This conception is unfortunate and to a large extent misguided. It overlooks the direct relationship between oral health and many systemic conditions. It also overlooks the fact that there are many debilitating and sometimes fatal oral diseases which are being subjected to intensive study by researchers working in many different areas.

For example, 10 to 12 percent of all malignancies occur in the mouth and adjacent structures, and 60 percent of all these are seen by dentists. Many investigators in cancer research and dental research are engaged in studies that are complementary to each other. Similarly, subacute bacterial endocarditis following oral surgery or other dental surgery is a serious condition of vital concern both to heart and dental research workers. Crippling congenital conditions such as cleft lip and palate receive the attention of teams of health scientists including dentists, plastic surgeons, speech therapists, radiologists, and many others. Other oral conditions, injuries, and diseases frequently involve disfigurements which have extremely serious psychological and medical consequences. Much of the research on caries and periodontal diseases involves bacteriological studies that have broad application in many fields in addition to dental science.

The dental research involving periodontal disease is of exceptional public importance. It involves one of the most widespread inspections known to man, and its effects on general health are barely beginning to be recognized. One writer has compared the oral tissues stricken by a common form of periodontal disease or pyorrhea to an area of 10 to 15 square inches on the back, arm, or other exposed part of the anatomy which emits pus constantly. He points out that periodontal disease afflicts 25 percent of the adult population, causing untold systemic disturbances and accounting for the annual loss of millions of teeth. At the present time some of the most promising research being conducted is in relation to periodontal disease. It is but one of the areas needing increased support and expansion.

The dental needs and conditions of the chronically ill and the institutionalized or homebound geriatric patient require more immediate and intensive investigation. I think this is becoming even more important than it has been previously because of the increased lifespan which has been extended by about 10 years.

There is a need for further epidemiologic and experimental research on nutrition in relation to chronic dental diseases such as dental caries and periodontitis.

Germ-free animals have been used dramatically to disclose certain fundamental characteristics of dental disease that heretofore have evaded effective demonstration. There should be established more germ-free animal centers in which to expand the productive studies of dental disease.

Crystallographic studies have brought forth important new knowledge of the submicroscopic structure of teeth, bone, and other body tissues. Additional facilities and highly trained specialists in this science are needed to explore these structures further and elucidate the nature of their normal development and their disease conditions.

Within the past year, there has been a remarkable development in the nature of a conceptual breakthrough in dental caries research. Experimental work utilizing the Syrian hamster was reported at the recent midwinter dental meeting in Chicago which presents strong evidence that dental caries is a transmissible disease, and that certain bacterial species are involved in its transmission from one individual to another. For the first time, we can envision a means by which dental caries can be wiped out by purging the entire population of the bacteria associated with it, perhaps by developing a widespread vaccination method as has been done with diseases such as small pox and diphtheria. This, of course, at present is speculation and great distances must be covered before it can be determined whether such a possibility can be brought to realization. But a whole new approach has been opened up and it should be eagerly pursued.

All these afflictions mentioned, and many additional areas could receive special attention, to give further indication of the size and seriousness of this country's dental disease problem and the importance of dental research in the total health picture. The association believes it is clear that despite the excellent dental research program that has been started and is underway at Bethesda and at virtually all of the country's dental schools, there is a long way to go in following up current investigations and expanding into new fields of inquiry. The association believes that additional research, some of it of a broader more basic type than heretofore, is essential.

Up to the present time, virtually all of the dental research effort has been placed in the dental schools. This has been a wise policy and has resulted in impressive advances in the short few years of its implementation. However, there are also advantages in placing research in nondental institutions.

Dental research talent naturally has concentrated in the schools where, for years, individuals have been highly trained for teaching; and it is only logical that the schools should be the primary source of progress in dental research. In turn, the financial support that has

been made available for research in the schools has strengthened them and raised the general caliber of the dental education provided.

However, while research workers in dental schools have a certain advantage in being close to the clinical problems at which the research is aimed, there also are disadvantages. For example, under such circumstances there has been too little opportunity for research of a basic nature necessary to the exploration of the underlying fundamentals of dental health and dental science.

There is a great need for research inquiries that are prompted by pure scientific curiosity about phenomena in the dental field without foreseeable relation to any clinical problem or condition.

Occasionally, investigators in dental institutions find time to conduct basic research of this kind. Generally, however, because of their special orientation and because of the pressing need for rapid and direct advance toward the solution of specific oral health problems, this kind of basic research must be laid aside for consideration at some indefinite future time. It is believed that such postponement is undesirable and unnecessary. There is a great amount of general research needed to be done which does not depend upon the close association between scientists and clinicians that exists in dental institutions. It can be conducted by competent scientists with no prior connection with dentistry. There are large numbers of such scientists in liberal arts colleges and technical institutions all over the country who could be brought into this important research endeavor. With very little guidance and assistance, this virtually untapped reservoir of highly competent and qualified manpower could be utilized in health related research.

Already, there are dental research projects in nondental institutions such as Stanford University, Western Biological Laboratory, Chicago Children's Memorial Hospital, Illinois Wesleyan University, the Age Center of New England, Rutgers University, Duke University, Michigan State University, and others. Research scientists in these institutions, with a minimum of direction from specialized dental research workers, are conducting investigations of fundamental benefit to mankind. Additional, much needed personnel can be brought into the dental research picture if funds and facilities are made available to encourage them. The anticipated yield in terms of new knowledge and health-oriented researchers is vital to the growth of our dental research program.

The Association believes the project grant program also would be strengthened by implementation of the proposal to establish institutional grants to be used for assisting dental schools and related institutions. Such grants will permit the flexibility that is needed to initiate investigations in areas that may be difficult to delineate for regular grant applications but which nevertheless may prove to be extremely productive.

### CLINICAL RESEARCH CENTERS

Consideration might also be given to the development of centers where specifically oriented laboratory research, clinical studies and rehabilitation could be carried on. For example, the devastating condition known as cleft palate or harelip would lend itself well to this approach. At present, there is a pitiable insufficiency of research

on and specialized treatment available for this condition which occurs at the rate of 1 in every 800 live births. There are now approximately 250,000 persons so afflicted in America with 5,000 new ones being added each year.

The causes of cleft palate and cleft lip are only empirically understood. We know that the cleft persists because the tissues did not close at certain stages of embryonic development. Animal studies have enabled workers to produce clefts in poultry, mice and dogs, and there is evidence of a nutritional factor in its causation, at least in certain animals. With these living examples available for study, experiments are going forward to seek out the underlying causes of the defects and to develop preventive remedies, if possible. This humane work must be expanded and, coextensively, work must go forward and facilities expanded to help those who now have the affliction.

The dental profession, in cooperation with medical and other health professions, has been working on the problem for several decades. There is continuing progress in the development of better surgical techniques, prosthetic devices to obturate the palatal defect and more effective means and methods to improve speech and personality. I might say this is a problem that affects the entire family, not just the patient involved.

The Lancaster Cleft Palate Clinic in Pennsylvania is an outstanding example of a treatment center in which teamwork among the professions and the utilization of pooled knowledge are being combined for the best results available today. But it is recognized generally that this and a few other institutions are not enough. Treatment is delayed for many unfortunate youngsters who simply cannot be fitted into the schedules, and comprehensive treatment is denied to many for whom arrangements can be made only to correct immediate surgical needs or to construct a vitally necessary appliance.

Through the use of X-ray motion pictures, a few investigators have been able to divulge new knowledge of the movements of the organs of speech and mastication. These investigations with cineradiography already are being applied to the improvement of surgical and prosthetic techniques both in cleft palate patients and in patients who require correction of other crippling oral defects. But there are too few places where this research is being done, and we are moving slowly in an area where we should be progressing rapidly. Fully equipped and staffed cleft palate centers should be established in several parts of the country. In addition to providing more acutely needed services and opportunities for research, such additional centers would be the nuclei for training more resource personnel from dentistry, medicine, psychology, and social science.

The members of this committee would enjoy a highly rewarding experience by visiting the institution in Lancaster, Pa., devoted to cleft palate therapy, and observing at firsthand the remarkably successful results that are being achieved with children born with even the most severe oral, facial, and speech defects. In more and more instances, these children are being rehabilitated physically and psychologically so that they are able to live comfortably and function normally in society.

It might be brought to the attention of the chairman that the Joseph Samuels Dental Clinic in Providence, R.I., would be a natural location for a regional clinical training and research center specializing

in oral, facial, and speech defects in children. Such work would go hand in hand with the work that is being done in that institution on the dental needs of handicapped and retarded children.

There also should be participation by dental scientists in the cooperative utilization of the clinical centers which we understand are being established by NIH in various parts of the country for metabolic and other special studies. Such centers would provide outstanding opportunities for investigating dental problems and pathologic changes in health and disease under ideal conditions of study. As indicated previously in relation to congenital oral and facial defects, some of dentistry's greatest contributions to health may be expected to arise from cooperative teamwork of dentists, physicians, and basic scientists in centers like these.

There is special need for the cooperative approach in research relating to periodontal diseases which affect and are affected by various systemic conditions that are under the treatment and control of physicians. These conditions include diabetes, pregnancy, menopause, cardiovascular disease, blood dyscrasias, and so forth. Dentally oriented studies conducted simultaneously with medically oriented studies of diabetic patients at the regional metabolic disease centers would be of great value and would conserve facilities and reduce duplication. Studies of bacteremia obviously could be performed with great benefit and efficiency under similar circumstances. Many other vital research projects lend themselves advantageously to the multidisciplinary approach.

The need for additional teachers and research workers continues to be serious in all of the country's dental schools. If several new schools are established within the next few years as expected, the teacher shortage will become even more critical.

This problem deserves urgent attention at this time if the quality of dental education is to remain at an acceptable level.

It is estimated that the 47 dental schools could easily absorb at least 150 full-time teachers each year and, according to the survey made recently by the Dental Schools Association, the presently existing backlog of budgeted vacancies on dental faculties is over 250. The 5 new dental schools that may come into existence in the next 5 years each will require in the neighborhood of 100 teachers. Two of these schools, one at University of California at Los Angeles and one at the University of Kentucky, will be in operation in the near future; both are now recruiting faculty members. Obviously, the needs in this area are crucial and the efforts to improve the situation should be stepped up.

The training grant program which was inaugurated in 1956 to produce additional teaching and research personnel only now is beginning to produce results. Certainly, it should be continued and expanded.

Nearly half of the dental schools have training programs in operation and the funds allowed for this operation for fiscal 1960 already have been exhausted. Many applicant schools received far less than was needed and they are prepared to use additional funds immediately. Moreover, several additional schools are ready to make their training programs operative if sufficient funds can be made available.

The American Dental Association and the American Association of Dental Schools believe strongly that expansion of this program is essential.

The association also believes that the training grant program should be extended into another area that would increase substantially the availability of dental care to the general population of the Nation.

Studies conducted by the association and other agencies have demonstrated that the productivity of dentists can be increased by the employment and effective use of auxiliary dental personnel. The extensive USPHS studies on dental care services for school children which were conducted in Richmond, Ind., and Woonsocket, R.I., demonstrated that a close, efficient relationship between the dentist and auxiliary personnel can expand the output of high quality dental care. In these two programs it was found that "significantly more dental care services per dentist were achieved, thus extending a health service to a greater proportion of a child population." (Waterman, G.E., "The Richmond-Woonsocket Studies on Dental Care Services for School Children," Journal, American Dental Association, 52:676, June 1956.)

A survey conducted by the association showed that dentists with one auxiliary employe averaged 47.4 percent more patients than dentists with no employees. (Journal, American Dental Association, 54:691, May 1957.)

Another reliable study has shown that dentists may increase their weekly patient load as much as 68.8 percent through the expert use of auxiliaries. (Journal, American Dental Association, 41:505, October 1950.)

Recently, pilot studies completed in six dental schools have indicated that dental students trained in the effective use of dental assistants could produce significantly higher quality and greater quantity of services than those not given such training. In one of the schools, the students achieved an average increase in productivity of 37 percent. In the six schools, the increases ranged from 25 to 40 percent.

I might say that not only the higher percentile students were used in this study. Students in the lower percentile of the class and in the higher percentile were used so the sampling would be comparable throughout all the study.

It has not been possible to increase the number of graduates through the expansion of dental school enrollments and through establishments of a few new dental schools to the extent necessary to keep up with the increasing need for dental service. Nor does it appear likely that this can be done in the reasonably near future. It is possible, however, with proper training to increase appreciably the amount of dental service which each dental graduate of the future can provide. This can be accomplished by training dental students in the effective utilization of dental auxiliary personnel. Such training cannot take the form of didactic methods of instruction; it must emphasize experience with patients in which chairside assistants participate with the students in as many operations as possible.

The experience of the six schools that have experimented with this type of program provide evidence that it is both practical and desirable.

The request for funds to enable all of the dental schools to embark on a sound and complete program of training dental students to use

chairside assistants is a most important one. Students must be given this experience while in dental school, not only so that they will understand how to use these personnel effectively, but also to assure that, after becoming accustomed to using chairside assistants, they will insist upon using them when they enter dental practice. Establishing training programs of this type in dental schools means employing well educated and experienced dental assistants, adding teaching personnel, readjusting many of the courses in the dental curriculum, modifying the physical structure of the clinics to accommodate the chairside assistant and acquainting the entire dental faculty with the expanded objectives of the program.

All dental schools should be given the opportunity immediately to establish training programs of this kind. The association believes that by this means further lengthening of the gap between dental needs and available dental care can be forestalled.

The continual training of resource personnel is vital to the dental research program, and the committee has been informed of what is being done and is contemplated within the training programs at existing dental schools and related institutions. For the advanced research worker, and for the promising graduate and undergraduate, however, the kind of training provided in the research fellowship program of the NIH also is essential. The postdoctoral fellowships, senior fellowships and special research fellowships permit the candidate to obtain advanced training in departments and institutions which offer special teaching opportunities and facilities that are not always accessible through the training program at a single dental school. These fellowships permit the individual to go to a laboratory where he may obtain specialized training and experience which may not be available anywhere else. A substantial number of dental scientists and potential research investigators are now ready for special training, and funds are necessary to meet their needs in order fully to utilize their talents. The number of persons entering the fellowship program has increased significantly over the past few years and it is growing continually.

Of special importance is the productive expansion which is developing in the use of student part-time research fellowships. Last year, 376 undergraduate students entered this program. Exposure of these young men to research disciplines in their undergraduate years is productive not only in terms of the specific contributions they make to our knowledge of dental phenomena but even more so in terms of stimulating their interest in becoming career research investigators after graduation. Many of the men who worked under a part-time fellowship wish to continue in scientific research after they obtain the doctoral degree, and additional funds must be provided to give them the training they need through the postgraduate fellowships just discussed. The undergraduate fellowships, the postdoctoral, senior, and special fellowships and the training program grants are inseparably linked to each other in the overall developmental program which dentistry has now established.

The association believes strongly that this program should be expanded during the next year.

SUMMARY AND RECOMMENDATIONS

The American Dental Association and the American Association of Dental Schools beleive strongly that this country's dental research program should continue to progress. The exploding population together with the existing and predictable dental manpower shortage makes expansion in several critical areas imperative.

The excellent progress made during the last year in both Federal and non-Federal institutions has been brought to the attention of the committee by the administrators of the National Institute of Dental Research programs. Highlights of some of this work have been referred to today. Obviously, however, time does not permit more than a glimpse of the encouraging results that are being produced at many institutions throughout the country. The forward-looking and commendable support given to dental research and education by the members of this committee has been a large factor in the achievements that have been obtained heretofore and in setting the stage for even more promising gains in the future.

For fiscal 1961, the associations believe that some facets of the dental research and training programs require more expansion and acceleration than are contemplated in the budget that has been submitted by the President. For the reasons that have been outlined, it is the association's considered judgment that unless this is done, the dental disease problem will continue to outrun our ability to cope with it by an increasingly lengthening margin.

Accordingly, the associations recommend that the committee give special attention to the increasing acute need for dental research and teaching personnel and for the need to increase the availability of dental care by training dental students in the efficient use of dental auxiliary personnel. For this purpose, it is recommended that the President's budget item for training grants be increased by $3 million. This would permit a reasonable expansion in the existing program and would allow the dental schools to inaugurate the much-needed programs related to the efficient and effective use of dental assistants.

The associations also recommend an increase in funds for the project grant program to permit reasonable progression in the research projects to be undertaken and continued in dental schools and other dental institutions, the establishing of a few clinical centers as described, and also the introduction of some dentally oriented basic research projects at nondental centers of learning. For these purposes, an increase over the President's budget of $1,225,000 is recommended.

Finally, the associations recommend that the fellowship grant program be permitted to go forward to encourage a continuing source of qualified individuals who have demonstrated interest and ability in research and teaching. For this purpose, the association recommends an increase over the President's budget of $1 million.

The American Dental Association believes that the appropriation of the $5,225,000 increase over the President's budget as recommended for the activities indicated will provide a well-rounded, reasonably progressive dental research and public health program for fiscal 1961.

I appreciate very much the opportunity to come here today and present our views.

Mr. FOGARTY. Thank you, Dr. Nagle. I have asked other doctors this week the same question I shall ask you.

We have a real problem on this side of the table, as far as raising appropriations is concerned. The budget we have before us, the President's budget, is weak in many areas. I have enumerated some of the cuts he has made in existing programs this year. Vocational education has been cut back $2 million. Hospital construction has been cut back $60 million. Help for the schools in federally impacted areas is about $80 million short of what they are, by law, entitled to. Grants to States for waste treatment plants to try to clean up our streams has been cut back $25 million. Construction of medical research facilities has been cut $5 million.

So before we get around to thinking of these increases, speaking for myself now, I think we should restore these cuts which the President has made in these important programs. This amounts to about $175 million or $180 million. Then we have all of the medical groups coming in this week, and their recommendations go over $200 million in addition to what the President has requested.

So how do we explain to Members of Congress who want to balance the budget and cut Federal spending, that we think $4 million or $5 million more ought to be spent on dental care research? What would be your answer to these people who think more of a balanced budget than they do of improving medical care?

Dr. NAGLE. I think we can approach this realistically from the standpoint, first of all, of the cost of dental treatment and the dental repair program. We call it a repair program because that is what it is. The figures on dental disease are so great today they are almost fantastic even to mention. The cost of dental care is more than a billion dollars. The number of patients who are today going without even the barest dental care and are neglected is tremendous. Only 50 percent of the population is getting adequate care.

If we look to the future, if we are to take care of the needs of the people, if we are to take care of the problems which are fast coming to our attention because of the increase in life span, then we need more research to find out what we can do to lessen the impact of dental disease on the health of the Nation.

To do this we must have schools which are adequate in staff to teach the so-called exploding population of the 1960's that is facing us. We can see this now.

Secondly if we have the school space we must have qualified faculties to teach these students. Our fellowship program is the thing which will produce that.

Then lastly, the facilities program. I regret very much that the health research facilities were cut back, because this we need very much. I am fortunate at New York University. I was able to get a grant last year, so I am expanding my research institute. In 3 years my research institute became so crowded that I would like to have pushed the walls out. This is happening all along the line. If we get facilities and do not have the personnel or if we get new schools and do not have the staff, then we are not accomplishing our objective. We have gone far enough in our research program today to see that

we shall break through and have a control of some of the perhaps most devastating dental diseases.

FLUORIDATION PROGRAM

We speak of the simple thing of pyorrhea, which sounds quite easy. But when we take a look at it from the standpoint of its impact on the total health of the individual, then it becomes a very serious matter.

Mr. FOGARTY. Is not the research that was conducted in the field of fluoridation a good example of that?

Dr. NAGLE. I think this is an excellent example of what can be done in the control of just dental caries. Also, it not only has demonstrated a great advance in research in the area of dental caries, but it also has demonstrated that because of this public health measure we are getting a better growth and development of teeth of the children in the areas that are fluoridated. This is the important thing.

Mr. FOGARTY. You people are still very much in favor of the fluoridation program?

Dr. NAGLE. Yes indeed.

Mr. FOGARTY. Have the opponents of this program, who many times are in the minority but very loud in their protests, had any dentists on their side?

Dr. NAGLE. Yes; they have. A number of dentists seem to speak against fluoridation. This is a little difficult for those of us who favor fluoridation to understand. If they were not scientifically educated, if they did not have a knowledge of the picture, and if they could not see the results of fluoridation, then we would understand their attitude. I do not understand the attitude of some of those who speak against fluoridation, because the evidence is based on scientific fact. It is not based on guess or judgment of the individual. This is hard to understand.

Mr. FOGARTY. We have not had that problem in my State. I guess my State is ahead of all others.

Our dental society was one of the first to endorse this program when it first came into being a few years ago.

Dr. NAGLE. That is right.

Mr. FOGARTY. Most communities have fluoridated their water supplies since then.

Mr. DENTON. In my home town there is a doctor who leads the opposition to fluoridation. He writes me a good many letters about it and leads quite a fight.

Dr. SMITH. May I comment on that? I think you will find all over the country an occasional medical doctor who is opposed, but scientifically they cannot prove their point of opposition. The fluoridation program has been endorsed not only by the American Dental Association but by the American Medical Association and the United States Public Health Service. Fluoridation has been installed in various Government areas, controlled by the U.S. Government. I do not think there is any question about its value. We will always have minority groups, however.

Mr. DENTON. That is all.

Mr. MARSHALL. No questions.

Mr. FOGARTY. Thank you very much, gentlemen.

THURSDAY, MARCH 3, 1960.

## WATER POLLUTION STUDY, RED RIVER

### WITNESSES

JOHN W. HOLTON, ADMINISTRATIVE ASSISTANT TO HON. SAM RAYBURN, SPEAKER, HOUSE OF REPRESENTATIVES
R. L. McKINNEY, JR., REPRESENTING CHAMBER OF COMMERCE, DENISON, TEX.
HAL RAWLINS, CITY ATTORNEY, CITY OF DENISON, TEX., REPRESENTING CITY OF DENISON

Mr. FOGARTY. Mr. Holton, are you ready with your group? We are sorry that the Speaker is unable to be with us because of a death in his family. We understand that is the reason he is not appearing this morning.

Mr. HOLTON. That is correct, Mr. Chairman.

I wish to tell you that I am very privileged and honored to be able to be here to present two of Mr. Rayburn's constituents from Denison, Tex., who are very much interested in a grave problem we have in that area of water pollution of the Red River. We have Mr. R. L. McKinney from Denison, Tex., representing the chamber of commerce, and we have Mr. Hal Rawlins from Denison, Tex., attorney representing the city of Denison.

Mr. FOGARTY. As you know, this committee paid attention to Speaker Rayburn last year, and I assume we will continue to support anything which he supports. You go right ahead.

Mr. McKINNEY. We appreciate the opportunity of appearing before you again this year and your hearing us.

As you know, this program started 2 years ago, and this year the U.S. Department of Health, Education, and Welfare has $400,000 in its budget to survey the Arkansas and Red River Basins. Primarily the problem there is salt pollution from salt springs in west Texas and Oklahoma. They have made great strides and can actually see daylight in the program. We believe before they finish they will come up with a solution to keeping the salt out of the river.

As you know, we have Lake Texoma, a large body of water, polluted with salt which makes it unsuitable for many purposes, and very expensive to treat.

So we are appearing before you today in support of this program, and urgently request that you appropriate this money for the Department of Health, Education, and Welfare at this time.

I should like to leave these statements with you, and also we have a pamphlet prepared by the Department of Health, Education, and Welfare which explains their program and shows where these salt flats are in the basin.

Thank you very much, Mr. Chairman and gentlemen.

(The statement referred to follows:)

STATEMENT SUBMITTED BY THE DENISON CHAMBER OF COMMERCE, DENISON, TEX., IN SUPPORT OF POLLUTION CONTROL SURVEY BY THE U.S. PUBLIC HEALTH SERVICE FOR THE FISCAL YEAR 1961 TO CONTINUE THE WATER POLLUTION STUDY OF THE RED RIVER IN TEXAS, OKLAHOMA, ARKANSAS, AND LOUISIANA

My name is R. L. McKinney, Jr., and I represent the Chamber of Commerce of Denison, Tex., which has sent me to appear before your committee in the interest of curbing the pollution of Red River.

Like all American cities, Denison is anxious to have a large supply of good quality water available for municipal use, industrial development, and agricultural development purposes. We are fortunate in having Red River and the Denison Dam Reservoir, but are most concerned with the increasing mineral pollution we are experiencing.

Of course our water in Lake Texoma has been attractive to industry, but unfortunately we are immediately at a disadvantage with the same industry because the high mineral content of our water creates a treatment problem costing approximately 10 times normal treatment costs, and the nature of the pollution rules out the location of all food processing concerns.

The problem of pollution in the Red River is unique in that a great amount of our pollution is natural pollution from salt springs in a two-State area and affects areas other than Denison. Red River discharges 18,420,000 acre-feet of water at Shreveport each year. This makes it evident that the Red River is potentially a tremendous source of water for municipal, agricultural, and industrial use in several States. Also it is quite evident that the high mineral content cuts down the suitability of this water for all of the people in the multi-State Red River Valley.

Great strides have been made by the Department of Health, Education, and Welfare in surveying our problem of mineral pollution in Red River.

We, therefore, urge your committee make every effort to assure the immediate completion of the pollution survey on Red River.

Mr. RAWLINS. May I add a couple of words, if you please, Mr. Chairman and members of the committee?

As Mr. Holton has said, I am appearing primarily on behalf of the city of Denison as city attorney of Denison. I urge that this program be continued. Certainly we have a local and personal interest in this matter, but it covers a larger area than just the city. It is a problem involving more than one State.

Our municipal water supply is presently supplemented with water from Lake Texoma, but that water is mostly unfit for industrial uses and is not desirable even for domestic use because of the high mineral and salt content. We think continuation of this program of study which has been started will find a way, and I believe ways are known now, that that natural pollution can be stopped. If that is done, then that area will benefit greatly from that, because it will permit industrial growth and prosperity all through that valley.

Again I should like to join with Commissioner McKinney in expressing our appreciation to the committee.

Mr. FOGARTY. Thank you very much.

Mr. HOLTON. Thank you, Mr. Chairman.

52692—60——25

THURSDAY, MARCH 3, 1960.

## GNAT CONTROL, LAKE COUNTY, CALIF.

### WITNESS

### HON. CLEM MILLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. FOGARTY. We are glad to have you with us, Congressman.

Mr. MILLER. Mr. Chairman, I appreciate the opportunity of appearing before this committee, and understand the strictures on your time. I have a prepared statement which I would appreciate the opportunity of introducing into the record.

Mr. FOGARTY. We will put that in the record. Then you may summarize it.

(The statement referred to follows:)

TESTIMONY OF CONGRESSMAN CLEM MILLER BEFORE THE SUBCOMMITTEE ON DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE OF THE COMMITTEE ON APPROPRIATIONS, HOUSE OF REPRESENTATIVES

Mr. Chairman, there is a serious infestation in my congressional district of a gnat designated as *Chaoborus asticopus*, more commonly called the Clear Lake gnat. This pest has plagued an entire county, Lake County, for decades despite Federal, State and local research and control programs. Clear Lake, upon which the entire county depends for its livelihood, is about 20 miles long and from 1 to 6 miles wide.

Annually, these gnats invade the area surrounding the lake by the billions. It becomes impossible to see in front of you. The recreation industry, livelihood of most of the county, comes to a halt. It is impossible to describe the effect these gnats have on an individual. They invade your eyes, ears, nose, and mouth. You dare not turn lights on in the house. This is not only a nuisance but, as we will see later, also constitutes a health menace.

Research on the Lake County gnat problem has gone on for many years. Local, State and Federal Governments have all participated.

Interest of the State of California in the problem goes back more than 40 years.

Between 1916 and 1936 the University of California contributed valuable information on the biology of the Clear Lake gnat.

In 1938 Congress appropriated funds to the U.S. Department of Agriculture Bureau of Entomology and Plant Quarantine (now Agriculture Research Service, section on insects affecting man and animals) to make further studies of the biology and control of this species. Between 1938 and 1942 much additional basic information was obtained through the efforts of the USDA group assigned to this project. This activity was discontinued with World War II without large-scale control projects having been undertaken.

Following the war, USDA scientists were successful in demonstrating the value of certain newly developed chlorinated hydrocarbon insecticides in controlling the gnat larvae. In February 1948 the Lake County Mosquito Abatement District was organized. Through this agency local tax funds were procured to provide for control of mosquitoes as well as to undertake a full-scale gnat control project. An additional $10,000 was made available by the California State Legislature for the 1949–50 fiscal year to assist in financing the project.

Clear Lake was treated for the first time in September, 1949, along with 22 smaller lakes and reservoirs within 40 miles of Clear Lake. This treatment, which utilized dichloro-diphenyl dichlorethane (DDD), a relative of DDT, was an outstanding success from the standpoint of gnat control. Extensive seining and bottom sampling over the next 18 months failed to recover a single Chaoborus larva. Gradual reinfestation took place, however, and the lake was again treated in 1954, and again in 1957, with declining rates of effectiveness in each case. Gnat mortality amounted to 96 percent in the last case. Considering the biotic potential of the species, this fatality rate was considered a failure. True control requires a mortality rate of 99 percent plus.

In addition to decreasing effectiveness, it was discovered that there was accumulation and storage of the insecticide in the tissues of fish which populate

the lake. In the judgment of the California Department of Public Health, this did not then represent a public health menace but it was decided that further control work with DDD was unwise.

For the past 2 years, the Lake County Mosquito Abatement District, with partial financial assistance from the California Department of Public Health, has carried on a research program. They have been screening the more recently developed insecticides in hope of finding one that would be effective against the gnat without adversely affecting fish, aquatic birds, or man. This work now focuses on a material called methyl trithion (an organic phosphate) and methyl trithion in combination with parathion. Full treatment of Clear Lake with these chemicals would cost in the neighborhood of $180,000. Both State and local authorities have high hope for success in gnat control through use of these substances. All experiments to date point in that direction.

However, experimentation is not complete. Just last month a conference of experts from the California State Department of Public Health, State Department of Agriculture, State Department of Fish and Game, Lake County Mosquito Abatement District, the University of California, and the U.S. Public Health Service reviewed status of available information concerning potential hazards. They were concerned not only with toxicity to fish but possibilities of residual contamination of the flesh of the fish, and contamination of water in public water systems having Clear Lake for a source of supply. The conference reached these conclusions:

1. Several field trials with application of the proposed new combination of chemicals to agricultural ponds infested with Chaoborus larvae, should be carried out to demonstrate effectiveness in control of larvae under natural conditions. This would supplement small-scale experiments already completed by the mosquito abatement district.

2. Additional experiments to demonstrate acute toxicity of the proposed chemicals to fish are needed to supplement those already performed by the mosquito abatement district.

3. Evidence should be secured as to stability, or rate of decomposition of the proposed chemicals when dispersed in large bodies of water.

4. Evidence should be obtained as to concentration of the proposed chemicals likely to result in flesh of fish exposed to a treated water.

These experiments are needed not only to prejudge the success and safety of expensive, large-scale treatment of lakes, but also to provide legal evidence necessary prior to registration of methyl trithion and parathion for use in California.

The high cost of these experiments, on top of the large price tag on full-scale treatments if the experiments are successful, will make it impossible to bring the gnat problem under control this year or next year if only local and State funds are available. California State authorities, and Clear Lake Mosquito Abatement District authorities, want a Federal grant in the budget now under consideration to assist them in this experimentation.

The problem is not confined to Clear Lake. If it were, it would be severe enough. The larva is now being found in Lake Mendocino, a Corps of Engineers flood control reservoir, and in Lake Berryessa, a Bureau of Reclamation project. Dr. Malcolm H. Merrill, California director of public health, wrote me recently: "The Clear Lake gnat is, in fact, not confined exclusively to Lake County, but is showing indications of developing to critical population levels in a number of localities." The large number of Federal water impoundments in California, both built and planned, gives the U.S. Government a clear responsibility in this problem. The State and Federal water programs laid out for the next 10 years in California give an indication of how serious a problem the Clear Lake gnat will become.

The gnats have, in the past, been considered primarily a nuisance. Now, physicians in the area are becoming convinced that there is a health menace. Dr. Charles A. Craig, of Lakeport, Calif., who has been practicing there for 40 years, says, "During that time I have treated many cases of hay fever and asthma due to gnats. I have had gnat extract made, and tested many of these patients and have given them desensitizing shots to try to prevent their attacks. Numerous patients have been sent out of town to Adams Springs or Cobb Valley, a distance of 20 to 30 miles, to get them away from gnats. These cases within a very few hours are free of their symptoms. * * * There is no doubt in my mind, whatever, but what the gnats, aside from being a nuisance, are very much of a health menace to Lake County." Other physicians report much the same experience and some mention an anxiety factor, caused by the gnat nuisance, as an additional health hazard.

Mr. Chairman, in view of these facts I am asking that the sum of $60,000 be added to the fiscal 1961 budget of the Department of Health, Education, and Welfare; more specifically for the Bureau of Health within the Department of Health, Education, and Welfare, to be used as a grant to either the Lake County, Calif., Mosquito Abatement District, or, in the alternative, to the California Department of Public Health, to be used for research into control or elimination of *Chaoborus asticopus*, the so-called Clear Lake gnat.

Mr. MILLER. The reason I take this time, Mr. Chairman and gentlemen, is that this is a new problem which has arisen in my congressional district. There is strong evidence that it is spreading to other areas of my congressional district. There is a strong possibility that this may be very shortly an interstate problem.

This has to do with gnats. It goes under the complicated Latin name of *Chaoborus asticopus*. It infests Lake County. Clear Lake is its dominant feature, about 14 miles long and several miles wide.

These gnats infest that whole area by the billions and trillions. You can scarcely drive down the street. As the principal industry of this whole county is recreation and fishing, the entire county grinds to a halt when this infestation occurs.

It has been growing more and more serious by the year for the last several decades. It is now spreading to federally operated reservoirs in the area.

I have additional exhibits which I should like the privilege of introducing to indicate that this is becoming a general problem.

(These exhibits follow:)

The first is a letter from Dr. Malcolm H. Merrill, director of public health for the State of California, in which he outlines the present situation relative to combating the infestation and describes the need for a Federal assistance grant:

STATE OF CALIFORNIA,
DEPARTMENT OF PUBLIC HEALTH,
*Berkeley, Calif., February 5, 1960.*

Hon. CLEM MILLER,
*House Office Building,*
*Washington, D.C.*

DEAR MR. MILLER: On February 4 a conference was held in our building attended by 20 people representing our department, the State departments of agriculture and fish and game, the Lake County Mosquito Abatement District, the University of California, the U.S. Public Health Service and our department's technical consultants in the fields of entomology and toxicology.

We carefully reviewed the experimental and research work done to date by the Lake County Mosquito Abatement District using methyl trithion, and a combination of methyl trithion and parathion.

We also reviewed the status of available information concerning the potential hazards involved in the addition of these chemicals to a large water impoundment such as Clear Lake, having in mind not only the toxicity to the fish themselves, but the likelihood of residual contamination of the flesh of the fish, and contamination of water in public water systems having Clear Lake for their source of supply. Our conclusions were as follows:

1. Several field trials with application of chemicals to agricultural ponds, infested with *Chaoborus* larvae, using the proposed concentration of chemicals should be carried out to demonstrate the effectiveness of the proposed chemical in the control of gnat larvae under natural conditions.

This is necessary to supplement work already done by the mosquito abatement district in which gnat larvae have been exposed to these chemicals in laboratory scale jar tests.

2. Additional experiments to demonstrate the acute toxicity of the proposed chemicals to fish are needed to supplement those already performed by the mosquito abatement district. These experiments, performed in aquaria, should involve the exposure of several species of fish found in Clear Lake. To date, all of the work carried out by the mosquito abatement district has been performed on blue gill.

3. Evidence must be secured as to the stability, or rate of decomposition of the proposed chemicals, when dispersed in large bodies of water.

4. Evidence must be secured as to the concentration of the proposed chemical likely to result in the death of the fish exposed to a treated water. To the best knowledge of those present at the conference no such evidence is available at the present time.

It was the consensus of those present that it would be improper to proceed with a treatment of Clear Lake with either methyl trithion or a mixture of methyl trithion and parathion until these four types of evidence have been developed. The Lake County Mosquito Abatement District indicated their intention to accumulate the first two types of information, proceeding at once with the fish toxicity tests and carrying out insecticide trials on agricultural ponds as soon as weather conditions permit (probably in June).

A representative of the State department of agriculture pointed out that under the California Economic Poisons Act, no insecticide may be sold in this State until it has been investigated and registered by the bureau of chemistry in the department of agriculture. He reviewed the nature of the necessary investigation and made it clear that all four types of evidence above referred to must be presented before an insecticide may be registered. It is the responsibility of the manufacturer to present such evidence to that department when it applies for registration. Neither methyl trithion nor a combination of it with parathion has been registered to date.

It may be seen from the foregoing that the three State departments represented at this meeting cannot endorse the proposed treatment of Clear Lake until further evidence is secured, and that under the California statute, above referred to, the product may not be used without registration based on the same type of evidence.

The next step rests with the manufacturer of the chemical compound to present the compounds for registration for this type of use and the information set forth above will be conveyed to this firm.

It appears unlikely that all of these steps can be completed in time for a treatment of Clear Lake this summer or fall. If sufficient evidence were presented to the department of agriculture early in the summer, however, a fall treatment would be possible.

The State department of public health has a deep concern over the problem presented by the occurrence of Clear Lake gnats (*Chaoborus astictopus*). Not only do these gnats constitute a grave public problem in Clear Lake, but there is evidence that they occur in other existing large water impoundments, and may expand to the new large reservoirs already constructed or planned for construction under the California water plan.

We consider that expanded research is urgently needed whether or not a treatment of Clear Lake this year is possible.

Any support which you can give to an expanded research program would be greatly appreciated by the agencies in this State. Decision as to whether Federal support should be in the form of a Federal grant, a Federal project, or a research grant is one on which we are unable to give a firm answer, but believe that all three possibilities should be explored.

Very sincerely yours,

MALCOLM H. MERRILL, M.D.,
*Director of Public Health.*

The second letter is from Robert J. Anderson, Assistant Surgeon General of the United States, who describes the Public Health Service's view of the same meeting described by Dr. Merrill. Like the California public health director, he emphasizes the need for more research into the use of the currently promising chemicals before full-scale treatments of large bodies of water are undertaken.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
PUBLIC HEALTH SERVICE,
*Washington, D.C., February 18, 1960.*

HON. CLEM MILLER,
*House of Representatives,*
*Washington, D.C.*

DEAR MR. MILLER: In answer to your request to Dr. George H. Bradley, Assistant Chief of the Communicable Disease Center in Washington, we are sending you this letter to report on the attendance of Dr. William M. Upholt, CDC regional representative in San Francisco, at the meeting held on February 4 at the California Department of Public Health to discuss control of the Clear Lake gnat. This meeting was attended by Mr. W. H. Kline, trustee, Mr. Robert E.

Dolphin, manager, and Mr. Robert N. Peterson, research entomologist, all of the Lake County Mosquito Abatement District. Also, representatives of the California Departments of Fish and Game, Agriculture, and Public Health were present. Dr. Upholt was the only employee of the Federal Government in attendance.

Mr. Frank Stead, chief, division of environmental health, department of public health, opened the meeting by reviewing correspondence with the Honorable Clem Miller. Mr. Stead indicated that the directors of the three State departments directly concerned had agreed that treatment of Clear Lake would be inadvisable unless there is adequate evidence that the treatment would be effective in the control of the gnats and safe from the standpoint of drinking water and also the food chain of fish. Everyone in this conference agreed with this basic policy.

Mr. Dolphin then presented the evidence which he and his staff have accumulated regarding the effectiveness of methyl trithion, parathion, and a 50–50 mixture of these two insecticides. This evidence, which was largely based upon laboratory tests, indicated that 0.013 parts per million or 1 part in 75 million would be adequate (in the 50–50 mixture) to control the gnat. Though there has been some testing of these two insecticides separately in field plots in ponds, approximately 50 by 150 feet and up to 10 feet deep, the mixture has not yet been field tested. The entire group agreed that there would have to be considerable field testing of this mixture before its effectiveness could be assured.

Only limited fish toxicity data have been obtained. Dr. Upholt promised to obtain for the group whatever information is available from the Sanitary Engineering Center of the Public Health Service on insecticide toxicity to fish. Dr. Upholt also will see what data are available on toxicity to warmblooded animals of the compounds proposed for use to control the gnat.

Considerable question was raised as to the persistence of methyl trithion-parathion in natural waters and the levels of the mixture which can be expected to be deposited in the flesh of the fish. Dr. Charles Hine, consultant to the department of public health, pointed out that the half life of parathion in water at pH7 is about 120 days. He did not know the half life of methyl trithion under similar circumstances. The pH of Clear Lake is about 8 and there is of course considerable organic debris in the water, both of which would tend to shorten the half life. In any case the group as a whole agreed that considerable information is still needed regarding the persistence of the mixture in the water of Clear Lake and its deposit in the flesh of fish as well as its toxicity to fish.

Mr. Andrew Lemmon, State department of agriculture, pointed out that, at present, methyl trithion is not licensed for sale in California, nor has the manufacturer, Stauffer Chemical Co., approached the State department of agriculture regarding licensing. Before the material can be licensed for sale the applicant, presumably the Stauffer Chemical Co., would have to provide adequate experimental evidence as to its effectiveness for the purpose in question, and as to its safety both from the standpoint of direct human hazard and the danger of contamination of food or water. A great deal of information must be provided to the State department of agriculture and evaluated by them before this material or its mixture with parathion could be licensed for sale. The group agreed that this law is in complete accordance with the policy that the three State agencies consider essential in the case at hand.

The net result of the discussion was that it was apparent that much more research needs to be done before a decision could be reached as to the desirability of using the pesticide mixture proposed for the control of the Clear Lake gnat. It was considered impossible to complete this research until June at the earliest.

The long-term research project that is needed could not be counted upon to solve the immediate pressing problems of Lake County. The State department of public health feels, however, that such research will in the long run be of value not only to Lake County but to many other areas of California and even to other States which are facing increasingly important problems from this or closely related gnats.

We recognize, as did Dr. Upholt at the meeting, that the Clear Lake gnat situation is a health-related problem, particularly as it affects recreational activities. However, presently available funds of the Public Health Service are utilized for higher priority work on various disease entities, thus confining assistance we may give for the present to technical consultation available through the California Department of Public Health.

Sincerely yours,

ROBERT J. ANDERSON,
*Assistant Surgeon General.*

The situation I face in contacting Federal agencies is: Where can we get relief from this problem?

Mr. Denton. Would Fish and Wildlife not be the place?

Mr. Miller. Fish and Wildlife, possibly, but this also is a growing public health menace.

The local county is doing everything it can. It has a 37-cent tax rate trying to cope with this problem. This exhibits the degree of gravity they attach to it. The State of California has appropriated substantial amounts to fight it. But this is a bigger problem than either local government or the State of California can cope with. That is why I am here this morning: To see if there is an opportunity for the Federal Government to appropriate $60,000 to institute research in this field, to ascertain what is the best method of control and to find out whether or not a larvacide can be used safely.

There have been several applications previously of DDD. One of the aspects which should be studied is: What is the effect of such applications on animal life and particularly on human life? None of us want another cranberry episode for any reason, and we feel that proper research could prevent this.

Let me repeat this statement by Robert J. Anderson, Assistant Surgeon General, in a letter to me of February 19:

> The long-term research project that is needed could not be counted upon to solve the immediate pressing problems of Lake County. The State department of public health feels, however, that such research will in the long run be of value not only to Lake County but to many other areas of California and even to States which are facing increasingly important problems from this and closely related gnats. We recognize, as does Dr. Upholt—

their representative at a recent meeting—

> that the Clear Lake gnat situation is a local problem, particularly as it affects recreation activities.

I would appreciate the consideration of this committee. I realize the severe budgetary problems it faces. My reaction to the question which you raised with the previous witness is that the administration is very shortsighted in its views on the health, education, and welfare. I would simply explain to the people of my district that we have to do something about these problems. I would vote for the increased appropriation. I would tell the people of my district why we need these additional appropriations. Perhaps we are described as spenders, but I feel we can justify every penny adequately and completely.

Mr. Fogarty. Mr. Denton.

Mr. Denton. We have a problem something like that with blackbirds and starlings before the Interior Committee. I wonder if they have ever made a study along that line.

Mr. Miller. The only study of a Federal nature which has been done has been by the Public Health Service in the 1930's when the Federal Government did cooperate with the State of California. I have contacted all the Federal agencies. I have talked to the officials. They tell me that they are very anxious to do something about it as long as it does not involve any money.

There is a very delicate point here. They have found DDD—previously used on the lake—to be the cause of the death of certain grebes, a bird of that locality. They have found it in the muscles of the birds, and it is probably the cause of their death. We do not want to raise any alarms prior to careful investigation of the problem.

If it became widely known or widely feared that the birds and fish were dying because of the applications of DDD or any other substance, it would sound the death knell of this county. That is why there is some considerable urgency to do something about it.

I admit quite frankly the difficulty of making a Federal justification for this. It is all very well to lock the barn after the horse is stolen, but if we wait till this gnat has crossed State lines, we may be in a very serious situation. The wisest course would be to control it now, while the problem is still manageable.

Mr. DENTON. That is all.

Mr. FOGARTY. Mr. Marshall.

Mr. MARSHALL. Approximately how much have the local governments and the State of California spent trying to control this problem?

Mr. MILLER. I am unable to give you offhand a precise total, but it is in the millions of dollars. They have been working on this since about 1916. At the present time they have a 37-cent tax rate in the county for this one program alone, and they have an amount in the county treasury of about $70,000 to conduct continuing studies of the problem. The State of California recently appropriated $20,000, last week, to continue the study of it. But they estimate that to complete the studies will require more than the combined resources of the county and the State. In addition, after their studies have been completed, a single application of the most likely larvacide would be in the neighborhood of $200,000.

Mr. MARSHALL. Thank you.

Mr. FOGARTY. Thank you very much, Congressman.

---

THURSDAY, MARCH 3, 1960.

## FOOD SANITATION

### WITNESS

### CHARLES FISTERE, COUNSEL, NATIONAL ASSOCIATION OF DAIRY EQUIPMENT MANUFACTURERS

Mr. FOGARTY. Mr. Fistere, you represent the National Association of Dairy Equipment Manufacturers?

Mr. FISTERE. That is correct.

Mr. FOGARTY. You wish to speak on the food sanitation problem?

Mr. FISTERE. Yes, Mr. Chairman.

My name is Charles Fistere, and I am appearing today as a substitute for John Marshall, who is executive vice president of the National Association of Dairy Equipment Manufacturers, who was stormbound in Atlanta yesterday afternoon and is making his way up to Washington by train, and was fearful that he would not arrive in time for his appearance this morning. He asked me if I would make the statement for him.

Mr. FOGARTY. Go right ahead.

Mr. FISTERE. I am counsel for the National Association of Dairy Equipment Manufacturers. We have offices at 1012 14th Street in Washington, D.C.

The association is composed of 44 member companies who produce approximately 85 percent of the Nation's annual supply of such equip-

ment. This equipment is used in all types of dairy processing plants including milk plants and ice cream manufacturing plants, milk drying plants, butter and cheese manufacturing plants. Our members also produce thousands of farm bulk milk tanks and other dairy equipment used in dairy farms throughout these United States. These refrigerated bulk milk tanks are a relatively recent and growing development in this country and are now installed on some 150,000 dairy farms throughout the country.

Last year our association joined with other dairy industry organizations in requesting a modest increase of from $350,000 to $400,000 for the milk, shellfish and food sanitation program of the Public Health Service. At that time we pointed out that these activities, which for many years have been of the greatest value to the public, to State and local governments and to our industry, had declined to a point where essential services were being conducted at levels far below that required. We particularly stressed the deficiencies in basic research required to keep pace with technological developments; the lag in sanitary standards development; and the failure of the service to meet its responsibilities in the conduct of the voluntary program for certification of the milk shippers.

We were gratified that this committee, as well as the House and Senate Conference Committees last year directed the Secretary of Health, Education, and Welfare to strengthen, within existing appropriations, the milk, shellfish, and food sanitation activities of the Public Health Service. However, so far as we know, the amount transferred within the Department, pursuant to your instructions, while enabling the strengthening of field operations concerned with interstate milk shipments and shellfish sanitation, did not enable the service to undertake vitally needed research. This we determined in conferences with the Secretary during the past year.

The most vital research requirements were outlined by Assistant Surgeon General Hollis, at your request, when he appeared before the committee a year ago (see p. 164, hearings on HEW appropriations for 1960). The need for strengthening the research phase of this program is more urgent today than even 1 year ago.

We respectfully request your committee, Mr. Chairman, in any action it may take in this matter to see to it that not only existing milk, shellfish, and food sanitation activities are maintained but also that their efficiacy be not diminished by reason of a failure of the service to conduct the research needed to make these programs adequate for today's requirements. It is our firm belief that a minimum of an additional $150,000 is required to undertake the most urgently needed research projects as outlined to this committee by Mr. Hollis in his statement referred to above.

We are also concerned, Mr. Chairman, that in this year's budget presentation the milk, food, and shellfish activities have been combined with interstate carriers and general sanitation activities into a single item entitled "Milk, Food, and General Sanitation." It is our understanding that the term, "General sanitation," includes such unrelated items as municipal and rural sanitation, refuse disposal, and swimming pool sanitation. We are apprehensive that this broad grouping may only serve to further subordinate milk, food, and shellfish sanitation activities which this committee has previously said should be strengthened.

We thank you for the opportunity to again appear before this committee to acquaint you with the views of the National Association of Dairy Equipment Manufacturers in behalf of the milk, food, and shellfish activities of the Public Health Service.

Mr. FOGARTY. Thank you very much, Mr. Fistere.

Mr. DENTON. No questions.

Mr. MARSHALL. No questions.

Mr. FOGARTY. Thank you very much.

Mr. FISTERE. Thank you.

## VOCATIONAL EDUCATION

### WITNESS

### HON. JOHN KYL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA

Mr. FOGARTY. We are happy to have Congressman Kyl with us. Please proceed, Congressman.

Mr. KYL. Mr. Chairman and members of the committee, I am Representative John Kyl of the Fourth Iowa District. I appreciate the opportunity to appear before this committee in connection with the transfer of funds within the Defense Education Act.

I respectfully submit the following facts concerning the use of the George-Barden funds in the State of Iowa. When that program started, the State department of public instruction reimbursed the schools at the rate of 50 percent on teachers' salaries, mileage, and evening schools. During 1958–59 the Department reimbursed the schools on teachers' salaries as follows:

| | *Percent* |
|---|---|
| 1. Agriculture | 22 |
| 2. Distributive | 50 |
| 3. Homemaking | 20 |
| 4. Trades and industry | 28 |

The drop in reimbursement has been due to the fact that funds have remained the same, but salaries and other expenses have been rising. The number of schools served has remained nearly the same.

May I also submit the following tables, which delineate the number of students in the various areas of training and the way in which the costs of these programs are met. I would like to add that vocational education is comparatively expensive, since more equipment is needed and, as a rule, the classes must be smaller.

*Schools*

| Area | Number of departments | Day students | Adults |
|---|---|---|---|
| Agriculture | 286 | 10,673 | 15,543 |
| Distributive | 23 | 377 | 2,195 |
| Homemaking | 211 | 16,334 | 8,121 |
| Trade and industry | 39 | 1,998 | 10,047 |

*Funds available*

| Area | Smith-Hughes, George-Barden I, Federal | State | Local |
|---|---|---|---|
| Agriculture | $412,327.77 | $124,811.42 | $1,101,337.74 |
| Distributive | 44,354.11 | 19,857.17 | 48,374.47 |
| Homemaking | 211,293.12 | 95,548.56 | 811,675.99 |
| Trade and industry | 149,273.31 | 59,782.85 | 356,485.00 |
| Total | 817,248.31 | 300,000.00 | 2,317,873.20 |

Before funds are ready for distribution to schools, the Federal funds are reduced by the following:

| | |
|---|---|
| 1. Teacher training | $48,133.92 |
| 2. State office expense | 48,220.26 |
| Total | 96,354.18 |

Amounts actually available to schools:

| Area | Smith-Hughes, George-Barden I | State | Local |
|---|---|---|---|
| Agriculture | $377,116.88 | $124,811.42 | $1,101,337.74 |
| Distributive | 28,517.19 | 19,857.17 | 48,374.47 |
| Homemaking | 178,455.98 | 95,548.56 | 811,675.99 |
| Trade and industry | 136,804.08 | 39,782.85 | 356,485.00 |
| Total | 720,894.13 | 300,000.00 | 2,317,873.20 |

I submit the following statement from Mr. B. H. Graeber of the division of vocational education of the Iowa State Department of Public Instruction.

During 1958–59 we used $6,481.33 of an allotment of $85,654. During 1959–60 we will use possibly $40,000 of $160,072 allotted. We hope to be using more during 1960–61, but we will not use all of it. Under those conditions we would lose $48,000 from George-Barden I funds and gain $45,000 under George-Barden III, which we could not use. If we don't use the funds, they are given to other States.

The following table was submitted by the Subcommittee on Special Education here in Washington. It shows the changes which would result from a transfer of funds.

| Title I | 1961 | 1960 | Change |
|---|---|---|---|
| Agriculture | $300,024 | $322,284 | −$22,260 |
| Home economics | 182,760 | 196,453 | −13,693 |
| Trades and industry | 105,071 | 113,519 | −8,448 |
| Distributive | 38,855 | 42,678 | −3,823 |
| Total | 626,710 | 674,934 | −48,224 |
| Appropriation title 8 | 205,807 | 160,072 | +45,735 |

The superintendent of public instruction in Iowa, Mr. J. C. Wright, of Des Moines, explains that the money released in the past was released because Iowa schools were not prepared to utilize the funds under terms of the law. This was true in part because the local

budgets are made up a year in advance and no local money was allotted to take advantage of the Federal funds. Mr. Wright assures me that provision is being made to utilize the funds in the future.

The agriculture and home economics programs in the State of Iowa have not been diminished. Furthermore, because of the nature of instruction in agriculture especially, that program does offer much specific training in technique skills. If these Federal funds were ever justified, as was indicated by congressional action on the bill, I submit that in Iowa they are still justified on the same basis.

May I, therefore, ask respectfully that you give consideration to maintaining the funds for agriculture and home economics for this year, at least in the instances where a State has, in fact, returned unused portions of the Federal aid to the program for distribution elsewhere. I ask for this consideration, not simply because I am a Congressman from the State of Iowa, but because of the personal knowledge of the situation. I am an educator, I have a permanent professional certificate to teach in the State of Iowa. I know the educational situation in the State, and I know the great contribution your consideration of this request can make to the training of our young people.

Thank you again, Mr. Chairman, for the privilege of admitting my presence at this hearing.

In view of the fact that Iowa has released a total of $6,000 out of $85,000 and in 1959 we will use possibly $40,000 of $160,000 allotted, in view of the fact that some of these funds have been returned and in view of the fact that we need these funds for agriculture and home economics, I would appreciate your considering allowing those educational functions in agriculture and home economics to continue on the same basis in the instances, at least, where the States have returned money under this program in the past.

Mr. Fogarty. Thank you very much, Mr. Kyl.

Mr. Kyl. Thank you very much, gentlemen.

## Food Sanitation

### WITNESS

### DAVID H. WALLACE, DIRECTOR AND SECRETARY-TREASURER OF THE OYSTER INSTITUTE OF NORTH AMERICA

Mr. Fogarty. Mr. Wallace, we will be glad to hear you now.

Mr. Wallace. My name is David H. Wallace. I am the director and secretary-treasurer of the Oyster Institute of North America with offices at 6 Mayo Avenue, Bay Ridge, Annapolis, Md.

In the interest of time the statement may be inserted in the record.

Mr. Fogarty. We will insert the statement in the record.

(The statement referred to follows:)

Statement By David H. Wallace, Director, Oyster Institute of North America, March 3, 1960

My name is David H. Wallace. I am the director and secretary-treasurer of the Oyster Institute of North America with offices at 6 Mayo Avenue, Bay Ridge, Annapolis, Md. The organization is a trade association of approximately 225 shellfish growers and dealers from all coastal sections of the United States. Affiliated with us also are 6 local or regional associations, who represent an additional 500 growers and packers. Approximately 90 percent of the oysters and hard clams harvested in the United States are produced by our members.

I am appearing before your committee today to request support for certain items in the Public Health Service budget, including research funds for the milk, shellfish, and food program and additional aid for the construction grants program.

### SHELLFISH RESEARCH

For the past 2 years we have appeared to appeal for financial support for the unit, which administers the cooperative shellfish sanitation program for the Service. We were gratified indeed at the action of the committee in directing the Service to allocate additional funds to the milk and shellfish work. Insofar as we can determine the serious deficiencies in administration of the shellfish sanitation surveillance within the PHS regions have already been, or are in the process of being, corrected even though additional money was transferred only recently. This budgetary adjustment has reduced our concern for the program, and we wish to express our appreciation to the committee and to the Department for their support and action.

Unfortunately, the transfer of funds has only been partially accomplished. While administrative needs have been largely solved, no further funds have been made available for research in shellfish as far as we can determine. It is obvious that an equitable sanitation program cannot be administered soundly, unless scientific facts are available as a foundation for its administration. Limited research is being carried out by PHS scientists on sanitary significance of certain micro-organisms, development of methods for examination of sea water and shellfish, simple tests to determine rate of deterioration of raw oysters, and assay methods for paralytic shellfish poison.

These are essential problems which need expansion and additional financial support. But alone these studies are not sufficient. Before positive steps can be taken to control paralytic shellfish poison, studies are necessary on the ecology of the organism suspected of producing it, methods to detect its presence in marine waters and bottom sediments, and sufficient monitoring to predict or forecast its occurrence. Within the past 2 years this poison has been found in both Washington State and Maine. Other areas must be studied such as Massachusetts. Rhode Island, Connecticut, New York, Oregon, and possibly northern California.

In the past shellfish sanitation research has been confined almost exclusively to sewage contamination. For modern utilization of our marine waters we must broaden the studies to include the source and effect on shellfish of chemical and radioactive contaminants in growing areas. We have already suffered damage from adverse publicity which magnified the dangers of marine oil and radioactive contamination of shellfish all out of proportion to the findings of the scientists. This points up the need for more thorough and complete research along these lines. We urge that sufficient funds be made available to make these studies possible.

We note that in the House Appropriations Committee report of last year, the Public Health Service was requested to make a thorough study of environmental health problems in order that the most effective means of solving these problems might be developed. This report will undoubtedly point up areas of needed health research, and we hope that the Congress will make it possible for the Service to implement the findings of their study.

### CONSTRUCTION GRANTS PROGRAM

Another program of continuing interest to the shellfish industry is the incentive grants program for sewage treatment works construction. In my testimony before this committee last year, I testified that new waste treatment facilities constructed under the program have made possible the utilization of areas previously restricted under the sanitation program because of sewage pollution.

Seventy-one of the 2,017 pollution abatement projects approved through last year are located adjacent to shellfish-growing areas in 17 different States. Thirty-one of these projects have been completed and are instrumental in the abatement of pollution in surrounding tidal waters. Fifty-one more are under construction and will soon be in operation. The total cost of these projects is $33 million and only 23 percent of this has come from Federal aid.

While our industry is primarily interested in the impact of these projects on shellfish-growing areas, we are also aware of the beneficial effects on other water uses such as boating, fishing, and swimming where clean waters are also important for our health and welfare.

The reduction of this item in the executive budget will seriously retard the Nation's advance on pollution abatement. Our experience during the last 3

years provides incontrovertible evidence of the program's success. Clean water is the most important resource we have on which to build our future.

We strongly urge your committee to appropriate this fund to the $50 million level authorized in the initial legislation.

Mr. WALLACE. I am appearing here today primarily for two specific items, or two specific needs, in the budget for the Department of Health, Education, and Welfare, particularly in the Public Health Service. These are research funds needed in the milk, shellfish, and food program, and additional aid as we see it for the construction grants program for pollution control.

For the past 2 years we have testified before this committee to request financial support for the shellfish unit, It has been gratifying to see the action of the committee in requesting that the Public Health Service make funds available to this unit, and insofar as we can see the deficiencies in administration which were prevailing have been largely corrected, and we want to take this opportunity to thank your committee for the assistance you gave this particular work.

There are still some needs in this regard, particularly in the field of research. I believe it was the idea that funds would be made available for some specific research needs, as Mr. Fistere pointed out.

So far as we can determine at the present time, no moneys have been made available for shellfish research, even though they were proposed to be appropriated.

This is particularly difficult in a field such as shellfish sanitation where you must have scientific facts on which to base your whole administrative program. There are some rather serious deficiencies in knowledge on which this administrative program is based.

A couple items that are of major importance, I believe, one of which affects every clam-producing area in the United States, is this matter of paralytic shellfish poisoning which has been discovered in the last couple years in the State of Washington and in Maine. This is a very serious problem. We know little about it. There have been some techniques for assaying and determining the poisoning but we know nothing about the ichthyology of the organism that causes it or any possible methods of control, and we need these studies in Oregon, California, Massachusetts, Rhode Island, Connecticut, and in New York at least.

There is one other item I want to comment about. In the House Appropriations Committee report of last year the Public Health Service was requested to make a thorough study of environmental health problems in order to determine the most effective means of solving these problems.

While we have no idea of what is in the report, we certainly want to say that we feel that this is a very important thing and we hope that this program can be expedited because we feel it involves water pollution, and this is a matter of very major importance and in need of prompt action.

The other thing I want to say is that we strongly hope that funds for the construction grants program can be appropriated to the full extent of the authorization of $50 million.

In shellfish we have had some direct experience with this program. There have been grossly polluted areas which have been opened again for the use of the shellfish as a result of the construction which has taken place under this program.

Mr. FOGARTY. What do you think about the President cutting this budget in half?

Mr. WALLACE. We are very disturbed about this because the program is very slow even at best. Our needs are very great. We cannot keep pace with the growing pollution. Unless we step up the program we feel we are facing really serious trouble.

These things are so close to us, they have such a great potential for many uses, and we have to keep these waters clean. Unless we have this program effective we feel we are in for very serious trouble.

## ENVIRONMENTAL HEALTH PROGRAMS

Mr. FOGARTY. Thank you very much.

### STATEMENT OF CONFERENCE OF STATE SANITARY ENGINEERS

We have received a statement from the conference of State sanitary engineers on this same subject of food sanitation and other environmental health programs which we will place in the record.

(The statement referred to follows:)

STATEMENT OF ROBERT M. BROWN, MARYLAND STATE DEPARTMENT OF HEALTH, REPRESENTING THE CONFERENCE OF STATE SANITARY ENGINEERS, MARCH 3, 1960

Mr. Chairman and members of the committee, I am Robert M. Brown, chief of the bureau of environmental hygiene of the Maryland State Department of Health. I am a member of the Conference of State Sanitary Engineers and officially represent the executive board of the conference at the request of the chairman, Mr. Arthur N. Beck, of Alabama. The Conference of State Sanitary Engineers is composed of the chief engineers of the State health departments who are responsible for programs and activities in the fields of environmental control and health which are of great and increasing importance to the health and welfare of all the people of this Nation.

The environmental health programs of the State health departments and the Public Health Service have been closely allied for many years. Our close working relationships are based upon unity of purpose and mutual respect for our complementary roles at the State and Federal levels. Because of this, the conference maintains a deep and not altogether detached interest in the activities and programs of the Public Health Service. In a great many instances the State programs depend upon the Public Health Service for assistance in program evaluation, certification of interstate programs, for research, training, expert consultant services, and occasionally for direct services when unusual technical competence may be required.

The Conference of State Sanitary Engineers is confining its recommendations today to two environmental program areas which are of unusual importance to related State activities. These are:

Milk, food and shellfish sanitation; and

Water pollution control (under which there are three pertinent phases):

1. Grants for expansion of State water pollution programs.
2. Grants for construction of municipal sewage treatment works.
3. Funds for direct water pollution control operations by the Public Health Service.

Four expressions of position and endorsement with regard to these programs are presented as follows:

STATEMENT OF POSITION OF EXECUTIVE BOARD, CONFERENCE OF STATE SANITARY ENGINEERS, RELATING TO THE CONTINUED NEED FOR INCREASED BUDGETARY SUPPORT FOR PUBLIC HEALTH SERVICE, MILK, FOOD, AND SHELLFISH SANITATION RESEARCH ACTIVITIES

The executive board of the conference of State sanitary engineers in session on February 3, 1959, issued a statement strongly urging that every effort possible be made to provide sufficient funds for the effective conduct of the Public Health Service milk and food program activities. The importance of these Service activities in providing leadership and technical assistance to State and local programs has long been recognized, and was reemphasized in the statement.

The executive board is gratified to learn that, as a result of directives from both the Senate and House Subcommittees on Appropriations, the Public Health Service made available from within its overall appropriation, additional funds to strengthen its milk, food, and shellfish sanitation activities. This increase made it possible for the milk and food program to bolster the cooperative State-Public Health Service programs for certification of the sanitary quality of milk and shellfish shipped interstate. The executive board is pleased with the progress being made by the Service in strengthening these activites.

There remains, however, the very important area of research which, in the opinion of the board, still requires a substantial increase in support to cope adequately with present day problems. As was pointed out in the 1959 statement of the board, the majority of the States lack the resources to conduct research investigate the public health significance of new processes, products, and equipment, and to develop technical methods and procedures essential to the conduct of State and local milk, food, and shellfish sanitation programs. Such developments as bulk handling of milk, new processes of pasteurization and packaging, the increase in the amount of perishable foods served to the public through vending machines, the high incidence of food-borne illness traced to meals prepared for service to the final consumer, and the increase in volume, type, and potential of pollution in shellfish-growing waters, make many established control methods difficult to apply and may even affect the reliability of present standards for safeguarding the public health. The resulting problems require intensive study, and can be handled more efficiently and effectively on a unified basis by the Public Health Service rather than piecemeal by the several States. It is obvious that more knowledge of the ecology of micro-organisms, including staphylococci, salmonella, viruses, and rickettsia, is needed to provide a sound basis for the development of effective public health controls.

The lack of an adequate and continuing research program by the Public Health Service is depriving the States of the knowledge necessary to protect the health of their citizens in an era of rapidly changing technology. Therefore, the executive board of the conference of State sanitary engineers, in session on February 2, 1960, again strongly urges that every effort be made this year to provide sufficient funds to support the Public Health Service milk, food, and shellfish sanitation programs, particularly in the area of research, which are designed to provide the States with the necessary technical assistance, information, and data needed to cope with the emerging problems in the areas of milk, food, and shellfish sanitation.

February 2, 1960.

---

STATEMENT OF POSITION OF EXECUTIVE BOARD, CONFERENCE OF STATE SANITARY ENGINEERS, RELATING TO FEDERAL GRANTS FOR WATER POLLUTION CONTROL PROGRAM

The program of Federal grants to State and interstate agencies has been in effect for 4 years. In that time, these grants have accomplished much toward their purpose of assisting such agencies in establishing and maintaining adequate water pollution control programs. The most impressive accomplishment of the grants has been to stimulate the States in appropriating more of their own funds for water pollution control activities. In fiscal year 1956, the year before the grants program began, the States appropriated a total of $4.2 million. In fiscal year 1960, State appropriations approach $7.6 million, an increase of close to 80 percent after 4 years of the grant program.

As a result of increased State appropriations, and with the assistance of the Federal grants, State water pollution control agencies have been able to achieve significant program expansion and improvement. The employment of needed technical and allied personnel has increased by nearly 50 percent. The States have been able to initiate or expand pollution surveys, research, basic data

collection, and more aggressive enforcement of State laws. Grants have made it possible to purchase major items of field and laboratory equipment needed in support of expanded programs.

The primary responsibility for control of water pollution rests with the States. State programs must continue to expand and improve if the increasing number and complexity of pollution problems resulting from population and industrial growth, and a changing technology, are to be controlled. The statutory expiration date for Federal program grants is fiscal year 1961. If these grants are allowed to terminate, State water pollution control programs will be seriously affected at a time when they need to be further expanded.

Because the Federal grants have demonstrated their effectiveness in stimulating expanded and improved State water pollution control programs, and because such grants are needed to support much further expansion and improvement to meet growing problems, the executive board of the Conference of State Sanitary Engineers, in session on February 2, 1960, recommends that the Water Pollution Control Program Grants authorization in Public Law 660 be extended beyond the expiration date of 1961 and that the appropriation authorization be increased to $5 million annually.

---

STATEMENT OF POSITION OF EXECUTIVE BOARD, CONFERENCE OF STATE SANITARY ENGINEERS, RELATING TO APPROPRIATIONS FOR FEDERAL GRANTS FOR CONSTRUCTION OF MUNICIPAL SEWAGE TREATMENT WORKS

Federal grants to municipalities have proven to be a decided stimulant to the construction of needed sewage treatment works. In contrast to the 5-year pre-grant period of 1952–56 when sewage treatment construction averaged $222 million annually, construction levels since the grant program began have exceeded $350 million each year and the $389 million achieved in 1958 is the highest on record. The level of construction of projects not participating in the grant program has continued at about the 1952–56 level, showing that grants have not been a deterrent to communities proceeding on their own initiative, and that the increase in contract awards since 1956 has been stimulated principally by the availability of Federal construction grants.

The Nation's present and future water supply needs actually require construction of municipal sewage treatment facilities at a $600 million annual level, substantially higher than the $363 million average stimulated by the grants, and nearly 3 times the level of non-grant-supported construction. Any reduction in Federal construction grant funds now would seriously retard municipal sewage treatment facilities construction at a time when real progress is being made, when the need for clean water is becoming more and more critical, and when public support for pollution control is in the ascendency.

Therefore, the executive board of the Conference of State Sanitary Engineers, in session on February 2, 1960, expresses its emphatic support for the appropriation for fiscal year 1961 of the full authorization for construction grants under Public Law 660, and urges the Congress to increase the appropriation for waste treatment construction grants from $20 million to $50 million for fiscal year 1961.

---

STATEMENT OF POSITION OF EXECUTIVE BOARD, CONFERENCE OF STATE SANITARY ENGINEERS, RELATING TO PROPOSED INCREASES IN FISCAL YEAR 1961 BUDGET FOR DIRECT WATER POLLUTION CONTROL OPERATIONS BY THE PUBLIC HEALTH SERVICE

After the Federal Water Pollution Control Act was enacted in 1956, a supplemental appropriation of $2.2 million was provided to initiate the broadened and strengthened Federal program of direct operations authorized in the act. This amount was not sufficient to initiate all of the responsibilities assigned to the Public Health Service, and most of those which were gotten underway could be done so only partially.

There have been no increases in appropriations for any substantive program expansion since passage of the act. Therefore, the proposed increase of $2.2 million in the fiscal year 1962 budget marks the first time since the act passed 4 years ago that an increase for direct operations has been included in the budgeting which will provide for program expasnion.

52692—60——26

The executive board of the Conference of State Sanitary Engineers, in session on February 2, 1960, urges the appropriation of at least a $2.2 million increase for direct operations in water pollution control activities for the Public Health Service in the fiscal year 1961.

---

I should like to take advantage of this opportunity to express to you our Maryland viewpoint on the matters which have been presented to you in these statements. As you know, Maryland is one of the heaviest producing States insofar as shellfish are concerned. The interstate certification program, operated by the Public Health Service, is not only essential to safeguarding the public health but involves at the same time, the economic well-being of a Maryland industry. The resources of the Public Health Service to administer this program with effectiveness and uniformity throughout the country is a highly desired objective. We believe that further budgetary support is necessary in order to accomplish this.

Recently, as a result of interstate cooperative studies coordinated by the Public Health Service, a new bacteriological market standard for oysters has been developed. This was a substantial service not only to the administrating agencies but to the public as well. We recognize a need for a new standard as it relates to the bacteriological purity of the waters in which shellfish are produced. With further research resources, the Public Health Service might be able to undertake work on this standard. The program objectives and the need for research leading to more effective standards applies in the area of milk sanitation and food sanitation as well. I shall not go into detail on this other than to say that we perceive every day new need for equipment standards as they involve the processing of milk and the freezing, packaging, and vending of many different types of foods. The Public Health Service can be of material assistance in working out these standards if the financial resources to do the work are provided.

With regard to the water pollution control program, Maryland communities have benefited greatly by the construction grant funds for construction of sewage treatment plants. We believe that in Maryland we have measured up in full to the State and local responsibilities for construction of such works because of the supplemental matching program which has been established. By action of the Maryland General Assembly and operated for the last 3 years, Maryland grant funds have been provided which will supplement Federal grants up to 40 percent of the cost of the sewage treatment works or appurtenances or $500,000, whichever amount was less. Our general assembly has, in its session just concluded, increased the State grant to a total of 50 percent of the total cost or $500,000, whichever was the less. Our department of health, in administering this program, intends to work out the grant arrangement so that of the total cost 50 percent will be borne by the community, 25 percent by the State and 25 percent through the Federal grant funds. We would commend this arrangement to you for consideration as a logical basis for pursuing the Federal water pollution control program in the future.

I should like to mention to you also that a move is underway in Maryland coordinated by our State planning department to organize a comprehensive water quality management and pollution control study of the Chesapeake Bay located within the limits of our State. This body of water not only provides deep-water navigation into the center of the State but it is an important source of seafood and provides the base for extensive recreational activities. The bay also must serve as the ultimate receiver for the waste water of our cities and industries. With our rapid increase in population the problem of maintaining the quality of the waters of the bay is assuming greater importance. We have asked the Public Health Service to collaborate with us in organizing such a study and, if possible, assuming responsibility for carrying out many of the highly technical phases required to produce the answers needed. We understand that if water pollution research and direct service funds of the Public Health Service are increased they will be in a position to aid us effectively in the study of important national water resources.

I appreciate very much the opportunity to appear before you on behalf of the Conference of State Sanitary Engineers and trust that these additional remarks may be of interest to you as you study the fiscal needs of the Public Health Service.

WITNESSES

**MILTON P. ADAMS, EXECUTIVE SECRETARY, MICHIGAN WATER RESOURCES COMMISSION, LANSING, MICH., AND CHAIRMAN, STEERING COMMITTEE OF THE STATE AND INTERSTATE WATER POLLUTION CONTROL ADMINISTRATORS**

Mr. Fogarty. Mr. Adams, we will be pleased to hear from you now.

Mr. Adams. Mr. Chairman and members of the subcommittee, I have a copy of my statement to which is attached three exhibits.

Let me say that I appear again as secretary of the Michigan Water Resources Commission and also as recently elected chairman of the so-called steering committee of the State and Interstate Water Pollution Control Administrators.

My statement is prepared. Part of it makes a comparison with certain recommendations contained in the President's veto message of last week relative to H.R. 3610.

Mr. Fogarty. What did you think of that veto?

Mr. Adams. Well, it was a disappointment to us. We had written the President on February 12 hoping that he would permit it to become law. This was not only our Michigan opinion but that of the States represented in the Chicago Conference on January 26 and January 27.

Mr. Fogarty. The majority of the House thought so, too, that it should become law.

Mr. Adams. Yes. In my slide rule I figured out you mustered 61.5 percent vote to override, and most public bodies that vote bonds, if you get a three-fifths vote, that is wonderful.

However, 66⅔ is pretty high. May I read a couple paragraphs dealing with that?

Mr. Fogarty. Surely.

Mr. Adams. Mr. Chairman, my statement before your subcommittee on April 13, 1959, with exhibits I, II, III (pp. 16–26 inclusive of last year's record) are pertinent today for the most part. I am here again, representing such interests as my Commission has in the appropriations you have under consideration. Last year I also reported as a member of the Federal Water Pollution Control Advisory Board and on the result of my canvass of sentiment of the State and Interstate Water Pollution Control Administrators on certain pending issues.

The second conference of these administrators was held in Chicago on January 26–27, 1960; 33 States and 5 of the 7 interstate agencies were represented. My report here today is on the actions taken at the Chicago conference. Our work as State administrators is closely related to that of the Water Supply and Water Pollution Control Division of the Public Health Service. Federal appropriations for support of this national effort, including that for waste treatment construction grants have an immediate effect on programs of all the States and interstate agencies.

I also appear as the result of the January conference action naming me the new chairman of its so-called steering committee. Other members of the committee are vice chairman David F. Smallhorst, director, division of water pollution control, State department of health at Austin, Tex.; Earle C. Hubbard, director, division of stream

sanitation and hydrology, water resources commission at Raleigh, N.C.; Joseph C. Knox, secretary of the New England Interstate Water Pollution Control Commission at Boston, Mass.; and Curtiss M. Everts, secretary and chief engineer, State sanitary authority at Portland, Oreg., the retiring chairman of this group.

The conclusions and recommendations of our group consist of some 10 conclusions and 24 recommendations. They will be found within the 6½ page record designated as my exhibit I. Reference will be made to numbered conclusions from this record in the course of my statement.

Last week's action by the President in vetoing the conference-approved form of H.R. 3610 and the unsuccessful attempt in the House of Representatives last Thursday to override the veto, would seem to dispose of our conference recommenadation No. 1. It was the considered opinion of the conference that the maximum grant should be doubled and appropriate changes made in the total program authorization. Other important matters demonstrated by the past 4 years' experience with section 6 of Public Law 660, called for an amendment to authorize the Surgeon General to rescind unused grant funds after a certain period, and reallot such sums to other States where the funds were needed. A second amendment would have provided more adequate consideration of the financial needs of multi-municipal projects. While nothing is to be gained by further belaboring this issue which is apparently settled for this session, I would be less than frank if I failed to point out from the record of my own State the inadequacy of the total amount provided for construction grants. This is shown in last year's exhibit I in the "Summary of Applications and Recipients of Federal Grants Under Public Law 660, July 31, 1956, to June 30, 1959." I bring with me this year the record of allotments to municipalities of the first 4 years of the program. These construction grant funds have in general accommodated only about one-third of the applicants, both in number and amount of requests. May I further point out the very significant experience in Michigan which you will note appears in the footnotes at the bottom of my first page of this four-page exhibit—a marked departure from the national average in this program to date. Whereas Elsewhere about 6 local dollars are joined with every Federal dollar in construction work which is advancing pollution abatement, the Michigan record shows between 9 and 10 local dollars are being expended with every Federal dollar in the advancement of water-pollution control. Grant funds amounting to $5,573,675 allocated to date are responsible for 51 projects, constructed or assured, at a cost of over $50 million. This four-page summary from Michigan is our 1960 exhibit II.

I now pass to recommendation No. 2 in the January administrators' conference record. Federal appropriation for municipal construction grants for fiscal year 1961 is sought up "to the maximum authorized by law." Our conference recommendation would seem to raise a second and as yet unresolved issue with the administration. Twenty million dollars for grants is recommended at the White House for fiscal year 1961 in comparison with past annual appropriation of $45 million or more, which have been made available during the past 4 years. Section 6 of Public Law 660 calls for a 10-year authorization totaling $500 million for the Nation, an average of $50 million

per year. Members of our conference as well as my commission, are strongly opposed to the cut proposed. You may recall a similar proposal was made a year ago coupled with permission to levy a State excise tax on telephone service for those States desiring to continue sewage disposal construction and vocational education grants.

When the decision was made by the administration to have Public Law 660 signed into law back in 1956, including its controversial section 6 on grants, we felt this was a Federal commitment upon which the States and interstate agencies could rely—at least for the 10-year period. The record of grant-inspired increase of municipal progress is incontrovertible. To reduce now the previously authorized appropriations for construction grants may well provide excuses for inaction, all of us, including the President, desire to avoid. We know in Michigan of many projects which would not have gone forward had it not been for the grants your appropriations have made available.

We respectfully and urgently request therefore, both for our State and others that this recommendation of the administration be ignored as was done last year. We recommend not less than the $45 million in funds with authority to allocate again on a $50 million basis for fiscal 1961.

Our recommendation No. 3 calls for the extension of section 5, Public Law 660 with a recommended increase in the annual appropriations. Strangely enough the third recommendation to Congress as to appropriate Federal-State relations in the President's veto message on H.R. 3610 calls "for continuation of the modest financial assistance (our conferees say the present amount is too modest) for the administration of control programs by State and interstate agencies." Extension of this program is apparently fully justified by the President as one examines the veto message.

Recommendation No. 4 is a national conference on water pollution control. Here again we do not know who thought of this first. It seems clear to us, however, that our conclusion No. 4 on a national conference on water pollution control may have been "dressed up" for the President. It is held out as his No. 1 step in the veto message to "help local taxpayers and business concerns to realize the obligation they have to help prevent pollution."

Recommendation No. 5: Conference conclusions with respect to H.R. 8494 was to oppose one portion of this bill but go along with other possible amendments. The ability of the States to carry their share of enforcement duty will stand or fall depending on how section 8 of Public Law 660 is amended. We do not know whether the Dingell bill, H.R. 8494, is in accordance with what the President has in mind as step No. 2 of his message calling for "strengthening the enforcement provisions of the Federal Water Pollution Control Act."

The President's fourth and last step, calling for greater Federal research and technical assistance, will be found to come close to our conference recommendation No. 7 on the same subject.

Recognizing that your appropriations in behalf of the Division of Water Supply and Water Pollution Control will have much to do with determining not only their ability to function effectively but certain progress within the States as well, may I spend the next few minutes in discussing figures I sought and obtained from the Chief of that Division shortly after the first of this year? Mr. McCallum's letter

contains presumably the official figures for the fiscal year 1960 appropriation and the proposed fiscal year 1961 budget. His answer was received by me on February 5, 1960.

It was most gratifying to note and I have so informed Dr. Flemming of our appreciation of the administration's request for the increased support of this work in the approximate amount of $2 million; divided as follows:

| Item: | *Budgeted increase* |
|---|---|
| Research | $512, 200 |
| Basic data collection and analysis | 257, 100 |
| Comprehensive water pollution control program development | 528, 900 |
| Enforcement of interstate pollution control | 505, 600 |
| Colorado River study | 313, 700 |

I find the following statements relative to each item of increase which are convincing to me as I hope they will be to you and members of the committee.

RESEARCH

The major portion of the increase is to be used to initiate the "ultracleansing" project for developing entirely new processes for separating contaminants from municipal wastes. The first phases of the project will be devoted to evaluation of chemical, physical, and biological processes which may be adaptable to sewage treatment and to the basic research required to make such adaptations.

The remainder of the increase will be used to strengthen the effort in current research projects now underway involving more efficient waste treatment by present methods, characteristics of important new industrial wastes, detection of wastes in receiving streams, origin of wastes, waste disposal into tidal waters and ground formations, and engineering studies preliminary to developing plans for controlled environment facilities which will permit the conduct of more research more efficiently than is accomplished by field studies.

BASIC DATA

The increase is to be used for expansion of the national water quality network from its present 60 sampling stations to 120 stations and for supplementing the necessary laboratory and processing services required by this expansion. The minimum number of sampling stations considered necessary to provide effective intelligence on pollution conditions and trends in interstate waters is 300.

COMPREHENSIVE PROGRAM DEVELOPMENT

The increase of $528,900 for this activity will be directed into comprehensive water pollution control planning in the river basins where the most extensive Federal planning for water resources development projects is in progress. The river basins in which this need is most urgent are—

1. The Columbia River Basin, for which the Corps of Engineers recently has completed a water resource development report, and where there is an increasing demand to integrate all the aspects of water management in a way that will both conserve natural resources and meet the increasing needs of a rapidly growing area;

2. The lower Missouri River Basin, including the Kansas and Osage tributaries, which is rapidly industrializing and where an extensive program for water control is developing and there is need for intensive consideration of all water needs in order to plan adequate quality control;

3. The lower Arkansas and Red River Basins, where there will be coordination of, and benefit from, the current Public Health Service Arkansas-Red River water conservation project; and

4. The several basins in the Middle Atlantic States where reservoir projects are under active study by the Corps of Engineers. These projects affect the water supply and pollution control in a heavily industrialized and populated area

INTERSTATE ENFORCEMENT

The increase of $505,600 for enforcement activities will be used to initiate enforcement actions in the New England, Middle Atlantic, and Southeast regions. Enforcement programs in the Missouri and Mississippi Basins will be expanded. Plans anticipate completing 200 preliminary surveys of interstate pollution areas, the holding of 10 conferences and 6 hearings, participation in any necessary court actions, and compliance with increasing obligations for surveillance of interstate pollution situations following enforcement actions.

COLORADO RIVER STUDY

Following the Animas River conference on interstate water pollution by wastes from radioactive ore processing, serious public concern was expressed in the Colorado River Basin over such pollution in waters of this basin. Concern was expressed over the continued radioactive pollution of streams by ore processing wastes and toxic chemicals, the effects of radioactive materials already deposited in streambeds, and the safety of ground waters subject to radioactive pollution.

A thorough investigation of water pollution by uranium, radium, and thorium mills was planned for the Colorado River Basin and for the first phases of which $88,000 has been requested as a supplement to the fiscal year 1960 appropriation. In fiscal year 1961, the radioactive waste studies will become a part of the comprehensive Colorado River study.

At the January 13 conference on interstate pollution of the Colorado River, the conferees recommended that the Public Health Service plan and undertake in cooperation with the State water pollution control agencies concerned, a comprehensive investigation and study of the interstate water pollution problems and their specific causes and methods for securing the best possible water quality for multiple water use, including all legitimate purposes. The initial stages of the study are to be directed toward determining the most critical and pressing problems in order that data needed to secure remedial action on such problems will have highest priority. It is estimated that this comprehensive study will require several years for completion.

The increase of $313,700 in the budget items for control of pollution from processing of radioactive ores shown in the attached table is to be used to initiate the first stages of the comprehensive Colorado River study in fiscal year 1961 and the budget item will be changed accordingly in the future.

It has taken a long time, gentlemen, for this agency to get up to speed to take care of the several activities under Public Law 660. I believe Mrs. Hobby testified back in 1955 to the extent that her estimate was $4 million for the additional activities for this agency under old Senate bill 890. This was before the section 6 on construction grants had been added by way of the Blatnik bill. Frankly, I do not know how so much has been accomplished with the limited funds available. Your appropriation last year, so far as we can find it to exist, was just under $4 million. The $2 million increase for fiscal year 1961 is fully justified. Being recommended also by the administration, as I understand it is, should this not have quick approval of this committee?

In closing, may I repeat a request made by some conservation witnesses last year? They pointed out how difficult it was to find out how much was actually being spent on water pollution control. If it is possible in framing the budget to get all of these items together, including that of construction grants for waste treatment works, it would seem to be a step in the right direction both for information of the public as well as Members of Congress.

Finally, I would leave for your record my exhibit III. This lists within Michigan our anticipated pollution control needs for the next 5 years. Included are 85 projects. The estimated cost for 73 of them stands at $88,765,250. Continuation of the construction grant allotments at not less than the present amounts for the next 5 years is

likely to spell the difference between winning or losing this rate of accomplishment.

Thank you for the privilege of again appearing before your committee.

Mr. FOGARTY. Thank you very much, Mr. Adams. That is a very fine statement.

Mr. ADAMS. I am sorry Mr. Cederberg is not here—the Michigan member of this subcommittee.

Mr. Cederberg and I have had a few differences, as you may know, but back 10 years ago Mr. Cederberg was mayor of the city of Bay City. His committee, headed by a Mr. White, called on Governor Williams and me to see if there was not some way that the old public law of 1948 could be implemented by appropriations. Governor Williams was asked to come down here for that purpose to see if money could be made available to help Bay City.

Now Bay City raised its own; they have a fine plant; and we wish this Congressman could see his way clear to go along with this program.

Mr. FOGARTY. Thank you very much.

We will include the attachments to your statement in the record at this point.

(The material referred to follows:)

CONFERENCE OF STATE AND INTERSTATE WATER POLLUTION CONTROL ADMINISTRATORS, CHICAGO, ILL., JANUARY 26–27, 1960

CONCLUSIONS AND RECOMMENDATIONS

*Federal legislation*

1. H.R. 3610: The conference went on record in recommending that the amount of maximum grant be increased from $250,000 to $500,000 and that the annual appropriation be increased to $100 million and with the total authorization for appropriations under the act be increased to $1 billion.

The conference went on record as favoring Senate version of section 6 in that sums allotted to States which are not obligated within 6 months following the end of the fiscal year for which they were allotted, such funds be reallocated.

2. Appropriations for fiscal year 1961: Conference recommended that the appropriation for construction grants for fiscal year 1961 be the maximum that is authorized by law.

3. Extension of section 5, Public Law 660: The conference recommends the extension of section 5, Public Law 660, and an increase in the appropriation under the section from $3 million to $5 million, and that the program grants be administered under the same techniques as the administration of other Public Health Service grant funds.

4. National Conference on Water Pollution Control: It was the consensus of the conference that as an aid to State programs we should seriously consider such a conference. Two things would be of paramount importance in considering such a conference. They are (1) adequate financing, and (2) meticulous planning.

5. H.R. 8494: Conference was opposed to broadening the scope of the act to include all navigable waters. It was not opposed to some broadening of the act to cover those situations where pollution abatement is not being effected.

6. House Joint Resolution 522: The conference concurred in the items contained in House Joint Resolution 522 and recommends that adequate appropriations be made to permit implementation of the studies proposed.

*State-Federal relations on research, special studies, and investigations*

7. The conference recommends that increased appropriations should be made to the U.S. Public Health Service to support research and special studies related to water pollution control to meet the increasing demands for answers to the many complex problems which are existent in this field. More assistance should be given to States in the form of advice and guidance in solving many pollutional problems. This is urgently needed and can only be developed and given when supported by research and special studies carried on in a much more intense form than has prevailed in the past.

The U.S. Public Health Service is the logical agency to carry on an adequate program of research and special studies in the water pollution field as the basis for assisting State and interstate water pollution control agencies in the administration of State and interstate pollution control progress. Accordingly, adequate funds for the purpose should be made to the U.S. Public Health Service to enable it to discharge its responsibility in this research and special studies field.

It is recommended that the present level of expenditures for research and special studies in the water pollution control field be tripled next year to a level of approximately $2 million and that it be increased thereafter as the needs warrant.

8. It is recommended that the Public Health Service set up necessary machinery within its organization to provide for more prompt printing and distribution of technical reports. It is also recommended the Public Health Service establish necessary organization to serve as a clearinghouse for all technical information in the water pollution control field with full distribution to all States and associated organizations.

Distribution to the field of the summary of research presently underway should be continued.

9. It is concluded that there are many areas needing research and it is recommended the executive committee of the conference appoint a research committee to work with the PHS to develop mechanics whereby research and special studies needs may be made known to research organizations.

10. State and interstate water pollution control agencies have a definite responsibility and need for carrying on applied research in relation to many specific water pollution problems. Accordingly, strong efforts should be made to provide in addition to regulatory funds, reasonable sums in the budgets for these State and interstate agencies to enable them to engage in such research work. It is suggested that all agencies interested in water pollution control do what they can to impress on the various State governments the need for provision in the budgets of State and interstate agencies reasonable sums of moneys to enable them to carry on much needed research of an applied nature and related to the solution of specific problems. In connection with this matter it is also recommended that consideration be given to a Federal-aid program to support research and special studies related to specific pollutional problems to be carried on by State and interstate agencies under a matching fund arrangement.

11. This conference recognizes the fact that the necessity of water reuse, water supplementation, and water conservation is current in some areas of the Nation and foresees numerous complex problems involving water quality presented by such practices. It is recommended, therefore, that water pollution control agencies consider water conservation and water supplementation programs as legitimate areas of official interest and encourage necessary research and studies in this field.

*Role of State, interstate, and Federal water pollution control agencies in enforcement activity*

12. The conference made the following conclusions:

A. That the States have primary responsibility in pollution control and while substantial accomplishments have and are being made, some present State laws may be inadequate with respect to enforcement.

B. Where interstate compacts are in operation, they have proven to be an effective mechanism in the coordination and promotion of regional programs.

C. That the Federal Government under Public Law 660 has an important role with respect to the enforcement of interstate water pollution control, and that it has proven to be an effective element in the progress of the overall program.

D. That Federal Government authority in relation to enforcement should be exercised only after the other enforcement procedures have failed, and then only in cooperation with the States concerned.

13. The following recommendations were made by the conference:

A. That States examine their laws, rules, regulations, and administrative procedures with a view toward further improving their program.

B. That States take full advantage of aids available through the Federal Government as a further means of expediting their programs.

*Relationship of water pollution control to overall programs for water resource management, including the relationship of water pollution control administrators to the Interstate Conference on Water Problems*

14. Inasmuch as water quality and water pollution control are important aspects of water resource management, it is recommended that the water pollution control administrators become more prominently identified with the Interstate Conference on Water Problems.

*Recruitment, training, and compensation of personnel, including advance training for administrative personnel*

15. Compensation schedules in most States are quite unrealistic. They need revision upward in order to maintain a high level of professional and management competency in the increasingly complex field of water pollution control programs.

*Basic data programs and performance standards*

16. Correlation of the collection and evaluation of information:

A. From State, interstate, and Federal basic data programs:

1. This conference recognizes that comprehensive water quality basic data is essential to the operation of State and interstate water pollution control programs and recommends that:

(*a*) Water quality basic data networks be developed and extended by State and interstate agencies.

(*b*) Municipalities and industries be encouraged to collect basic data on streams both above and below waste discharges as a part of their responsibility in the overall water quality control program.

(*c*) State and interstate control agencies consider the development or expansion of split sampling procedures using municipal and industrial laboratories for analyses as well as their own.

(*d*) Data be processed in a uniform manner by State, interstate, and Federal agencies to permit more effective use of the information available.

2. This conference endorses the operation of the national water quality network and recommends its expansion in accordance with current plans, cooperating with State and interstate agencies.

3. This conference recommends that there be continued coordination of the activities of the U.S. Geological Survey, the U.S. Public Health Service and other Federal agencies engaged in water quality basic data survey work.

4. This conference recognizes that the lack of adequate manpower and facilities has caused the collection and analyses of samples collected in water quality survey programs to become a problem in some areas, and recommends that a program of research and development for instrumentation and automation for all conditions of climate and streamflow be undertaken not only to extend present manpower but to enable agencies to carry on a more adequate and comprehensive program. U.S. Public Health Service assistance for service and development programs would be of benefit.

B. Operation and performance of waste treatment facilities:

Operation and consequent proper performance of waste treatment facilities have not always kept pace with progress in construction of such waste treatment facilities.

This conference recommends that water pollution control agencies exert all possible effort to develop properly qualified operators, and urge owners of waste treatment facilities to employ only competent, adequately compensated personnel.

*Development of criteria for measuring progress or lack of progress in pollution control programs*

17. The following conclusions were reached:

A. That we know of no universal parameters which have been used for this purpose and which can be properly applied to measure progress in pollution control. It is the opinion of this conference that there is sufficient need for such a parameter to justify continued and extensive exploration of the subject.

B. Parameters which have been used by individual States and groups of States with the same general stream pollution conditions have merit and deserve consideration for specific areas.

C. Until better parameters are developed it is recommended that professional evaluation by the respective State water pollution control administrators be utilized to measure progress in water pollution control.

D. The conference recommends that the PHS be requested to develop suggested criteria for measuring progress of pollution control programs and report to the next conference of water pollution control administrators.

## Exhibit II

### State of Michigan, Water Resources Commission

*Federal grant projects, fiscal 1960*

| Applicant | Amount of grant | Total project cost |
|---|---|---|
| 1. Detroit (interceptor) | $250,000 | $1,440,000 |
| 2. Woodland | 36,020 | 140,768 |
| 3. Oakland County Department of Public Works | 250,000 | 6,900,000 |
| 4. New Baltimore | 219,600 | 1,465,000 |
| 5. Cheboygan | 4,545 | 15,150 |
| 6. Battle Creek | 250,000 | 3,500,000 |
| 7. Detroit (S.T.P. expansion) | 250,000 | 7,162,000 |
| 8. Paw Paw | 106,200 | 354,000 |
| Total | 1,366,365 | 20,976,918 |

*Summary*

| | Grant funds allotted to Michigan | Grant funds allocated | Number of projects | Total cost of projects |
|---|---|---|---|---|
| Fiscal 1957 | $1,389,675 | $1,258,168 | 13 | $5,630,733 |
| Fiscal 1958 | 1,386,275 | 1,447,017 | 17 | 7,013,752 |
| Fiscal 1959 | 1,394,550 | 1,389,810 | 14 | 20,539,113 |
| Fiscal 1960 | 1,403,175 | 1,366,365 | 8 | 20,976,918 |
| Total | 5,573,675 | 5,461,360 | 52 | 54,160,516 |

*Federal grant projects, fiscal 1959*

| Applicant | Amount of grant | Total project cost |
|---|---|---|
| 1. Munising | $129,240 | $700,000 |
| 2. East China Township | 22,587 | 96,956 |
| 3. Warren | 97,710 | 8,380,465 |
| 4. Grant | 30,660 | 210,000 |
| 5. Detroit | 250,000 | 1,439,000 |
| 6. Howell | 97,500 | 325,000 |
| 7. Escanaba | 58,200 | 272,000 |
| 8. Sault Ste. Marie | 250,000 | 1,500,000 |
| 9. Fremont | 58,500 | 195,000 |
| 10. Milk River Drainage District | 146,616 | 6,319,000 |
| 11. Iron Mountain-Kingsford | 135,600 | 462,000 |
| 12. Tawas City | 36,420 | 121,400 |
| 13. Alma | 51,810 | 172,700 |
| 14. South Lyon | 24,967 | 345,592 |
| Total | 1,389,810 | 20,539,113 |

*Federal grant projects, fiscal 1958*

| Applicant | Amount of grant | Total project cost |
|---|---|---|
| 1. Almont | $43,056 | $158,856 |
| 2. Mount Pleasant | 131,792 | 890,000 |
| 3. Saugatuck | 32,217 | 142,217 |
| 4. Evart | 20,789 | 120,789 |
| 5. Imlay City | 92,238 | 321,539 |
| 6. Chesaning | 55,456 | 670,000 |
| 7. Brighton | 66,432 | 221,442 |
| 8. Stambaugh | 58,047 | 213,946 |
| 9. Fowler | 10,800 | 36,000 |
| 10. Bronson | 64,988 | 603,474 |
| 11. Iron River | 58,940 | 220,301 |
| 12. Manistique | 209,420 | 927,640 |
| 13. Traverse City | 143,531 | 555,340 |
| 14. Coloma | 29,541 | 216,220 |
| 15. Dearborn | 90,000 | 340,000 |
| 16. Mason | [1] 89,770 | 460,810 |
| 17. Muskegon | 250,000 | 915,178 |
| Total | 1,447,017 | 7,013,752 |

[1] Residual grant.

*Federal grant projects, fiscal 1957*

| Applicant | Amount of grant | Total project cost |
|---|---|---|
| 1. Corunna | $49,604 | $438,205 |
| 2. St. Clair | 157,159 | 684,000 |
| 3. Roscommon | 38,505 | 235,000 |
| 4. Dundee | 105,649 | 409,270 |
| 5. Elberta | 25,200 | 87,105 |
| 6. L'Anse | 73,655 | 277,789 |
| 7. Marlette | 87,600 | 415,000 |
| 8. Lapeer | [1] 82,223 | 727,147 |
| 9. Flushing | 126,333 | 444,695 |
| 10. Ontonagon | 78,631 | 364,371 |
| 11. Grand Rapids | 149,703 | 516,045 |
| 12. Portland | 95,206 | 352,406 |
| 13. Ironwood | 188,700 | 679,700 |
| Total | 1,258,168 | 5,630,733 |

[1] Residual grant.

## Exhibit III

### Michigan Water Resources Commission

*Tentative Estimate of needed water pollution control projects, 1960–65—Compiled Jan. 19, 1960*

| Location | Project required | Estimated cost |
|---|---|---|
| 1. Algonac | New plant; interceptor | $264,000 |
| 2. Allegan | Improvements | (1) |
| 3. Ann Arbor | Enlargement | (1) |
| 4. Belding | New plant; interceptor | 443,000 |
| 5. Belleville | Plant replacement | 172,000 |
| 6. Bridgeport Township | New plant | 505,000 |
| 7. Bridgman | do | 97,000 |
| 8. Buchanan | Enlargement | 225,000 |
| 9. Cadillac | Plant replacement | 685,000 |
| 10. Capac | New plant; interceptor | 333,000 |
| 11. Cedar Springs | Plant replacement | 140,000 |
| 12. Center Line | New plant | 573,200 |
| 13. Centreville | do | 88,000 |
| 14. Charlevoix | Improvements | 57,000 |
| 15. Chelsea | Enlargement | 233,000 |
| 16. Columbiaville | New plant | 80,000 |
| 17. Concord | do | 40,000 |
| 18. Crystals Falls | do | 231,000 |

See footnotes at end of table, p. 411.

*Tentative estimate of needed water pollution control projects, 1960–65—Compiled Jan. 19, 1960*—Continued

| Location | Project required | Estimated cost |
|---|---|---|
| 19. Dearborn (West Side) | Replacement | $500,000 |
| 20. Decatur | New plant | 166,000 |
| 21. Delhi Township | do | 288,000 |
| 22. Detroit | Additions and enlargement | 7,162,000 |
| 23. DeWitt | New plant | 82,000 |
| 24. Dowagiac | do | 300,000 |
| 25. East Lansing | Enlargement | [2] 2,500,000 |
| 26. Fenton | do | [1] |
| 27. Flint | do | [3] 10,000,000 |
| 28. Fowlerville | New plant | 150,000 |
| 29. Frankenmuth | Enlargement | [1] |
| 30. Genesee County | New plant | 8,500,000 |
| 31. Grandville | Replacement | 300,000 |
| 32. Greenville | do | 295,000 |
| 33. Grosse Ile Township | New plant; interceptors | 1,500,000 |
| 34. Grosse Pointe Park | Interceptor | 550,000 |
| 35. Hancock | New plant; interceptors | 522,000 |
| 36. Harrison Township | New plant | [1] |
| 37. Hart | New plant; interceptor | 217,000 |
| 38. Holland | Additions and enlargement | [1] |
| 39. Houghton | New plant; interceptors | 383,000 |
| 40. Ionia | New plant | 320,000 |
| 41. Ishpeming | New plant; interceptor | 450,000 |
| 42. Jackson | Enlargement, plant and interceptors | 936,000 |
| 43. Jonesville | New plant | 80,000 |
| 44. Kalamazoo | Interceptor | 250,000 |
| 45. Lansing | Enlargement | 2,500,000 |
| 46. Lathrup Village | Interceptor | 120,000 |
| 47. Lawton | Enlargement | 195,000 |
| 48. Linden | New plant | 261,000 |
| 49. Lowell | Replacement | 150,000 |
| 50. Mackinac Island | New plant | 150,000 |
| 51. Memphis | do | 222,000 |
| 52. Midland | Enlargement | [1] |
| 53. Montague | New plant | 80,000 |
| 54. Muskegon Heights | Enlargement | [1] |
| 55. Nashville | New plant | 75,000 |
| 56. Newberry | do | 140,000 |
| 57. Norway | do | 163,000 |
| 58. Ovid | do | 140,000 |
| 59. Paris Township | do | [1] |
| 60. Parma | do | 162,000 |
| 61. Paw Paw | Additions and enlargement | 354,000 |
| 62. Pentwater | Enlargement | [1] |
| 63. Perry | New Plant | 275,000 |
| 64. Pontiac | Enlargement | 3,050,000 |
| 65. Richmond | Addition and enlargement | 282,000 |
| 66. Rochester | Additions | 292,000 |
| 67. Rollin Township | New plant | [1] |
| 68. Romeo | Enlargement | 300,000 |
| 69. Roscommon Township | New plant | 200,000 |
| 70. Scottville | do | 75,000 |
| 71. South Macomb Sanitary District | Additions and enlargement | 1,000,000 |
| 72. Southeastern Oakland County sewage disposal system. | Interceptor | 4,145,000 |
| 73. Springfield | New plant; interceptor | 1,022,000 |
| 74. Stephenson | Enlargement | 87,000 |
| 75. Sturgis | Additions | [1] |
| 76. Union City | New plant | 100,000 |
| 77. Utica | Replacement | 313,000 |
| 78. Wakefield | New plant | 167,000 |
| 79. Wayland | do | 100,000 |
| 80. Wayne County | Additions, enlargement, and new interceptors | 31,280,000 |
| 81. Webberville | New plant | 60,000 |
| 82. White Pigeon | do | 100,000 |
| 83. Yale | do | 150,000 |
| 84. Ypsilanti | Additions | 903,000 |
| 85. Ypsilanti Township | Enlargement and new interceptor | 535,000 |
| Total of 73 project estimates | | 88,765,200 |

[1] No estimate currently available.
[2] Includes Meridian Township.
[3] Includes treatment for adjacent developed areas.

WITNESSES

HON. FRANK IKARD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS
ROY MATHIAS, EXECUTIVE VICE PRESIDENT, RED RIVER VALLEY ASSOCIATION
R. L. McKINNEY, JR., RED RIVER DEVELOPMENT COMMITTEE, DENISON CHAMBER OF COMMERCE, DENISON, TEX.
HAL ROLLINS, CITY ATTORNEY, DENISON, TEX.
JOHN W. HOLTON, REPRESENTING SPEAKER SAM RAYBURN
FRED PARKEY, GENERAL MANAGER, WICHITA COUNTY WATER CONTROL IMPROVEMENT DISTRICTS 1 AND 2, WICHITA FALLS, TEX.
ORAL JONES, PRESIDENT, WICHITA COUNTY WATER CONTROL IMPROVEMENT DISTRICT 1, WICHITA FALLS, TEX.

Mr. Fogarty. We are happy to have you with us, Congressman Ikard.

Mr. Ikard. I am Frank Ikard, representing the 13th District of Texas.

Mr. Fogarty. Please proceed, Mr. Ikard.

Mr. Ikard. My remarks will be very brief, Mr. Chairman.

First, we would like to thank the committee for your consideration and kindness last year regarding the appropriation of the water quality survey on the Red River. We are happy to note that there is $400,000 presently budgeted for this survey.

It is my understanding, from talking to the Speaker's office this morning, that Mr. McKinney is due to be with us, and Mr. Rollins, the city attorney of Denison, and John Holton, of the Speaker's office, already have filed their statements.

Mr. Fogarty. They appeared and testified.

Mr. Ikard. Here with me today is Mr. Roy Mathias, executive vice president of the Red River Valley Association, and Mr. Fred Parkey, general manager, Wichita County Water Control Improvement Districts 1 and 2, Wichita Falls, Tex.

He and Mr. Oral Jones, president of the Wichita County Water Control Improvement District 1, Wichita Falls, Tex., are very fine constituents of mine, and if I may, Mr. Chairman, they would like to have permission to file statements with the committee, and may we make a few brief remarks?

Mr. Fogarty. It is hard to refuse you. You are one of our most popular and valuable Members of Congress.

Mr. Ikard. Thank you very much.

I would like to introduce Mr. Roy Mathias.

STATEMENT OF MR. ROY MATHIAS

Mr. Mathias. I have no statement, Mr. Chairman. I just want to take one moment to explain a little something.

Last year we gave you a taste of the water. This year we took 8 ounces, and this is all natural pollution, from the Elm Fork River which is a tributary to the Red River and contributes about 300 tons of salt a day.

We took these 8 ounces of water and put it in both bottles and evaporated this one bottle, so there you see the salt content.

I thought your committee might be interested.

Mr. FOGARTY. That is a very good exhibit.

Mr. MATHIAS. It speaks for itself far better than I.

We do appreciate the courtesy that you extended us last year in approving our request and we hope you will retain this year's appropriation.

Mr. FOGARTY. It is difficult to turn down a man like Mr. Ikard and the Speaker of the House of Representatives.

Mr. MATHIAS. This is a very sorely needed study. We know you will treat us right.

Mr. FOGARTY. Thank you very much.

STATEMENT OF MR. FRED PARKEY

Mr. PARKEY. I would like to file this statement, Mr. Chairman. (The statement referred to follows:)

RED RIVER AUTHORITY OF TEXAS,
*Wichita Falls, Tex., March 2, 1960.*

The SUBCOMMITTEE OF HEALTH, EDUCATION, AND WELFARE,
*House of Representatives, Washington, D.C.*

GENTLEMEN: The Red River Authority of Texas is a political subdivision of the State of Texas comprising nearly all of the counties within the State of Texas situated in the Texas watershed of Red River and its Texas tributaries. The authority was created by the 56th Legislature of the State of Texas. The population of the authority will exceed one-half million people.

The authority has control of approximately 1,200,000 acre-feet of water which is runoff from the Texas tributaries to the Red.

The primary purpose of the authority is the preparation of a master plan for development of the Red River Basin. In the preparation of this plan for the development of the water resources of the authority, it is necessary to consider the great pollution problem involved, both from artificial as well as natural sources, and the control thereof.

Throughout the authority it has been conservatively estimated that natural pollution contributes 25 percent to the pollution of waters within the authority, while in the local area an excess of 50 percent of the water pollution is attributable to artificial sources.

In connection with artificial or manmade pollution, the authority has, by the exercise of its police powers, adopted rules and regulations calculated to control the same, carrying adequate penal provisions for the enforcement thereof. Various regulatory agencies of the State, as well as the U.S. Department of Health, Education, and Welfare, are cooperating with the authority.

The attitude of the authority is that it is not expected for the Government to bear the expense of the correction of the pollution problems in the Red River Basin alone, but that the people effected fully expect to bear the burden of a portion of this responsibility.

Assuredly, with cooperation of your Committee on Appropriations, the excellent work heretofore done by the U.S. Health, Education, and Welfare Department can be continued.

Very truly yours,

TOM FOLEY.

Mr. PARKEY. Mr. Jones will file another statement in behalf of Wichita Water Improvement Districts 1 and 2, Mr. Chairman.

The Red River Authority of Texas is a political subdivision of the State of Texas comprising nearly all the counties within the State of Texas situated in the watershed of the Red River and its Texas tributaries. The population of this authority is approximately one-half million people.

The authority has control of approximately 1,200,000 acre-feet of water which is runoff water from the Texas tributaries to the Red.

The primary purpose of the authority is the preparation of a master plan for the development of the Red River Basin. In the preparation of this plan for the development of the water resources of the authority, it is necessary to consider the great pollution problem involved both from artificial as well as natural sources and the control thereof.

Throughout the authority it has been conservatively estimated that natural pollution contributes 25 percent to the pollution of waters within the authority, while in the local area an excess of 50 percent of the water pollution is attributable to artificial sources.

This authority now has the power by law, and have drawn up rules to regulate the control of man-made pollution through the oil fields. This has been done.

We have accomplished very little unless we can control the natural pollution to go along with it.

We urge the full cooperation of your committee in an appropriation to help in this work and ask this appropriation be continued in the budget.

STATEMENT OF MR. ORAL JONES

Mr. Oral Jones. Mr. Chairman, our sole purpose is to present to you for your consideration this amount of $400,000. The main object of this survey was to find the source of this pollution. The Wichita Water Control Improvement District No. 1 in Wichita County Water Improvement District No. 2 has constructed two lakes impounding approximately 500,000 acre-feet of water.

This water now is unfit for human consumption because of the high chloride content. It would be possible for us to serve a city of 120,000 population if the water were potent. Its average total solids have ranged over the years approximately 2,000 parts per million. There is approximately 350 tons of salt that flows from natural springs into these lakes each day from natural pollution.

Our community has spent approximately $6 million on these lakes and other improvements for domestic water supply and yet find water unfit for human consumption.

We feel that the proper approach has been made in solving this pollution problem and urge that the appropriations be made this year.

May I file my statement at this point?

Mr. Fogarty. Yes.

(The statement referred to follows:)

Wichita Falls, Tex., *March 2, 1960.*

The Subcommittee of Health, Education and Welfare,
*House of Representatives,*
*Washington, D.C.*

Gentlemen: We would like to thank you for your cooperation in securing the appropriation of $400,000 for the U.S. Public Health Service to initiate an investigation of the pollution problem in the Arkansas-Red River Basins in cooperation with other Federal and State agencies.

The main object of this study was to find the source of pollution, determine the type and volume and to devise a practical means of controlling it. This survey is scheduled for completion in 1962. This area has sufficient quantities of water to supply its needs if the water was of good quality.

Wichita County Water Control and Improvement District No. 1 and Wichita County Water Improvement District No. 2 have constructed two lakes impounding approximately 500,000 acre-feet of water. This water is unfit for human

consumption because of the high chloride content. It would be possible for us to serve a city of 120,000 population if the water was potent. Its average total solids have ranged over the years approximately 2,000 parts per million. There is approximately 350 tons of salt that flows from natural springs into these lakes each day from natural pollution.

Our community has spent approximately $6 million on these lakes and other improvements for domestic water supply and yet find the water unfit for human consumption. We feel that the proper approach has been made in solving this pollution problem and urge that appropriations be made this year to continue these studies in order that natural pollution control will become a reality.

Very truly yours,

ORAL JONES.

## BUREAU OF LABOR-MANAGEMENT REPORTS

### WITNESSES

**THEODORE R. ISERMAN**
**HERBERT LIEBENSON, RESEARCH DIRECTOR**

Mr. FOGARTY. Mr. Iserman, are you ready to proceed?

Mr. ISERMAN. My name is Theodore R. Iserman. I am a member of the law firm of Kelley, Drye, Newhall & Maginnes, 70 Broadway, New York 4, N.Y. I appear here today on behalf of the National Small Business Men's Association. It is a member of an industry advisory council that the Secretary of Labor designated to consult with him and members of his staff concerning reports that employers must file with the newly created Bureau of Labor-Management Reports pursuant to section 203(a) of the Labor-Management Reporting and Disclosure Act of 1959. The members of the advisory council are American Retail Federation, Associated General Contractors, Association of American Railroads, National Association of Manufacturers and U.S. Chamber of Commerce. Our views are consistent with those that other members of the council have expressed in statements they filed with the Department of Labor.

Representatives of these organizations have conferred with the Secretary of Labor three times and jointly with representatives of the Secretary and the Bureau of the Budget once concerning employers' reports and the Secretary's proposed regulation concerning them and his proposed form of reports and instructions for filing them.

It is our firm view that the proposed regulation, reporting form, and instructions, in their most recently published versions, purport to require of employers reports on matters that the statute expressly exempts from the reporting requirements of section 203(a). The form and instructions are so prepared that they will elicit other reports Congress palpably did not intend to require. In consequence, we anticipate that the regulation, the form, and the instructions, if unchanged, will bring in hundreds of thousands, if not millions, of reports that the statute does not require and that will be useless and meaningless. By the same token, the Secretary's proposals would increase the cost to the Government of receiving, examining, classifying, filing, and warehousing the reports far beyond what the cost ought to be.

Mr. DENTON. I don't understand what we have to do with that.

Mr. ISERMAN. They are asking for an appropriation of $5 million to cover expenses of the Labor-Management Reporting Bureau. We are appearing in opposition to that in view of the fact they are asking

for their requirement, reports that the statute says employers do not have to file.

If the proposed appropriation is based on what they are asking as a way of report from employers, then the appropriation is grossly excessive.

Mr. DENTON. Your statement is that the employers do not have to file them, but unions do?

Mr. ISERMAN. No. Our position is that the statute requires certain reports of employers and it exempts certain other reports, but the Secretary's regulations require of employers reports that the statute expressly exempts.

For example, the first point on page 2 is that the statute expressly exempts noncoercive communications to their employees.

Section 405.6 of the proposed amendment discusses the relation of section 8(c) of the National Labor Relations Act, as amended, to section 203 of the 1959 act. It states that while nothing in section 203 shall be construed as amending or modifying the rights that section 8(c) of the National Labor Relations Act, as amended, protects—

> activities protected by [said section 8(c)] are not for that reason exempted from the reporting requirements of section 203(a) of [the Act] and No. 405.2 [of the regulations], and, if otherwise subject to such reporting requirements, are required to be reported if they have been engaged in during the course of the reporting fiscal year.

The foregoing construction of section 203(f) of the act conflicts (i) with the express language of the section and (ii) with its legislative history. It (iii) creates grave doubts as to the constitutionality of the section and (iv) is inconsistent with the well-settled rule that, when a statute imposes criminal sanctions, it must be strictly construed.

Section 8(c) of the National Labor Relations Act, as amended, provides as follows:

> (c) The expressing of any views, argument, or opinion, or the dissemination thereof, whether in written, printed, graphic, or visual form, shall not constitute or be evidence of an unfair labor practice under any of the provisions of this Act, if such expression contains no threat of reprisal or force or promise of benefit.

Section 203(f) of the Labor-Management Reporting and Disclosure Act provides as follows:

> (f) Nothing contained in this section shall be construed as an amendment to, or modification of the rights protected by, section 8(c) of the National Labor Relations Act, as amended.

Notwithstanding the provisions of section 203(f), the proposed regulation would require employers to report all expenses they incur (other than compensation to officers and employees in the regular performance of their duties) in publishing their views, arguments, and opinions, regardless of the lawfulness of what the employer has to say. Thus, if an employer buys space in a newspaper, buys radio or TV time, hires an advertising agency or public relations counselor to prepare a message to employees or pays a commercial printer to print the message, the regulation would require him to report on his agreement or arrangement with the third person and the amount of the employer's expenditures. This would be true regardless of the fact that the publication showed on its face that it was the employer's, and regardless, also, of the complete lawfulness, or even praiseworthiness, of what the employer said.

The proposed regulation would be needlessly onerous on all employers, and particularly so as to small employers who do not have facilities for preparing, printing, or distributing letters and bulletins to employees, house organs, and the like. It would call for a flood of reports that the statute clearly exempts.

1. The proposed regulation conflicts with the express language of section 203(f): The Department seems to read section 203(f) as though it said:

> Nothing contained in this section shall be construed as an amendment to, or modification of section 8(c) of, the National Labor Relations Act, as amended.

This is not what the statute says. It says:

> Nothing contained in this section shall be construed as an amendment to, *or modification of the rights protected by,* section 8(c) of the National Labor Relations Act, as amended. [Emphasis supplied.]

Thus, it is clear that this is not a mere assurance that section 203 does not amend or modify section 8(c) of the National Labor Relations Act, as amended. It is assurance that section 203 does not modify the rights protected by said section. Significantly, section 203(f) sets off the phrase "or modification of the rights protected by" in commas, making doubly clear that section 203 not only does not amend section 8(c) but that it does not modify the rights that section protects.

If an employer can exercise those rights only if he reports such exercise or runs the risk of fine and imprisonment if he does not report the same, clearly the right is modified. In view of the explicit provision that the section does not modify them, the proposed regulation directly conflicts with the clear terms of the statute itself.

Giving section 203(f) the meaning that the proposed regulation gives it would deprive it of all meaning. Nothing in section 203 amends or modifies section 8(c) or could possibly be deemed to do so. Consequently, if that is what Congress intended, then, in adopting section 203(f), it did a useless, futile, and meaningless thing. Assuming that Congress did this flies in the face of all the rules of statutory construction. We must assume that section 203(f) had a purpose. The only discernible purpose is the obvious one, that it preserves intact the rights that said section 8(c) protects.

2. The proposed regulation conflicts with the legislative history of section 203(f): The legislative history of section 203(f) shows clearly that Congress deliberately and intentionally provided that section 203 should not "impair" the rights that section 8(c) of the National Labor Relations Act, as amended, protects.

The Senate, in adopting S. 1555, excepted from reporting requirements that apply to employers—

> expenditures incurred in connection with the publication by such employer in his own name, of a newspaper, newsletter, or similar house organ or other letter, communication, or advertisement.

When the House Committee on Education and Labor held hearings on S. 1555 and similar House bills, the principal objections to the foregoing exemption were that it was discriminatory and too narrow: (i) only large companies had their own facilities for publishing house organs and the like, and (ii) the clause would impair the right of free speech section 8(c) gives to all employers by requiring them to report expenditures to third persons for addressing arguments and opinions to

employees, even though the publications contained no threats or promises and were otherwise unexceptionable.

In reporting H.R. 8342, the House committee struck out the narrow Senate exemptions for newspapers, house organs, letters, and advertisements, and substituted a broader exemption, as follows:

> Nothing contained in this section shall be construed as an amendment to, modification of, or limitation upon the rights protected by section 8(c) of the National Labor Relations Act, as amended, nor shall any person be required to file a report with the Secretary in regard to any matter protected by section 8(c) of such Act.

The Landrum-Griffin bill, which the House adopted as a substitute for H.R. 8342, included this language verbatim.

In the conference the Senate abandoned the language of its narrow exemption (sec. 203 (a)(1)(ii), supra), and the bill emerged from conference in substantially the form of the House version, with two exceptions:

(i) It omitted the words, "nor shall any person be required to file a report with the Secretary in regard to any matter protected by section 8(c) of such act."

(ii) Significantly, it omitted the words, "or limitation upon" preceding the words, "the rights protected by section 8(c)," et cetera, and substituted therefor the phrase set off by commas, "or modification of the rights protected by, section 8(c)," et cetera.

The Department of Labor apparently relies on the above-mentioned changes for its interpretation of section 203(f). The Department thus assumes, contrary to any reasonable assumption and contrary to a well-known canon of statutory construction, that the conferees intended to impose greater restrictions on the right of employers to communicate with employees than either the House or Senate bill imposed. The Department cannot properly assume that the conferees intended to require reports that both bills expressly excluded. Conferees on the part of the House and Senate do not have authority to write new legislation. Their duty is to insist on the provisions of their respective bills and to recede only to the extent they must do so in order to agree on conflicting terms, not to reject terms that are in both bills. (Zinn, "How Our Laws Are Made," H. Doc. 152, 84th Cong., p. 19; *United States* v. *Poland*, 231 F. 810 (1916), reversed on other grounds in 251 U.S. 221 (1920).)

Clear evidence as to the intent of Congress appears in the conference report. Concerning section 203(f), this report says:

> Subsection (f) of section 203 makes it clear that this section does not impair the free speech that is described in section 8(c) of the National Labor Relations Act, as amended.

Here, again, it is important to note that the assurance is not that section 203 does not "impair" said section 8(c) itself. (No such assurance was necessary or meaningful.) The assurance is that section 203 does not "impair" the "free speech" that section 8(c) protects. This is fully consistent with the provision of section 203(f) that section 203 does not "modify" the rights that said section 8(c) protects. It is far more consistent with both the House and Senate bills than the Department of Labor's strained construction of the new law.

In view of the fact that section 203(f) expressly disclaims any amendment of section 8(c) or any "modification of the rights protected by," said section, the words, "or limitation upon" and the last clause

of relevant provision in the Landrum-Griffin bill became repetitious and unnecessary.

It is worth noting that sections 203 (c), (d), and (e) constitute a series of broad exemptions from the reporting requirements of section 203. Section 203(f) is another item in the series.

3. The proposed regulation raises grave doubts as to the constitutionality of section 203: In attempting to extend the reporting requirements of section 203 of the act broadly to virtually all expenditures by employers for exercising the right of free speech in communicating with their employees, the Department of Labor, as well as disregarding well-known canons of construction, disregards also the equally well-established principle that where there is ambiguity in a statute, it should be resolved so as to avoid any conflict with provisions of the Constitution of the United States. (*United States.* v. *CIO.*, 335 U.S. 106 at 120–1.)

Congress enacted section 8(c) of the National Labor Relations Act, itself, to protect constitutional rights in the way the National Labor Relations Board administered the Wagner Act. In explaining section 8(c), the Senate Labor Committee, where the language originated, said:

> Section 8(c): Another amendment to this section would insure both to employers and labor organizations full freedom to express their views to employees on labor matters, refrain from threats of violence, intimation of economic reprisal, or offers of benefit. The Supreme Court in *Thomas* v. *Collins* (323 U.S. 516) held, contrary to some earlier decisions of the Labor Board, that the Constitution guarantees freedom of speech on either side in labor controversies and approved the doctrine of the *American Tube Bending* case (134 F. (2d) 993). The Board has placed a limited construction upon these decisions by holding such speeches by employers to be coercive if the employer was found guilty of some other unfair labor practice, even though severable or unrelated (*Monumental Life Insurance*, 69 N.L.R.B. 249) or if the speech was made in the plant on working time (*Clark Brothers*, 70 N.L.R.B. 60). The committee believes these decisions to be too restrictive * * * (S. Rept. No. 105 on S. 1128, 80th Cong., 1st sess.)

*Thomas* v. *Collins* throws grave doubts on the constitutionality of the Labor Department's proposed regulation. In that case, the Supreme Court held that a Texas statute requiring labor organizers to register conflicts with the first amendment to the Federal Constitution. The Court said:

> * * * decision here has recognized that *employers' attempts to persuade to action with respect to joining or not joining unions are within the first amendment's guaranty. National Labor Relations Board* v. *Virginia Electric & Power Co.* (314 U.S. 469). Decisions of other courts have done likewise. When to this persuasion other things are added which bring about coercion, or give it that character, the limit of the right has been passed. [Italic supplied.]

It thus is clear that requiring an employer to report his arrangements for exercising the right of free speech in a noncoercive manner and the cost thereof, "modifies" and "impairs" his rights under the first amendment. *Thomas* v. *Collins* held that requiring even a simple, free registration impairs rights under the free speech clause of the first amendment. Construing section 203 as requiring employers to file detailed reports concerning their noncoercive publications not only conflicts with the clear meaning and purpose of section 203(f) but constitutes a far greater invasion of their constitutional rights than *Thomas* v. *Collins* involves.

4. The proposed regulation conflicts with the rule that requires strict construction of a statute that imposes criminal sanctions for

violating its provisions: We do not believe we can fairly read section 203(f) to impose onerous burdens and conditions on the exercise of the right of free speech that section 8(c) of the Labor Relations Act protects, or that the section is ambiguous. But if this were so, inasmuch as section 203 imposes criminal sanctions, well-settled rules of construction would forbid so resolving any ambiguity in section 203 as to subject to its penalties persons who misconstrue its terms. (See: *United States* v. *Resnick*, 299 U.S. 207 (1936); *Avers* v. *Phillips Petroleum Co.*, 25 F. Supp. 458 (D.C. Tex., 1938); *Donner* v. *Parker Credit Corp.*, 10 N.J. Super. 350, 76 A. 2d 277 (1950).)

If the Secretary of Labor adheres to his latest public position, he will require funds for handling reports on employers' arrangements and expenditures for exercising their right of free speech that the statute expressly excludes from its requirements.

B. Part D of the proposed form ignores (i) the statutory exemption of compensation to regular officers, supervisors, or employees of the employer and (ii) the statutory protection of free speech.

(i) This part requires reporting pursuant to section 203(f) of the Reporting and Disclosure Act any expenditures whose object is to "interfere with, restrain or coerce employees * * *." Section 203(g) provides that these terms have the same meaning as in the National Labor Relations Act, as amended.

Section 203(e) of the Reporting and Disclosure Act provides as follows:

> Nothing contained in this section shall be construed to require any regular officer, supervisor, or employee of an employer to file a report in connection with services rendered to such employer nor shall any employer be required to file a report covering expenditures made to any regular officer, supervisor, or employee of an employer as compensation for service as a regular officer, supervisor, or employee of such employer.

This exemption is broad and unconditional. Other parts of the form to which section 203(e) applies—i.e., part C, relating to payments to employees to "persuade" other employees in connection with their organizing and collective bargaining; and part E, relating to payments to obtain information concerning activities of employees or a union in connection with a labor dispute, properly exclude payments to regular officers, supervisors, and employees which 203(e) exempts. Part D ignores the exemption.

Regular officers, supervisors, or employees of employers commit practically all unfair labor practices of employers. Indeed, Congress, in amending the original Wagner Act in 1947, changed the definition of "employer" (sec. 2(2)) to make clear that employers are responsible for acts only of persons acting as their "agents," and not for acts of persons "acting in the interest of" an employer. Hence, it is only when officers, supervisors, or employees of an employer are, indeed, acting within the real or apparent scope of their duties that the Labor Board can hold the employer responsible for their acts that constitute unfair labor practices. While it doubtless is true that few, if any, employers expressly instruct their supervisors to engage in specific unfair labor practices, any more than they instruct their truckdrivers to run down pedestrians or collide with other vehicles, nevertheless, when a supervisor so performs his duties as to subject his employer to a charge, he does so as a regular employee, and the statute provides

that the employer need not report the compensation the employee receives for performing his duties, even when he performs them incorrectly or unlawfully.

Part D, like other parts of the form, should include an instruction to exclude from the report—

expenditures made to any regular officer, supervisor, or employee as compensation for service as a regular officer, supervisor, or employee.

(ii) Part D ignores the statutory protection of free speech.

Calling for reports of expenditures "to interfere with, restrain, or coerce employees" in their organizing and bargaining activities, without exemptions or qualifications that both the Reporting and Disclosure Act and the National Labor Relations Act, as amended, contain, doubtless will mislead and confuse many employers, and particularly small employers, who do not have available, or are not in the habit of consulting competent counsel, or who cannot afford to do so. This again will result in many reports that the statute does not require.

We have shown that the statute expressly excludes from its reporting requirements any noncoercive exercise by an employer of his right of free speech that section 8(c) of the Labor Relations Act protects. The form should make this explicit.

C. Part F of the form calls for agreements and expenditures that section 203(c) expressly exempts.

This part of the form calls on employers to report pursuant to section 203(a)(4) of the Reporting and Disclosure Act any agreements or arrangements they make with labor relations consultants or other third persons under which such third persons undertake "activities" an object of which is, directly or indirectly, "to persuade employees" with respect to their organizing or collective bargaining, and payments pursuant to such agreements or arrangements.

Pursuant to the statute, the form excludes agreements under which such third persons (i) advise employers, (ii) represent employers in litigated matters, and (iii) engage in collective bargaining on behalf of employers.

After thus properly excluding items (i), (ii), and (iii), above, part D goes on, improperly and in direct conflict with the clear and express terms of section 203(c), to require an employer to report with respect to those items if he has made other arrangements with the consultant or other person that the statute requires him to report. It requires him on another occasion to prepare a statement to employees or to engage in collective bargaining or to advise the employer with respect to a litigation or to engage in one of these activities that is protected by section 203–C, the form would require reports concerning the protected activities as well as the report concerning the undertaking to persuade employees.

The exclusion is quite clear in section 203–C.

The pertinent provisions of the statute follow.

Section 203(a)(4) requires reports of—

any agreement or arrangement with a labor relations consultant or other independent contractor or organization pursuant to which such person undertakes activities where an object thereof, directly or indirectly, is to persuade employees to exercise or not to exercise or persuade employees as to the manner of exercising, the right to organize and bargain collectively through representatives of their own choosing, * * *.

Section 203(c) provides as follows:

(c) Nothing in this section shall be construed to require any employer or other person to file a report covering the services of such person by reason of his giving or agreeing to give advice to such employer or representing or agreeing to represent such employer before any court, administrative agency, or tribunal of arbitration, or engaging or agreeing to engage in collective bargaining on behalf of such employer with respect to wages, hours, or other terms or conditions of employment, or the negotiation of an agreement or any question arising thereunder.

Thus, it is perfectly clear that employers need not file reports of arrangements and payments "covering" items (i), (ii), and (iii), above.

The Department of Labor has expressed the view that while arrangements section 203(c) lists do not "trigger" or give rise to a duty to report, if some other arrangement involving activities to "persuade" employers does give rise to such a duty, then the report must include the activities that section 203(c) exempts. The trouble with this argument is that section 203(c), unlike section 203(a), does not speak in terms of creating a duty to report. It says, explicitly, that nothing in section 203 shall be construed to require "a report covering the services" section 203(c) describes. If the Department says that an employer must include in a report services section 203(c) lists if section 203(a) requires him to file the report because of other services, it is saying, contrary to the statute, that the report must "cover" the exempt services. Such a construction of the statute simply cannot stand up.

Section 203(b), which deals with reports by labor consultants and other third persons, expressly requires of such persons who undertake activities an object of which is "to persuade employees" in connection with their organizing or collective bargaining or to provide an employer with certain information, to report "its receipts of any kind from employers on account of labor relations advice or services." This appears to conflict to some extent with the provision of section 203(c) that no "employer or other person" need file reports "covering" advice and certain other services. But there is no conflict whatever between section 203(a), dealing with employers' reports, and section 203(c), setting forth the exemption. The mere fact that labor relations consultants, if they act to "persuade" employers, may have to report, also, advising the employer, because of the express terms of section 203(b), is no ground for requiring employees, as to whom section 203(a) contains no similar terms, also to "cover" in their reports matters that section 203(c) says they need not "cover."

D. Part B of the form should expressly exclude certain payments to labor organizations and their officers, representatives, and employees that Congress seems clearly to have intended to exclude.

Part B calls for reports of payments or loans of money or other things of value (including reimbursed expenses)—

to any labor organization or to any officer, agent, shop steward, or other representative or employee of any labor organization.

It excepts, among other things:

(1) Sporadic or occasional gifts, gratuities, or favors, of insubstantial value, such as traditional Christmas gifts. (This exemption has no statutory basis, but is an interpretation by the Secretary of Labor.)

(2) Payments or loans made in the regular course of business as a National or State bank, credit union, insurance company, savings and loan association, or other credit institution.

and

(3) Payments of the kind referred to in section 302(c) of the Labor-Management Relations Act, 1947, as amended.

There are several kinds of payments that employers normally and customarily make to unions and union officials, and particularly to officials, such as local union officers, committeemen, and shop stewards, who are the employer's active employees or employees on leave of absence. Some of these clearly are "of the kind" that section 302(c) refers to. Others are not, but are common. We will discuss some of them.

Initiation fees and assessments: Section 302(c) of the Labor-Management Relations Act, by its express terms, refers to payments to unions and their officials of "money deducted from the wages of employees in payment of *dues* in a labor organization." [Emphasis supplied.] The Attorney General has construed the term "membership dues" to include initiation fees and assessments. These certainly are payments "of the kind" that section 302(c) refers to, and the Department clearly ought to exempt them. However, unless the form explicitly exempts them, the Bureau of Labor-Management Reports may be flooded with reports of payments to unions of initiation fees and assessments that employers deduct from employees' wages.

Bargaining time: The National Labor Relations Act, as amended, in section 8(a)(2) provides that—

an employer shall not be prohibited from permitting employees to confer with him during working hours without loss of time or pay; * * *.

It is an almost universal custom for employers to pay employees who are union officials for time during working hours that they spend not only in conferring with the employer but also with employees, presumably, but not necessarily, concerning grievances. Some employers pay employees who are union officials not only for time they lose from their work in conferring with the employer, but also for time they spend outside their working hours. Probably more than half of all employers whose employees are organized, and particularly small employers, pay employees who are the union's representatives for time they spend negotiating with the employer concerning the terms and conditions of collective bargaining agreements.

The Wage and Hour Division has held certain of the time employees who are union officials spend in this manner to be "working time" for which the employers must pay minimum wages and that they must include in computing overtime (W.H.M. 45:36(g), 291, 292). On the theory that time that employees who are union officials spend handling grievances and negotiating collective bargaining agreements benefits the employer, payments for such time are "of a kind" with wages, which section 302(c) expressly refers to, and the form should exempt them.

Dividends and interest: Many unions own corporate stocks, bonds, and other securities. Many persons who are full-time union officials own corporate securities, and union officials, representatives, and employees who are also employees of employers own securities of their

employer or of other employers. Neither section 203 of the act nor section 302(c) of the Labor-Management Relations Act explicitly exempts payments of dividends or interest from the reporting requirements of section 203 of the act.

Section 202(b) of the act expressly exempts from the reporting requirements that apply to labor unions, their officials, and employees, income they derive from bona fide investments in securities traded on a national securities exchange or securities of investment companies or of public utility holding companies.

Aside from the fact that it is anomalous to require of employers reports of payments that section 202(b) exempts as to unions and their officials, we submit that there are grounds on which the Department of Labor can properly exempt such payments under section 203(a), and that it ought to exempt them.

We will not dwell on the virtual impossibility of a large corporation's determining which of its stockholders or other security holders are officers or other representatives of some union or another (note that this provision does not apply merely to representatives of a union with which the employer deals). Nor will we dwell on the utter futility of requiring corporate employers, within the limits of their capabilities, to file mountains of useless, meaningless reports concerning routine payments of dividends and interest.

If these payments do not come within the express exemptions of section 302(c), we submit that they clearly are "of the kind" that certain clauses of that section describe. Section 302(c)(2) refers to—

> payment or delivery of money or other thing of value in satisfaction of a judgment * * * or in compromise, adjustment, settlement, or release of any claim, complaint, grievance, or dispute in the absence of fraud or duress.

We believe that payment of interest or of declared dividends must be regarded as being in satisfaction of valid claims, and therefore are exempt under section 203 of the act. If there is any doubt about this, the Secretary's exempting them certainly would be as valid an exercise of his rulemaking powers as his exempting "gifts, gratuities, or favors of insubstantial value."

Mr. Denton. I just cannot see what we have to do with the regulations the Secretary of Labor issues. That is not our function

Mr. Iserman. My point is that he is asking for a great deal more money than he requires in order to administer the act properly.

Mr. Denton. I have been waiting to hear you say how much you thought it should be reduced.

Mr. Iserman. As far as the employers reports are concerned, I think that he is asking for about 30 percent more reporting than the statute actually requires.

How much of the proposed appropriation is for employers' reports and how much is for unions' and how much for labor relations consultants reports I do not know. I do not know how it is broken down.

To the extent, if at all, that the Department has broken down its requests for these $5½ million, I would say that whatever portion is allocated to employers' reports, two-thirds of that allocation would be liberal, if we assume the case that the request is based on the proposed regulations and report forms.

Mr. Fogarty. Of course, it could happen the other way, too. We had better look into this pretty carefully. You may have omitted

something here and we should perhaps be appropriating more than the $5 million to see that this law is fairly enforced.

Mr. ISERMAN. I assume that the Department is not limiting its request, but if you do find things which the Department has overlooked in asking for the appropriation, naturally you would have to make it up.

What I am trying to point out——

Mr. FOGARTY. Right in this area to which you are speaking, Mr. Iserman. We may find out from other counsel that instead of a decrease in this area alone we may find there are good reasons for an increase.

Mr. ISERMAN. That may be true, sir. What I am saying is that the Department is asking for a great deal of reporting that the statute in some instances expressly exempts, and in some other instances clearly does not——

Mr. FOGARTY. I am not a lawyer, Mr. Iserman. A good lawyer can find some kind of an argument for or against anything.

Mr. ISERMAN. That is true. Where you have very simple and clear language it does not take a lawyer.

Mr. DENTON. We should have a legal opinion on this and some court decision before you ask us to pass on it through appropriations. We are not a court. I think before you ask us to pass on this you should have this adjudicated.

Mr. ISERMAN. The form is not issued officially. There can be no court opinion until after somebody has failed to file.

Mr. FOGARTY. Proceed.

Mr. ISERMAN. Miscellaneous: Many firms allow discounts to employees including union officials and employees who are on leaves of absence while working as union representatives. These are not sales at the prevailing market prices but when they are available generally to employees, they are in the regular course of business just as paying wages is in the regular course of business. We submit that these sales are of the kind that section 302(c) refers to and should be exempt from the requirements of section 203 of the act.

Many employers, pursuant to definite, written policies, make available to all their employees, including those who are union officials or representatives, loans in limited amounts, ordinarily without interest or collateral security. Section 202 does not require employees who are union officials to report such loans. Section 302(c) of the Labor-Management Relations Act, 1947, exempts from the provisions of section 302(a) payments—

> to any officer or employee of a labor organization, who is also an employee or former employee of such employer, as compensation for, *or by reason of*, his service as an employee of such employer. [Emphasis supplied.]

When an employer makes loans available to employees generally, we submit that his lending money to an employee who also is a union representative is by reason of such employee's service and that the transaction therefore is exempt. Furthermore, to this extent, at least, the employer becomes a lending institution and, as such, should not have to report.

Some employers carry certain insurances for employees who are on leave as full-time union officials, or credit such employees with current service under pension plans. These favors, we submit, fall within

exemptions of (1) and (3) now appearing in part B of the form, or are de minimis.

The Department of Labor could avoid receiving many uncalled-for reports and, at the same time, avoid great unnecessary costs if, in addition to exempting gifts, gratuities and favors to union officials, it explicitly exempted dues, initiation fees and assessments deducted from employees' wages, payments for bargaining time, dividends, interest, and discounts and loans employers make available generally to employees as such.

E. The instructions and part A of the form do not make it clear that only employers who answer affirmatively one or more of the questions in parts B through G must fill out part A and file a report.

The two paragraphs of the instructions under the heading "What Must Be Filed," say how an employer can determine whether he must fill out a particular part of the form. The second of these paragraphs covers all situations, except where the employer need not complete any part or file any report. To cover this situation, we suggest that the Department of Labor add a new sentence at the end so that the paragraph will read as follows (new material italicized):

> The report form is divided into parts A through G. Part A is to be completed and signed by all employers who are required to file a report. Each of the other parts is introduced by an initial question pertaining to a particular type of activity. If the answer to the initial question of any part, taking into account the exclusions applicable thereto, is in the affirmative, that part must be completed, but only those parts for which a report is required need be completed. *If the answer to the initial question of all parts B through G is in the negative, the employer should not complete any part of the form or file any report.*

The Department could greatly reduce its workload and its appropriation by including in part A a direction that employers should not fill out that part or file a report unless they answer the question in parts B, C, D, E, F, or G affirmatively.

F. The instructions incorrectly state that employers who make certain expenditures must file reports.

Under "What Must Be Filed," the instructions say, in part:

> For example: An employer who made expenditures to a detective agency, a labor relations consultant, and an employee of another company, for the purpose of obtaining information concerning the activities of employees or of a labor organization in connection with a labor dispute in which he was involved, would report the expenditures to the detective agency on one sheet of part (E) the expenditures to the labor relations consultant on the second sheet of part (E), and the expenditures to the employees of another company on a third sheet of part (E); and he would number these sheets, sheet No. 1 of part (E), sheet No. 2 of part (E), and sheet No. 3 of part (E), respectively.

Under section 203(a)(4), employers need not report payments for information if the information is "for use solely in connection with an administrative or arbitral proceeding or a criminal or civil judicial proceeding." Consequently, unless the Department inserts the word "reportable" before the word "expenditures" or makes a similar change in the foregoing instruction, it will mislead many employers into filing reports that the statute does not require.

Congress ought not to appropriate funds covering the cost of handling reports to the Department of Labor of matters that the Labor-Management Reporting and Disclosure Act of 1959 exempts, or that employers will file mistakenly by reason of inaccuracies or deficiencies in the form and instructions.

The instructions incorrectly state that employers must report certain expenditures to certain persons, labor relations consultants, detective agencies, and people of that sort, in all instances, whereas the statute provides that they have to make such reports only when they are procuring information concerning activities of employees or labor organizations, and does not require the expenditures if the information is used solely in connection with administrative or arbitral proceedings or criminal or judicial proceedings. The instructions ought to mention those exclusions which are expressly in the statute itself.

Mr. FOGARTY. Thank you.

Any further questions?

Mr. DENTON. I wanted to ask just one. There are so many of these small business associations. Which one is this?

Mr. ISERMAN. This is the National Small Businessmen's Association, which the last time I heard had some 30,000 members.

Mr. DENTON. It is not the one which used to be at Evanston, Ill.?

Mr. ISERMAN. Yes, it is.

Mr. DENTON. Of course, there were a great many articles in the paper that it had big business backers more than small business.

Mr. LIEBENSON. At one time they had an Economic Educational Foundation which was a separate entity which they had taken in for educational purposes, not for publication or newspaper advertising, but economic education area only. It was a separate organization entirely.

Mr. DENTON. I remember the newspapers said their backing came almost entirely from big business. There were many articles in the papers on it.

Mr. LIEBENSON. It was an economic foundation.

Mr. DENTON. It was supported very largely by big business.

Mr. LIEBENSON. I was not with the organization at the time. Do you mean now?

Mr. DENTON. No. At that time. I don't know about the current situation.

Mr. LIEBENSON. At that time the economic foundation did have some big business backing.

Mr. DENTON. It was supported very largely by big business?

Mr. LIEBENSON. I could not really say to what degree.

Mr. DENTON. Are you supported now by big business?

Mr. LIEBENSON. Absolutely not.

Mr. DENTON. No big business association?

Mr. LIEBENSON. Absolutely not. Our records are open——

Mr. DENTON. How about Dewitt Emory?

Mr. LIEBENSON. Dewitt Emory died in 1954 or 1955. He was the general counsel at the time. After that they had some shift, and the organization moved to Washington in 1956.

Mr. DENTON. You have no backing from big business?

Mr. LIEBENSON. Absolutely not.

Mr. DENTON. Are there any members of your association which are big business?

Mr. LIEBESON. No, absolutely not.

Mr. DENTON. Do you receive any money from big business?

Mr. LIEBENSON. None whatever.

Mr. DENTON. That is all.

Mr. LIEBENSON. Let me add that our books are open. In the last year we have increased our membership over 17,000. Most of them are small retailers. Our books are open to anybody.

Mr. FOGARTY. Thank you very much.

## COMMENTS OF SECRETARY MITCHELL

Since this testimony is quite critical of the Department of Labor the committee will afford Secretary Mitchell an opportunity to comment on it if he wishes to do so.

(The comments of Secretary Mitchell follow:)

U.S. DEPARTMENT OF LABOR,
OFFICE OF THE SECRETARY,
*Washington, March 8, 1960.*

Hon. JOHN E. FOGARTY,
*Chairman, House Appropriations Subcommittee for Labor-Health, Education, and Welfare, U.S. House of Representatives, Washington, D.C.*

DEAR CONGRESSMAN FOGARTY: I feel it necessary to comment on the testimony before your committee of Mr. Theodore R. Iserman on behalf of the National Small Businessmen's Association. It is submitted that this testimony should have no effect upon our request for an appropriation in either fiscal year 1960 or 1961 because—

(*a*) it assumes adverse action on comments and recommendations of employer groups with respect to a proposed report form which is currently under consideration in the process prescribed by the Administrative Procedures Act,

(*b*) it presents the point of view of one particular group and does not reflect all of the considerations and recommendations of other interested groups which are being fully considered along with the recommendations of this group in the determination of the final report form to be adopted, and

(*c*) it makes hypotheses and assumptions as to the budgetary impact of these hypothetical decisions which are clearly shown to be incorrect by the budget justification before your committee. The fact is that no funds have been requested for processing the employers report; on the contrary, the justification assumes that this "can be accomplished with the resources allowed for other report operations."

With respect to the first point above, even before the publication of the draft form, I and several members of my staff met several times with members of affected organizations such as the chamber of commerce, the NAM, the Association of American Railroads, the Associated General Contractors, the American Retail Federation, and the National Small Businessmen's Association. After consideration of the results of the meetings with these organizations and others, a proposed report form was published in the Federal Register as provided in the Administrative Procedures Act with a request for written comments and recommendations by any interested parties.

All of the comments are now in, and are being carefully considered with a view to publication of the final report form within the next few weeks. These comments and recommendations include all of those contained in Mr. Iserman's testimony. Until the procedures prescribed by the Administrative Procedure Act have been completed it is premature to adopt or reject any of the specific comments under consideration in that procedure.

As stated above in (*b*), Mr. Iserman has set forth one side of the case on certain specific points. However, in making my final decision I must consider all of the various viewpoints which have been presented and determine what the act requires. For example, Mr. Iserman argues in effect that certain data should not be reported because to do so wou'd discourage the employer from exercising certain admitted rights or might even be construed as making the exercise of such rights an illegal act. Substantially the same argument was presented by certain labor representatives in arguing that some items should not be included in the financial report form required of labor unions. After a thorough review of the statutory language and the legislative history this position was not finally adopted in promulgating the union financial report. Whether the current objections advanced by Mr. Iserman and others justify a difference in treatment under the

statute in construing the provisions governing employer reporting can be administratively determined, as contemplated by the statute, only in the formal rule-making proceeding which the act requires. This proceeding is now in process, and I must reserve judgment until we have made a similar review of the evidence of legislative intent in the light of the arguments and authorities upon which Mr. Iserman relies as compared with those advanced for a different reading of the statute.

With respect to item (*c*) above, it would appear that the statement of Mr. Iserman would not have been filed with the committee had he not assumed that our budget requests include a request for funds based on an anticipated workload for handling a large volume of employer reports. That this assumption is unwarranted may be seen from the statement of justifications filed with this committee in support of the 1961 budget request for activities of the Bureau of Labor-Management Reports. In the section of that statement dealing with estimated workload for processing reports, you will note that the kinds of reports included in the estimated workload are the reports dealing with labor organizations. With respect to employer reports, we said "no estimate of the number of such reports is being made at this time because such an estimate would be too conjectural * * *. It is hoped that necessary handling of a small number of these reports can be accomplished with resources allowed for other reports operations."

On the basis of the most recent experience and the facts stated it is requested that the full amount of the estimate be approved.

Sincerely yours,

JAMES P. MITCHELL,
*Secretary of Labor.*

LETTER FROM THE NATIONAL LUMBER MANUFACTURERS ASSOCIATION

Mr. FOGARTY. We will also include in the record this letter from the National Lumber Manufacturers Association.

(The letter referred to follows:)

NATIONAL LUMBER MANUFACTURERS ASSOCIATION,
*Washington, D.C., March 4, 1960.*

Hon. JOHN E. FOGARTY,
*Chairman, Subcommittee on Labor, Health, Education, and Welfare, Committee on Appropriations, House Office Building, Washington, D.C.*

DEAR MR. FOGARTY: The National Lumber Manufacturers Association is a federation of regional, species, and products associations representing the lumber and wood products industries in all parts of the United States. We appreciate this opportunity to present our views concerning the pending request for appropriations by the Department of Labor. Included in its budget request is $5.5 million for administration of the Labor-Management Reporting and Disclosure Act of 1959.

Among all manufacturing industries, the lumber manufacturing industry ranks sixth in total employment in the United States. This work force is distributed among approximately 50,000 employers. Consequently, we have a major interest in the administration of the Labor-Management Reporting and Disclosure Act, particularly that part that deals with employer reporting.

We respectfully submit that the Labor Department is misconstruing the intent of the Congress in its proposed regulations and reporting form that requires employers to disclose information contrary to the provisions of the Reporting Act. Although section 203(F) of that act specifically preserves all rights of free speech protected by section 8(C) of the National Labor Relations Act, as amended, the proposed Labor Department regulations and reporting form ignore this provision. They require reports from the employer covering perfectly proper, open and above board activities designed to express—in the employer's name—views on employee relations matters.

Such an unauthorized demand for reports will undoubtedly increase the cost of administration of the act and will certainly impose an unwarranted burden upon our industry. We therefore urge that your committee specifically restrict the use of appropriated funds by the Department of Labor so as to correct this erroneous reporting requirement for employers.

We understand that a discussion of this matter has been presented to your committee by Mr. Theodore Iserman on behalf of the National Small Business Men's Association. We commend to your careful consideration the numerous

detailed deficiencies and errors in the Secretary's regulations discussed in his statement.

We are sending a copy of this letter to all members of the Subcommittee on Labor, Health, Education, and Welfare.

Sincerely,

A. Z. Nelson,
*Director, Industry-Government Affairs Division.*

---

Thursday, March 3, 1960.

## Offices of Education and Vocational Rehabilitation

### WITNESS

### HON. CLEVELAND M. BAILEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WEST VIRGINIA

Mr. Fogarty. Mr. Bailey, we are very happy to have you with us again.

Mr. Bailey. Mr. Chairman and members of the subcommittee, I appreciate the opportunity of appearing before your subcommittee in support of funds for the Department of Health, Education, and Welfare for the 1961 fiscal year. My particular purpose in appearing before you is to urge the importance of providing adequate funds for the Offices of Education and Vocational Rehabilitation. In this connection, I wish to comment briefly on the proposed appropriations for these offices.

#### OFFICE OF EDUCATION

##### GRANTS FOR LIBRARY SERVICES

The President's budget contains $7.3 million for grants to the States under the Library Services Act during fiscal year 1961. I recommend that your committee give consideration to increasing this amount by $200,000—thus bringing the appropriation up to the full authorization of $7.5 million.

Mr. Denton. I am certainly glad you said that, because the reason the budget isn't for the full amount is that Indiana isn't participating in the program. We hope the first of next year to have Indiana join the other 49 States participating in the program.

Mr. Bailey. This would bring it up to the full authorization, which is $7.5 million.

I also urge that your committee include in the bill the provision permitting State allotments to be made on the basis of the full authorization, namely $7.5 million, as well as the stipulation that the funds "remain available until expended."

As you know, the Library Services Act was not passed until the middle of 1956, and most of the 36 States which participated during the first fiscal year, ending June 1957, did not receive funds until January 1957 or later. The act has done much to focus the attention of our State governments on the need for public library development. All our States are now participating under the program; however, many library development projects begun by the States are not yet completed. As a result of this worthy program, 30 million rural

people now have new or improved public library services available to them. This cooperative State-Federal program has brought public library service for the first time to over 1 million rural children and adults. Nonetheless, there are today 25 million people in rural areas still without any public library service.

It is significant that State appropriations for public library service to rural areas have increased 54 percent since 1956. In my own State of West Virginia, whereas 5 counties had library service in 1956, today 22 counties are receiving library services. Our State has increased its per capita expenditure for public libraries from 26 cents in 1956 to 45 cents in 1959. This amount, however, is still only one-third of the minimum national standard.

The above factors, in my opinion, are the best evidence of the beneficial accomplishments under the Library Services Act of 1956 and justify your committee's recommending funds for the full amount authorized under the act, namely $7.5 million.

OFFICE OF VOCATIONAL REHABILITATION

The 1961 budget estimate for the Office of Vocational Rehabilitation is $54,500,000. Of this amount, $53 million is earmarked for Federal matching grants to States for rehabilitating physically and mentally handicapped individuals. These services, as you know, include medical restoration, as well as education and training of such individuals, so that they may prepare for and engage in remunerative employment to the extent of their capabilities. The difference of $1.5 million would be used under section 3 of the Vocational Rehabilitation Act, which authorizes grants to the States on projects which will extend or improve vocational rehabilitation services under the State plan or contribute materially to such an extension or improvement.

It is my understanding that the budget estimate does not match all the moneys that States have appropriated or made available for vocational rehabilitation services. As a matter of fact, the administration's allotment base of $63 million would be inadequate for matching purposes in 18 States. My own State of West Virginia has money in excess of $100,000, which is unmatched by Federal funds. In order for West Virginia to have all of its funds matched by Federal funds, it would be necessary to increase the Federal appropriation for rehabilitation from $53 million to approximately $55,600,000, and to increase the allocation base from $63 million to $77 million.

Since so many States are unable to pick up the full amount of Federal funds that their State funds would warrant, I trust that your committee will give favorable consideration to increasing the budget request for the rehabilitation appropriation and allocation base.

It is gratifying that the number of completed rehabilitations has been increasing annually; however, we cannot overlook that the national backlog is almost 200,000. In my own State of West Virginia, about 5,000 disabled persons are awaiting service because of lack of funds. In providing adequate funds for this program, we are not only increasing the social and economic well-being of handicapped individuals, but also the productive capacity of our Nation.

I cannot stress the importance of appropriating adequate funds to implement the existing provisions of Public Law 874, under which payments are made to assist in the maintenance and operation of schools in federally impacted areas, and Public Law 815, which provides assistance in the construction of school facilities.

It is estimated that in 1961 payments under Public Law 874 will be made to some 4,275 school districts in all the States, Guam, Puerto Rico, the Virgin Islands, and Wake Island. This represents an increase of 125 school districts over the current fiscal year, and the payments will benefit almost 1.5 million federally connected pupils.

The funds under Public Law 815 have aided in the construction of an estimated 52,890 classrooms, $1,400 million. The 1961 funds will assist in providing some 2,200 classrooms for about 66,000 children.

The budget estimates for these programs have been submitted on the basis of legislation proposed by the administration. I respectfully request that the committee recommend appropriations for these programs under the present law and not on the assumption that the law might be amended. In this regard, it is my understanding that appropriation figures to implement the existing law have been made a part of the record in these hearings.

Under existing law, appropriations would be $63,392,000 under Public Law 815 and $187,310,000 under Public Law 874. The President's budget request for Public Law 815 is $44,390,000, which is $19 million short of what the appropriation should be. The budget figure under Public Law 874 is $126,695,000, or $60.6 million less than the amount required under existing law.

Frankly, Mr. Chairman, the administration proposes and tries to do away with category 2 of this program, Public Law 874, which is the category including the youngsters who are benefiting from this legislation whose parents work on a base but the parents happen to be living in a school district adjoining the base, where the Federal Government assumes 50 percent of the cost of their education. They are trying to write off that part of the program.

Mr. FOGARTY. Thank you very much. That is a very fine statement, as usual, Congressman. I agree with you 100 percent.

Mr. BAILEY. Thank you very much.

---

THURSDAY, MARCH 3, 1960.

FOOD AND DRUG ADMINISTRATION

WITNESS

**ARNOLD MAYER, LEGISLATIVE REPRESENTATIVE, AMALGAMATED MEAT CUTTERS AND BUTCHER WORKMEN OF NORTH AMERICA, AFL–CIO**

Mr. FOGARTY. We shall hear now Mr. Arnold Mayer. You may proceed, Mr. Mayer.

Mr. MAYER. Mr. Chairman and gentlemen of the committee, my name is Arnold Mayer. I am the legislative representative of the Amalgamated Meat Cutters and Butcher Workmen of North America, AFL–CIO.

The AMCBW is a labor union with 375,000 members organized in about 500 local unions throughout the United States and Canada. The AMCBW and its locals have contracts with thousands of employers in the meat, retail, poultry, egg, canning, leather, fish processing and fur industries.

On behalf of our union, I would like to thank the chairman and all of the members of this subcommittee for the excellent work you have performed in previous years in increasing FDA's budget. We know that your work in recent years has not been easy. Highly expensive propaganda mills have been attempting to convince the American people that they cannot afford public services, including those which protect their health and welfare.

The fact that in spite of this campaign you have been able to avoid cutting FDA's budget merits you congratulations. The fact that you have been able to increase FDA's funds beyond the budget requests merits you thousands.

Quite frankly, the AMCBW's testimony on FDA's budget can be summarized into one sentence. It is: "Thank you for going over the administration's budget request in the past, and please, please do it again."

This year again, the Eisenhower administration has made the balanced budget—not the health and welfare of the American people—the goal of our Government's policy. We are certain that despite the confusion created by the propaganda mills, the American people do not approve such a policy.

To the packinghouse worker in Wisconsin, the balanced budget is an abstraction, but the danger that radiation will cause bone cancer in his children is a very real anxiety. To the meatcutter in New York, inflation is an overhuckstered bogeyman which has lost its fright, but the danger that adulterated foodstuffs will cause food poisoning among his family is something actual. To the poultry processing worker in California, the idea that our Nation cannot afford social services is difficult to understand, but the harm that inadequately tested drugs might do to his parents is easy to comprehend.

I should like to go from these general points to some specific parts of the Food and Drug Administration's budget. In the ever-continuing search for a better material life, science is developing, and industry is using, new chemical food additives, agricultural poisons, miracle drugs, and methods of processing and packaging. The consumer, himself, cannot keep up with these developments. He—or rather I should say—she, can have only a small idea of what is safe for the family and what is not. Today, we need research. Consumers need the help of an independent, incorruptible and highly expert scientific group. FDA is exactly that. Needless to say, its staff needs the resources to fulfill its function. Some $2,865,000 have been requested for continuing research into the safety of these scientific developments. I would suggest that this amount is insufficient.

The amount is no more than that paid for the annual electric and cleaning bill of the Pentagon. The health of America deserves more funds than that. Our union respectfully suggests that this is an area where the subcommittee could again do the job of providing more funds than the budget request contains.

And the research findings must be backed up by inspection activity. The rules developed on the basis of the findings must be enforced. The competitive pulls in industry sometimes result in the cutting of corners. Less socially conscious operators sometimes cut corners by a very wide margin. That is why FDA must inspect plants and products.

Yet the FDA's inspection of individual food, drug, and cosmetic establishments can go on only at the rate of once every 4 or 5 years per establishment. A sizable rise in the budget—to increase inspection manpower—merits the subcommittee's consideration. Increased funds could avert possible serious tragedy.

Another new and fantastic problem of our age is the increased incidence of radioactivity in our foods. Conflicting reports have thoroughly confused the public—and I think I can serve as a good example. We do not know what is what. But we are thoroughly afraid. The idea of radioactivity producing illnesses, such as bone cancer, and even more terrifying, the idea of future generations being marred, are fear-producing thoughts of the greatest magnitude.

Independent, nonpolitical research is necessary. FDA has such research underway. A supplemental appropriation of $332,000 has been requested. These funds, together with the budget request for fiscal year 1961, would allow about $1 million for research into radioactivity in foods. This amount is less than the funds spent on sending up one experimental rocket. The future survival of our Nation depends as much upon this research as it does on rocket research. Studies into radioactivity in foods truly deserves more money.

Foreign imports provide another area where inspection by FDA is insufficient. FDA is responsible for the investigation and analyses of all imports of foods, drugs, cosmetics, and related articles. Some $4 billion worth of goods of this type come into the United States each year. Yet FDA can inspect only 10 percent of these imports.

This lack of adequate inspection endangers not only the American consumer, but also the American worker and American industry. Here we have the possibility of critically unfair competition. No one—not even the protectionists, would ask that FDA be used as a backdoor tariff wall. But FDA should be able to assure that these products come up to the standard demanded by American law. Funds to provide an increased activity on the part of FDA in this area is highly desirable.

The four specific areas I have mentioned are not an exclusive list of the activities for which increased funds are necessary. Others are apparent; for example, funds to bring FDA's physical plant into a more rational shape. Undoubtedly, operational savings and expanded activity could be brought about by the initial expenditure of funds to modernize FDA's facilities and bring them physically together in Washington and in the field. But I am certain I need not burden this subcommittee, which has shown such tremendous expertise with and sympathy for FDA's problems, with further testimony on this need.

I should like instead, to turn to another problem faced in the protection of consumers against unhealthful foods—an area where FDA may have to assume new responsibilities. As you know, poultry is

inspected under the Poultry Products Inspection Act and the responsibility for this inspection is lodged in the Department of Agriculture.

The act provides for the inspection at the time of (1) slaughter and evisceration of poultry, and (2) further processing of poultry into products, such as soups, chicken pies and other much-eaten foods. Congress, in its wisdom, provided for inspection at both points for many excellent health reasons.

Yet, since the act has been in existence, the Department of Agriculture has not provided the required inspection for the further processing operations. For pennywise and dollar foolish budgetary reasons, it has used a temporary exemption section (sec. 15(a)(3)) in the law to avoid this part of inspection.

This section was written into the act to give the Secretary flexibility in administering the act during the difficult period of the initial 2 years of the law's effectiveness. The section was not put into the law to exempt an entire part of the industry. Yet for 2 years, it has been used for exactly this purpose by the Department of Agriculture.

This exemption section expires on July 1, 1960. But the Department of Agriculture has not asked for funds for further processing inspection for the fiscal year beginning July 1, 1960. Instead, the Department is attempting to get legislation from Congress making the exemption section permanent.

I recite this sorry history because it demonstrates again the lack of concern about consumers found in the top level of the Department of Agriculture. Poultry inspection at the operational level has gone very well. The Poultry Branch has done an overall good job. But the budgeteers will not allow them to adequately protect the consumer.

The answer to this problem may very well have to be to expand the function of FDA—to permit FDA inspectors to perform the inspection for further processing operations, and perhaps of poultry inspection, as a whole. FDA, at all levels, has demonstrated its concern for, and sympathy with, the consumer. On the higher levels of the Department of Agriculture exactly the opposite has been demonstrated. It appears as if the consumer can gain the full protection which the Poultry Products Inspection Act promises only by taking part, or all, of the inspection program out of the Department of Agriculture and bring it into a consumer-conscious agency, such as FDA.

Mr. Chairman and gentlemen of the subcommittee, our union realizes that the FDA budget proposals we have suggested are easier to recommend than to carry out. We realize that you must fight against a very tough "budget above all else" philosophy to increase FDA's funds.

But you have carried on such a battle magnificantly in the past. The Nation is better off because of your courage and your determination. That is why we ask that you again take up the cudgels and report to the House a budget which will truly meet the needs of our Nation.

Mr. Fogarty. Thank you very much. Any questions, Dr. Denton?

Mr. Denton. No questions.

Mr. Fogarty. Thank you very much, Mr. Mayer.

The committee is in recess until 2 o'clock.

THURSDAY, MARCH 3, 1960.

NATIONAL ORTHOPAEDIC AND REHABILITATION HOSPITAL, ARLINGTON, VA.

WITNESS

DR. O. ANDERSON ENGH, NATIONAL ORTHOPAEDIC AND REHABILITATION HOSPITAL, ARLINGTON, VA.

Mr. FOGARTY. The committee will come to order. We have Dr. Engh with us. Dr. Engh for the purpose of the record will you state who you are and whom you represent.

Dr. ENGH. I am Dr. O. Anderson Engh, medical director of the National Orthopaedic and Rehabilitation Hospital located in Arlington, Va. This institution has been designated as a pilot demonstration center in rehabilitation to act as a guide for the development of rehabilitation centers in other parts of the country. A little more than a year ago, Miss Mary Switzer, director of the Office of Vocational Rehabilitation in a splendid dedication address described the role of our center in the Federal-State program.

I believe this committee now realizes what we are trying to accomplish as a national demonstration center. In essence, the aims and objectives can be included under four headings, namely:

1. To give early and preferably immediate rehabilitation services to persons with potentially disabling conditions. Rehabilitation started months or years after an injury is undesirable. From the physical and psychological standpoint, valuable time is lost. The old adage, "an ounce of prevention is worth a pound of cure" applies most definitely in rehabilitation of the handicapped.

2. An "all under one roof program." The inclusion of outpatient, hospitalization, physical and occupational therapy, psychosocial, vocational and contract workshop facilities and services is our desire. This particular approach appealed to the Congress at the time legislation for the pilot center was enacted. The orderly and progressive rehabilitation through these various divisions terminating in employment of the individual is sound and logical. We have progressed to the point of the contract workshop and steps are being promulgated now for such a building.

3. Broad community medical participation. To be really effective all the doctors in the community should participate in rehabilitation. The patient's own physician is most important since he knows not only the physical but the emotional, domestic, economic and vocational problems. We now have 170 doctors on our staff serving in the outpatient clinics and in the hospital itself. We are convinced that as a pilot demonstration we must begin with the community and the family doctor must play an important role.

4. The volunteer program. This includes transportation of disabled persons, assistance to nurses, clerical help and job training. The volunteer program is designed to cut costs. We must be realistic and appreciate that the entire rehabilitation program will suffer if it becomes too expensive. In periods of economic recession, rehabilitation programs will be in jeopardy. I believe, Mr. Fogarty, that I

previously described the tremendous community volunteer effort being exhibited.

I want to stress our need for permanent support since we feel this type of demonstration will continue to be of value to the entire country.

These are my reasons:

1. A center carrying out experiments, demonstrations and research in the long run saves money and prevents failures in various attempts within the rehabilitation field. Proper planning is most essential in almost anything and since rehabilitation constitutes a tremendous part of our health program, this phase should not be neglected.

2. There is a definite need in this area for a permanent comprehensive rehabilitation center for Government workers. I have served as an orthopedic consultant for civil service employees under the Bureau of Employees Compensation program for almost 20 years. During this period I have treated many patients who have cost the Government large sums of money. By getting these individuals back to work tremendous savings have resulted. Continuation and expansion of such services is essential.

3. There should be a permanent outstanding rehabilitation center in the Nation's Capital which can be visited by American and foreign doctors and others concerned with rehabilitation.

4. There should be a permanent rehabilitation center close to the Federal Office of Vocational Rehabilitation where observation, guidance, special projects, and demonstrations can be closely observed.

In order to proceed with confidence and enthusiasm, we hope that the word "initial" can be removed from section 4(b) of the Vocational Rehabilitation Act. We also hope that if the new bill presented to the Senate, dealing with independent living and contract workshops is passed, it will include our pilot demonstration center without matching provisions, since we are set up separate and apart from State appropriations.

Mr. Fogarty. We have nothing to do with that.

Dr. Engh. I realize you do not, Mr. Fogarty, but if this bill is passed, we hope you will give consideration to our request. I believe we are deserving of such consideration not only because of the merits of the pilot demonstration center but also because of the great sacrifices which have been made in developing this center. It should be recalled that we proceeded with the construction of our institution before any money was available through Hill-Burton and as a nonprofit hosiptal we incurred a debt of $350,000. The donations of land, labor, materials, and so forth, resulting in the construction of a building valued at $2½ million, I believe also deserves consideration.

I appreciate the opportunity of having appeared before this committee today.

Mr. Fogarty. Thank you, Doctor.

THURSDAY, MARCH 3, 1960.

BUDGET FOR THE DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE

WITNESSES

HYMAN H. BOOKBINDER, LEGISLATIVE REPRESENTATIVE, AFL–CIO
BERT SEIDMAN, ECONOMIST, AFL–CIO

Mr. FOGARTY. Mr. Bookbinder, are you ready?

Mr. BOOKBINDER. Mr. Chairman, again we have a long statement. I shall try to improve upon my record; I started taking about 10 minutes for my oral summary several years ago. I think it was down to 5 minutes last year. I shall try to do it in even less than 5 minutes today.

Mr. FOGARTY. You go right ahead. We shall put the whole statement in the record.

Mr. BOOKBINDER. Thank you, Mr. Chairman, would you also include a resolution of the executive council of the AFL–CIO appended to the statement, which is referred to in the body of the statement?

Mr. FOGARTY. Very well.

(The statement and resolution follow:)

STATEMENT BY HYMAN H. BOOKBINDER, LEGISLATIVE REPRESENTATIVE, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

I appreciate the opportunity to appear before this subcommittee to present the views of the American Federation of Labor and Congress of Industrial Organizations on the proposed budget for fiscal year 1961 for the Department of Labor and the Department of Health, Education, and Welfare.

The activities of these Departments are more directly related to the needs of American workers than the programs of other Departments of the Federal Government. It is for this reason that the AFL–CIO is grateful for the opportunity to testify in detail on the budget for these two Departments. However, we recognize, as I am sure do the members of this subcommittee, that workers no less than other citizens are concerned with and are affected by the entire gamut of programs and activities of the Federal Government. Moreover, we cannot be unmindful of the important roles which the Federal Government plays in our overall economy, not only by direct expenditures but also by stimulation, or unhappily too often these days throttling, of private economic activity.

Let me make one thing clear at the outset. Organized labor has not in the past favored and does not now ask for a vast burgeoning of Federal activities or a huge expansion of Federal expenditures. We do insist, however, that it is essential to the prosperity of the American economy and the welfare of the American people that there be sufficient funds available to finance essential services and programs which the Federal Government alone can adequately provide.

We are alarmed by the glaring deficiencies in the public sector of our economy. These gaps were emphasized in a recent report prepared under the direction of Maj. Gen. J. S. Bragdon, Special Assistant to the President for Public Works Planning. This report stated:

"In almost every field in public works—hospitals, schools, civic centers, recreational facilities—shortages are the rule, not the exception. In almost every category we are falling farther and farther behind in meeting even current demands. Backlogs, inadequate replacement schedules, urgent new requirements are characteristic of public works problems across the Nation."

At its meeting last month, the AFL–CIO Executive Council had before it a statement on the President's Economic Report and Budget Message adopted by the AFL–CIO Economic Policy Committee. (I have attached the statement of the economic policy committee as an appendix to this testimony.) Based

on this detailed statement, the executive council came to the following conclusions:

"In the name of fighting inflation, the administration has assumed that a budget surplus, regardless of its consequences, is a necessity. The adminstration's budget proposals threaten the expansion of our economy, as they restrict necessary and economy-boosting activities."

Mr. Chairman, as I have already stated, I am of course well aware that your subcommittee is not concerned with all of the areas of the President's budget. However, what your subcommittee does will have a decisive effect on activities of the Federal Government which vitally affect the working conditions, health, education and welfare of all Americans. Let it be said to the credit of this subcommittee, Mr. Chairman, that under your leadership it has not hesitated to go beyond the recommendations of the Budget Bureau when the administration has failed to display a real understanding of important needs. We confidently anticipate that this subcommittee will evidence once again this same discretion, judgment, and fundamental humanity in considering the recommendations of the Budget Bureau for the next fiscal year.

As in the past years, we intend in this testimony to highlight what we consider to be activities and programs of particularly great concern and especially those for which the request of the Budget Bureau is in our judgment inadequate. You will find that in making our recommendations we will be considering not just the interests of working people but of all people, for we have by no means confined our recommendations to programs directly affecting the lives of workers exclusively. I should also like to emphasize that although we are directing your special attention to certain programs, failure to mention others should be attributed to our desire to economize your time and effort and not to any lack of support or interest on our part.

## Department of Labor

### WAGE AND HOUR AND PUBLIC CONTRACTS DIVISIONS

Each year we urge the Congress for an increased appropriation for the Wage and Hour and Public Contracts Divisions. We do so because each additional dollar it spends for enforcement of the Fair Labor Standards Act and the Public Contracts Act results in a restoration of at least several dollars to underpaid employees. Expanded enforcement activities also are needed to discourage noncompliance and outright chiseling by willful violators of the acts.

We are not criticizing the divisions. Considering how limited their funds are, they are doing a conscientious and commendable job. But they cannot provide the full enforcement needed in this area without a substantial increase in appropriations above the level formally requested of the Congress.

As the subcommittee is aware, the Divisions sought funds for fiscal 1961, as they have in the past, for the hiring of an additional 100 investigators to permit more adequate inspection of compliance, but the Bureau of the Budget has rejected the request for these funds, about $900,000.

Denial of such an appropriation bears heavily on thousands of low-paid workers who are illegally denied by chiseling employers even the pitifully inadequate $1 minimum wage and overtime compensation set by the Wage-Hour Act. Even with its limited staff, the divisions' investigations last year found 178,000 workers underpaid a total of $22.4 million—and this is estimated to be only about one-fourth to one-half the amount of noncompliance under the acts, noncompliance which could and should be erased through increased investigation.

We urge that the Congress provide additional funds for the divisions to employ another 100 investigators to detect and prevent chiseling on payments due workers under the Fair Labor Standards and Public Contracts Acts.

### BUREAU OF LABOR STANDARDS

*Welfare and pension plans*

The labor movement, in its historic role of seeking a greater measure of security for its members and their families, has, through collective bargaining, been responsible for the development of health, welfare and pension plans covering millions of Americans. The AFL–CIO has long urged effective disclosure of information on these plans not only to safeguard the interests of beneficiaries but also to satisfy a legitimate public and consumer interest in the honesty, integrity, and efficiency with which these plans are administered.

In 1958 the Congress passed the Welfare and Pension Plans Disclosure Act, in a form considerably diluted from that supported by the AFL–CIO. It can, however, be useful even in its present form.

At its 1959 convention, the AFL–CIO urged in unanimous action that "sufficient funds be appropriated for the successful and efficient operation of the Welfare and Pension Plans Disclosure Act, and to make possible studies and analyses based on the information contained in the reports filed under the act."

The Labor Department has requested $523,000 for this program for fiscal 1961, $147,000 less than the amount available this year. It is true that certain initial expenditures involved in launching the program will not have to be repeated. However, as we shall indicate, we believe that the amount requested is not enough. The Bureau of Labor Standards must have sufficient resources to file, examine, and process the reports, and to make information on the plans available to beneficiaries and to the public. We ask that the full amount requested for this phase of the program should be made available.

Furthermore, funds should be appropriated to enable the Department of Labor to gather information from the reports distributed under the act, and it is in this crucial field that funds would be lacking if the amount requested by the administration is not increased. Further welfare and pension benefits planning could be based on sounder foundations if more knowledge of present plans were available. No one knows how many workers are covered, what benefits they receive, how much money has been contributed, how much has been accumulated, and what the funds are invested in. The filing cabinets containing the plan descriptions and annual reports are a goldmine of information. We urge that a minimum of an additional $50,000 be appropriated to assure full utilization and dissemination of this most valuable information.

*Study of State safety codes*

During 1950, almost 2 million Americans suffered job injuries, including 13,800 deaths and 84,200 injuries resulting in permanent physical impairment. This is the highest injury total since 1953, and is 8 percent above the 1958 figure.

The AFL–CIO is concerned about this huge manpower loss and the human suffering involved. It is essential that each State have an active, aggressive safety program aimed at reducing the accident rate. We believe that the first step in this direction is the development of uniform safety requirements and promotion of their voluntary acceptance by the States. We are therefore in accord with the Bureau's plan to compare State safety codes with those recommended by the American Standards Association, and fully support the request for $62,400 for this important study. This project follows recommendations of the AFL–CIO and several of our international unions, the President's Conference on Occupational Safety, and the National Safety Council that the Bureau study the whole situation with a view toward promotion of standardization of safety codes throughout the United States, giving consideration of course to special needs of the individual States.

*Maritime safety*

A year ago, the Bureau had pending a supplemental appropriation request for funds to carry out activities under the 1958 amendments to section 41 of the Longshoremen's and Harbor Workers' Compensation Act. A spokesman for the AFL–CIO appeared before you a year ago to support the Bureau's request, and we are glad that both 1959 and 1960 estimates were approved as submitted. In full cooperation with labor, management, and State and Federal agencies, the Bureau has developed the safety codes for ship repair and longshoring activities which will become effective on March 21. We have been assured by the Department that the Bureau's staff will make investigations on board ships and in the repair yards and will be prepared to enforce the codes. This will be the first time that action against willful violators has been possible. At the same time, the Bureau will carry out the training and promotional activities authorized by the law. This is an essential job which must be carried out effectively. Although we note that no increase has been requested for fiscal 1961, we are doubtful that this program can be adequately handled without at least some increase in funds.

*Improvement of migratory workers' conditions*

Another activity of the Bureau of Labor Standards in which the AFL–CIO has a deep interest is that of promoting improvement of the working and living conditions of domestic migratory workers. There are more than half a million of these workers who follow the crops each year, often living and working under

substandard conditions, and for an annual wage which is estimated at somewhat less than $1,000. One of the most important phases of the Bureau's work is encouraging and assisting the States in the establishment of State migratory labor committees. There are, I believe, 29 of them at present, with approximately seven more States which have a sufficient number of migrants to warrant establishment of a committee. In addition, the Bureau works with interested groups in the States, including Governors and State officials, in proposing legislation to protect such workers. There were several pieces of such legislation passed by the various States in 1959, but much remains to be done. The $65,000 requested by the Bureau for 1961 is the bare minimum needed to carry on these activities.

*Protecting young workers*

Under the Fair Labor Standards Act, the Secretary of Labor is authorized to declare occupations that are too hazardous for minors under 18. All developmental work leading to such orders, including investigations, studies, etc., is conducted by the Bureau of Labor Standards. We believe that the Bureau has done a good job. However, working conditions are constantly changing, and the AFL–CIO believes that this program should be intensified in order to assure that young workers are afforded every protection.

It is my recollection that in the early days of the Fair Labor Standards Act, there was a total staff of nine people engaged in this work. The present staff is now down to three because of appropriation cuts. In addition, we feel that the Bureau should be encouraged to develop and issue advisory standards to cover employment of minors in agriculture. It is estimated that an annual average of slightly in excess of 700,000 minors 10 to 18 are employed in agriculture. Therefore, we urge an increase in funds for the Bureau's activities directed toward protecting young workers.

*Service to State Labor Departments*

The Bureau works with State officials and groups and individuals interested in improvement of State labor legislation. It gives technical advice and assistance to a vast majority of the States each year on such problems as workmen's compensation, wage payment and wage collection, child labor, safety, etc. Unfortunately, the amount of funds available for this work is very inadequate. We therefore urge that additional funds be appropriated for this purpose.

BUREAU OF LABOR STATISTICS

*Revision of Consumer Price Index and city workers' family budget*

The Bureau of Labor Statistics has requested an appropriation of $1,250,000 for fiscal 1961 to cover the second year's work in the revision of the Consumer Price Index now underway. This revision, which incidentally has been too long delayed, is planned to be completed for publication in January 1964. We understand that the work contemplated for the coming fiscal year involves mainly surveys of family expenditures which are an essential part of the revision of the Index.

I cannot stress too strongly the importance of having a reasonably up-to-date CPI for use in collective bargaining. This is especially necessary because the Index is applied in so-called escalator clauses in collective agreements involving millions of workers and their employers. We therefore fully support the request of the BLS for the revision of the CPI.

In this connection, I want to commend the initiative of this Subcommittee in requesting the Bureau to issue a revised City Workers' Family Budget. We understand that figures will be available in a few months for about six cities and for an additional 14 cities some months thereafter. We are eagerly awaiting publication of these extremely useful data and express the hope that they will be kept up-to-date on a reasonably adequate schedule.

*Collective bargaining and industrial relations*

You will recall that last year we urged that additional funds be provided to the BLS in the field of wages and industrial relations. We were therefore quite gratified when the Congress in a supplemental appropriation provided funds to permit expansion of the Bureau's wage statistics program. The additional information the Bureau will now make available should be of considerable use for collective bargaining and other important purposes.

We hope that it will also be possible for the Bureau to undertake a necessary expansion of its work in the collective bargaining field. If it is to do so, additional funds will be needed. More and current information for the use of labor

and management negotiators on collective bargaining practices would help to promote mature and peaceful collective bargaining relations and to minimize the area of industrial conflict.

Unfortunately, the Bureau has not had sufficient funds to keep current in this rapidly changing field involving such important and dynamic areas as health and welfare benefits, pensions, vacations, holidays, and methods of adjustment to changing technology. We therefore urge that the Bureau be provided with sufficient funds to provide, on a regular basis, expanded and up-to-date information on collective bargaining developments.

*Productivity*

We would like once again to direct the subcommittee's attention to the need for expanding and improving the Bureau's work in the field of productivity and technological developments. The revolutionary changes which are taking place in our industrial economy make more essential than ever before the availability of information and productivity trends as well as the casual factors operating to bring about changes in productivity. We would urge the need for productivity information in a much larger number of industries. Moreover, we should have more than just bare figures. We need to get back of the figures to know their implications for our future economic development. Such information is vital not only for analysis of our own economy, but for a valid comparison of economic growth in the United States and other countries, including the Soviet Union.

*Labor aspects of world markets*

The BLS has requested a small amount, only $40,000, to begin a study of the labor aspects of world markets. We in the labor movement are increasingly aware of this problem as one of considerable controversy on which the penetrating light of factual data must be focused. Policy decisions on our tariff and trade programs should not be made in a vacuum. It is most important that we have the facts to assure that well-considered policies attuned to national and world needs will be adopted.

Since, in the discussion of world trade problems, great emphasis has been placed on the labor aspect, it is most important that we have reliable international comparisons of wages, fringe benefits, and other labor costs. We doubt very much that the $40,000 the Bureau has requested will permit more than a small beginning on this extremely important job.

BUREAU OF EMPLOYMENT SECURITY

*Evaluation of unemployment insurance and employment office programs*

The role of the Bureau of Employment Security in collecting data, engaging in research, and drawing conclusions about the effectiveness of the employment security system is sometimes lost sight of. Unfortunately, the Bureau of Employment Security does not now do enough to evaluate the unemployment insurance and public employment office programs.

With additional funds amounting to as little as $50,000, the Bureau might be able to undertake the following worthwhile types of activities:

1. The feasibility of unemployment insurance coverage for farm labor, nonprofit employment, and other forms of noncovered employment could be evaluated. For public policy purposes, it is necessary to know how these types of employment differ from those already covered.

2. Special efforts must be made to obtain data on the distribution of earnings in covered employment State-by-State. Some States do not now receive weekly earnings records from employers. Sample studies should obtain this data because it is absolutely necessary in determining the application of the unemployment benefit standards recommended by the President.

3. Studies are needed to establish the extent to which the unemployment insurance system compensates for wage loss and acts as an anticyclical stabilizer.

4. More surveys must be made to evaluate the degree of adequacy of weekly benefits and the extent to which they cover nondeferrable expenditures.

5. More research is needed to establish the subsequent history of individuals exhausting unemployment compensation.

6. There is little now known about the previous work experience of those qualifying for unemployment compensation and the extent to which present wage qualifying requirements really measure "attachment to the labor force," which is a condition for eligibility.

These research projects need not be performed by the BES in all cases, but they must be initiated by the Bureau with State agencies or stimulated among

private research organizations. The Bureau should have funds to initiate and carry through the above research projects and to assist the States in setting up their own research studies in the above areas.

In addition, approximately $50,000 should be made available to be used for the following purposes:

1. To permit the Bureau to report on the number of those exhausting their unemployment benefits in each State on a current basis as are initial claims and total insured unemployment.

2. To inform workers of their rights under the program. This has been neglected with the result that there is considerable delayed filing and nonfiling of benefits to which the unemployed are entitled.

3. To improve the collection and accounting procedures administered in State experience rating systems.

BUREAU OF APPRENTICESHIP AND TRAINING

It is our understanding that the Department of Labor has requested only the same amount of money as last year for its Bureau of Apprenticeship and Training. The appropriation request is for $4,061,000.

Never before in our history have the skills and technical knowledge of free American workers faced the challenge which they face today. Modern apprenticeship and journeyman training systems, guided by committees jointly representative of labor and management, have proved effective in developing craft skills among workers entering the skilled trades and in assisting journeymen to keep abreast of the technological advances occurring since they served their apprenticeship.

The field staff of the Bureau of Apprenticeship is actively engaged in working with management and labor in developing apprenticeship programs. It is difficult for us to understand why the field staff of this Bureau is not substantially increased, when we observe the continual increase occurring in our industrial work force and the constantly increasing proportion of skilled craftsmen needed to meet growing industrial demand.

The Bureau's field staff, including its regional and State directors, numbers only some 235 men. These men carry the full load of promoting and developing joint labor-management apprenticeship programs needed in increasing number if we are to adequately meet the growing industrial demand for highly skilled workers.

This small staff has accomplished considerable in working jointly with management and labor, largely at the local level, in developing apprenticeship programs.

It should also be remembered that in recent years the Bureau of Apprenticeship has taken on the additional task of promoting journeyman training and other training. With this added work the necessary additional funds have not been available to increase the Bureau's field staff so as to allow for this additional function. There is a real need for more field representatives for the Bureau.

The development of apprenticeship programs has suffered. The present appropriations do not permit the bringing of the field staff up to adequate proportions so that the development of our national apprenticeship programs as carried on by the Bureau can keep pace with the growth of our civilian economy and our national defense needs for increasing skills in our work force.

The AFL–CIO therefore, in accordance with the clearcut mandate of its convention, urges that more adequate funds be provided to this Bureau. Such increase should be for the specific purpose of substantially increasing its field staff and extending its work in the promotion of apprenticeship and journeyman training in our national interest.

An additional specific appropriation of three-quarters of a million dollars, earmarked for field staff additions, would allow for up to an additional 100 persons, well versed in apprenticeship, to be employed in the field by the Bureau.

We earnestly recommend that serious consideration be given to such an increase. We know that a small additional expenditure for this purpose will pay large national dividends through resultant increases in our skilled manpower.

*Mexican farm labor program*

The Secretary of Labor has the responsibility to enforce the provisions of Public Law 78, the International Agreement and Standard Work Contract.

The U.S. Government is the guarantor under the agreement with Mexico regarding wages, transportation, and subsistence.

To carry out these obligations the Labor Department, Bureau of Employment Security, Farm Placement Service, has a compliance division with approximately 75 field representatives who work in direct contact with the workers and employers.

The importation of Mexican agricultural workers amounts to almost 450,000 workers every year. The present field staff averages about one field representative for each 6,000 Mexican nationals. These men have a staggering load and are expected to do a fair job on all the numerous duties with which they are charged as part of their responsibilities.

These field people make periodic checks on payroll records, review wage rates and workers' earnings. In addition, they gather information on the earnings of domestic workers in comparable activities to be sure that Mexicans are paid prevailing rates. Finally, they act more or less in the capacity of counselors, advising workers and employers of the policies and procedures governing the importation program. They conduct investigations, settle claims, and investigate complaints.

It seems to me perfectly obvious that a compliance representative could not possibly do an adequate job when he is assigned an average of 700 employers plus 6,000 workers, involving housing standards, wages, and all the other responsibilities of the International Agreement and Worker Contract; and unless he does his job adequately the ultimate effect is to adversely affect the American workers, something that Public Law 78 enjoins.

The Labor Department has requested funds for an additional 28 fieldworkers. This should improve the present investigation and compliance program but only a little. We believe that the amount requested by the Department should be considerably increased so that both American and Mexican workers will be assured of fully fair and effective administration of Public Law 78.

### BUREAU OF INTERNATIONAL LABOR AFFAIRS

The Department of Labor's budget includes a request for an additional $152,000 for the Department's international activities now carried on in its Bureau of International Affairs. The AFL–CIO strongly supports this request.

Recent developments in Africa, Asia, and Latin America reflect the degree to which trade unions in these regions are becoming increasingly important, not only in the economic and social fields, but in the governmental and political areas as well.

The current efforts of the Soviets to capture control of the working people throughout the world necessitate an expansion in the fields of reporting, research, and technical assistance on the part of our Government if we are to effectively meet this challenge. We understand that the bulk of the additional funds requested will be used to increase the number of area and country specialists so that there will be, in the Bureau, additional competent people well-versed in the developments affecting labor in the specific areas which are becoming of increasingly crucial importance to our own country. We strongly urge that the funds requested be appropriated.

## Department of Health, Education, and Welfare

### SOCIAL SECURITY ADMINISTRATION

The programs of the Social Security Administration are intimately involved with the welfare of every person in the United States. Large sums are paid out by the agency as benefits and grants to the States. Valuable as the programs have proved, they could be still more valuable if relatively small amounts were added by your subcommittee to the appropriations requested for improving administration in specified ways. These additional amounts in many instances would lead to such economies that in time, net costs would be reduced.

Less is being accomplished by the Social Security Administration during this fiscal year than would have been the case if the Budget Bureau had permitted the full appropriation authorized by Congress to be translated into expenditures. Instead the Bureau issued an order that expenditures be reduced 2 percent below the authorized appropriation for this as well as for other agencies.

It is no secret that the request by Department of Health, Education, and Welfare for the coming fiscal year has also been held down by the Bureau of

the Budget, acting for the President, in setting a ceiling on the total for which the Department might ask. The request therefore does not necessarily reflect the views of persons intimately acquainted with the needs of the programs.

BUREAU OF OLD AGE AND SURVIVORS INSURANCE

We should like to see additional funds, beyond those in the budget request, made available to the Bureau of Old Age and Survivors Insurance for the purpose especially of speeding up and improving administration of the disability benefits phase of the program.

As spokesmen for the AFL–CIO indicated to the Harrison subcommittee of the House Ways and Means Committee last fall:

"We applaud the record of economical administration that has been established by the Bureau of Old Age and Survivors Insurance in connection with the entire program. Its overhead, which comes to about 2 percent of benefits, or 2 percent of contributions, is remarkably low as compared with commercial insurance. We inquired as to the cost of administering the disability parts of the program and we are informed that the cost in the fiscal year 1959 came to 2.8 percent of the income of the disability trust fund. We think that this is not too high, particularly compared with the cost under similar benefits, insofar as they exist, that are administered by the commercial insurance companies. It would be appropriate to spend a still larger percentage, if necessary, to speed the processing of cases and maintain high quality, and we feel that we, as spokesmen for a group that are particularly interested in this program, can properly express the interest of our members in high quality, quick administration."

The present legislation on disability benefits does not provide for the most economical form of administration since it divides authority between the Federal agency and the State agencies, which make most of the actual determinations in regard to applications for disability benefits or the disability freeze. But so long as the Congress prefers to maintain this type of administration, we believe sufficient funds should be authorized to speed the handling of cases where additional medical examinations are required and so that appeals can also be handled promptly and effectively. We assume your committee can obtain estimates from the agency as to the sums required to achieve these objectives.

BUREAU OF PUBLIC ASSISTANCE

The budget request for this Bureau was apparently crystallized before consideration had been given to the report of the Advisory Council on Public Assistance which was created by the 1958 amendments to the Social Security Act. The Council presented its report to the Secretary of HEW and the Congress on December 31.

The Council made important recommendations for improvements in the program some of which can be put into effect without amendments to the Social Security Act. The Council was a representative group; it held nearly 2 weeks of meetings over a period of a year; and most of its recommendations in regard to administration were unanimous.

Since more than $2 billion of Federal funds are proposed in the budget for grants to the States for public assistance payments, we strongly urge that your committee implement the Council's recommendations in regard to administration by providing enough funds so they can be carried out this year. It seems desirable to ask the Bureau for specific plans and costs involved.

The major recommendations of the Council which can be put into effect by administrative action, without change in the basic legislation, are as follows:

Recommendation 5, on adequacy of assistance, recommends that:

"The Federal Government should exercise greater leadership in assuring that assistance payments are at levels adequate for health and well-being. It should promote greater public understanding as to what constitutes a level of living sufficient to maintain health and well-being, and the relationship of present payments to such level. As specific steps toward these ends, the Federal Government should exercise leadership in (1) developing up-to-date budget guides, for typical families, showing the items of living requirements and their costs necessary to sustain a level of living adequate for health and well-being; (2) making these budgets available for the guidance of States in evaluating their own budgets; (3) requiring periodic State reporting on budgets in use, and on actual individual payments in relation to these budgets; and (4) publishing

periodically information on budgets in actual use in individual States and other data significant in indicating adequacy of appropriations and assistance payments in each State."

The Council's supporting statement on this recommendation explains the importance of the recommended action.

Recommendation 6, on adequacy of medical care, points out that "future public welfare costs may increase, largely because of increasing medical care needs and costs." The Council recommends that the Federal Government should exercise greater leadership in stimulating and encouraging States to extend the scope and content and improve the quality of medical care for which assistance payments are made to or on behalf of needy individuals. Specific steps are recommended toward this end.

As the Council points out: "Low income and poor health work in a vicious circle. Malnutrition, untreated physical handicaps, debilitating chronic conditions, and the like, do not make for vigorous self-supporting people."

Recommendation 8 deals with community participation and use of voluntary agencies. The Council urges that the Federal Government encourage each State to work more closely with voluntary agencies, etc.

Recommendation 17, on training and personnel, includes four specific recommendations to improve administration, promote social rehabilitation, and help prevent dependency. Data are presented on shortages of social workers, on understaffing of public assistance agencies, and on the very heavy turnover among public assistance employees.

Recommendation 18, on strengthening family life, states in part:

"The Congress should appropriate funds authorized under the Social Security Amendments of 1956 for grants for research and demonstration projects such as those relating to the prevention and reduction of dependency, coordination between private and public agencies, and improvements in social security and related programs, and research leading to strengthening family life."

The President's budget request asks for only a fraction of the money that Congress authorized for such vital studies in 1956. The request totals $700,000 instead of the more than $2 million requested in the 1958 budget. Now that the Advisory Council has emphasized the importance of preventing dependency with the help of such cooperative research projects, we urge your committee to recommend the full appropriation authorized in 1956.

The total amount requested by the President for administrative expenses of the Federal Bureau of Public Assistance equals slightly more than one-tenth of 1 percent of the estimated Federal grants for the programs which the Bureau supervises. It is shortsighted economy to deny necessary additions to the staff of the Bureau for the purpose of improving the quality and effectiveness of administration at all levels so as to minimize dependency and potentially save vast amounts through restoring many thousands of families to self-sufficiency.

### THE CHILDREN'S BUREAU

The programs administered by this Bureau have enabled many mothers and children to achieve better health. They have contributed to the general welfare and through enhancing the productivity of many thousands of people, have increased Federal revenues. The administration has nevertheless again failed to ask for the full additional $5 million authorized in 1958 for each of the three major programs: Maternal and child health services, services to crippled children, and child welfare services. We urge you to appropriate the full amounts authorized so that they may be granted to the States for the support of adequate programs for the Nation's mothers and children. They are, respectively, $21 million, $20 million, and $17 million.

### OFFICE OF COMMISSIONER OF SOCIAL SECURITY

This Office performs vital overall functions for the entire social security program and is financed partly from general revenues and partly from the OASI trust fund. The total of $390,000 requested for this Office is a modest amount and in our view insufficient. Additional funds should be authorized to provide more staff for the appraisal and development of the social security programs, to permit the Social Security Bulletin to appear in more attractive format, and to issue other publications as necessary on basic materials relevant to the program. Even as little as $100,000 would be helpful for these purposes.

OFFICE OF EDUCATION

*Vocational education*

Although the 1961 budget request for vocational education as a whole totals $40,267,081, which is identical to the amount appropriated for fiscal 1960, there has been a reshuffling in the placement of such funds which we find most disturbing.

The President's budget estimate proposes a decrease of $2 million in the amount to be used under title I of the George-Barden Act for vocational education programs, including the related instruction for apprentices. The $2 million which the administration has cut from these title I programs, it has added to the so-called area vocational education programs under title III of the George-Barden Act (as established by title VIII of the National Defense Education Act).

In other words, to put it bluntly, and as admitted in the message accompanying the budget statement, the older programs, that is, the standard vocational education programs including related instruction for apprentices, are to be cut back in order to provide additional funds for the limited type programs under title VIII of the National Defense Education Act, which has only 3 more years to run.

We vigorously oppose this proposed reduction of funds for vocational education programs of a permanent nature, in favor of programs of a limited type and temporary duration as provided in the National Defense Education Act.

Such a shift cannot be justified. George-Barden Act, title I funds have all been committed and used. The States rely on the receipt of their portion of this item as basic to their established and continuing vocational education programs. A cut of $2 million and its shift to title III programs will disrupt existing and satisfactory State use of funds and will require a State to develop programs under title III (programs necessarily of limited life under title VIII of the National Defense Education Act).

The AFL–CIO is unalterably opposed to this proposed shift in funds. If the administration needs more funds for National Defense Education Act, title VIII programs, such funds should not come out of the amounts which previously were appropriated to generate and support our State vocational education programs.

Whatever else needs to be done to strengthen America's supply of skilled workers, the one thing clearly to be avoided is the weakening of our regular and established programs of vocational education. America cannot afford the shift recommended in this budget.

*Library services*

We regret that once again the President has requested less than the full amount authorized by the Library Service Act for assistance to State library services. Although worthwhile progress has been accomplished since the Library Service Act was passed in 1956, the essential job is by no means completed. We have only to remind the subcommittee that last year there were still some 25 million people in rural areas without any public library service and over 250 counties with no public library service within their borders.

Library services should be expanded as rapidly as possible so that they are available to all Americans, young and old. We therefore urge this subcommittee to recommend appropriation of the full $7,500,000 authorized by the Library Service Act. This is $200,000 more than the President has requested.

FOOD AND DRUG ADMINISTRATION

We strongly urge approval of at least the $16,852,000 requested in this year's budget for the Food and Drug Administration.

Our only concern is whether this figure is too low. As a result of several years of underfinancing, this agency faces a problem of basic expansion. In addition, new and heavy responsibilities have been placed upon it by the Food Additives Act of 1958. Finally, the continual multiplication of new technologies in the production of food, drugs, and cosmetics presents an expanding challenge in both research and enforcement.

The basic expansion program recommended by the Citizens Advisory Committee of 1955 must be continued and if possible, accelerated. The timetable developed to meet the Committee's recommendation of a "threefold to fourfold increase in from 5 to 10 years" calls for 1,763 budgeted positions in 1961. Not taking into account legislation enacted since the Committee report, the com-

parable number of jobs proposed in this year's budget is 1,748. This is "short weight," although not nearly as much as the administration request of last year Last year's deficiency was, of course, remedied only because of the initiative of this Appropriations Subcommittee and its distinguished chairman. This subcommittee is to be complimented for its keen watchfulness in seeing that the Food and Drug Administration is not undercut by deficient appropriations requests of the budget-minded administration.

There are now over 100,000 establishments subject to FDA inspection. The new funds will enable the FDA to bring the inspection cycle to one inspection every 4 years for each establishment. This will still be a long way from the goal of one inspection per establishment per year.

Under recent legislation the Food and Drug Administration has an important responsibility for establishing and policing tolerances on how much, if any, of a particular chemical used in food growing, processing, or as an additive to food itself is safe for human consumption. The FDA's resolute enforcement of this responsibility has aroused the fear and opposition of some groups whose profits may thereby be subjected to risk. It would be most unfortunate if, as a result of this opposition, the agency were to be weakened by any reduction in its requested appropriations.

We are pleased to note that the new budget stakes out more activity in the as yet little-known field of radiological contamination of foods. This is of vital importance. We cannot afford to neglect research in this area of potential danger to our health.

We are certain that we can rely upon this subcommittee to give serious and sympathetic consideration to the full needs of the FDA and approve appropriation of whatever amount is needed beyond the bare minimum represented by the current administration request.

## PUBLIC HEALTH SERVICE

We live in an age of constant and continuing scientific and medical discoveries that will lessen human suffering and prevent disability and premature death The most dramatic kind of breakthroughs seem to be just around the corner. The possibility of more productive lives for all the people of the Nation looms ever closer, while the unsolved problem of providing all of America's men, women, and children with the benefits of modern medical care grows increasingly acute.

In the face of this situation, it is staggering to the imagination that the President should propose a cut in the funds devoted to the Nation's health. The funds requested for the Public Health Service are some $74 million less than the amount appropriated last year.

### *Grants for hospital construction*

The administration has once again recommended a reduction from the previous year in appropriations under the Hill-Burton Hospital and Medical Facilities Act. For many years the AFL–CIO has been urging Congress to appropriate the full amount authorized under the Hill-Burton Act for construction of hospital and other health facilities in view of the continuing shortage of such facilities throughout the country. While the excellent work accomplished under this program has helped to meet the need for the additional beds due to population increases, the gain in reducing the total backlog has been minor.

The administration's proposed cut in appropriations for hospital construction comes in the face of full recognition by the Department of Health, Education, and Welfare that the broad purpose of the Hill-Burton Act has by no means been carried out and that, to quote the Department's own report, "adequate facilities of many kinds are still lacking if a high quality of medical care is to be provided for all the people."

The Secretary of Health, Education, and Welfare justifies the actual 30-percent cut in funds requested by suggesting that this is no reduction at all, because the entire fiscal 1960 appropriation will not have been spent by June 30. He fails to point out that, in order, to make orderly planning possible, Hill-Burton money may be used over a 2-year period. By adding the unspent funds from this year to the current requests for appropriations, the administration's budget may give the appearance of maintaining present levels of aid to construction. It misses the mark of actually doing so by some $60 million.

In view of the pressing need in this field, the third constitutional convention of the AFL–CIO called upon Congress to "Increase the appropriations to the hospital and medical facilities construction program to the maximum levels authorized by the basic legislation." This would require, instead of the cut that is suggested, an appropriation of $211.2 million.

*National Institutes of Health*

It is gratifying to note that the administration takes cognizance of the importance attached by the American people to the possibilities to be realized through large-scale medical research. At least no cut in the total appropriations for the National Institutes of Health has been proposed. There is no reason, however, for not expanding these funds in line with ever-increasing opportunities for progress.

We call attention once again to the report of the Secretary's Consultants on Medical Research and Education which states that "the expansion of medical research and education required in the national interest will be costly and should not be restricted by lack of funds," and that the consultants "believe it conservative to project total national medical research expenditures of $900 million to $1 billion per year by 1970 * * *."

Most urgently we suggest that now, while hopes of dramatic progress are so bright, is hardly the time to cut the appropriations to the National Cancer Institute, to mental health activities, and to neurology and blindness activities, as the administration recommends. We reiterate our position that the only legitimate limitation on appropriations for medical research should be the availability of professional resources to use such funds productively. We trust that once again this committee will exercise its inspired and responsible leadership in this direction.

*Health of the aged and chronic disease*

It is virtually impossible to understand how the President could propose a cut of almost $2 million in the funds to provide the States with technical assistance and support for health services and training, in the face of blatant unmet needs which exist in this area.

We will confine our comments to one of the items under "Assistance to States," that of "Health of the Aged and Chronic Disease." In this category are the funds which are to enable the Department to continue "studies to develop and improve methods for the identification and prevention of chronic illness, for the restoration of the chronically ill and aged, and for meeting special health problems of the aged," and give assistance "in the application of proven techniques through technical assistance, demonstrations, and training."

We are distressed to discover that the year 1960, which finds the number of aged and chronically ill increasing daily and which finds the existence of an ever-growing body of knowledge and techniques to reduce the burden of chronic illness and improve the health of the aging, also finds the administration asking for the stinting sum of $1,354,100 as the Federal Government's contribution toward finding ways to bring the benefits of that knowledge and those techniques to the people.

For the past 20 years, many public health programs of great significance have been initiated by Federal grants to the States. This was true in venereal disease control, tuberculosis control, and many other programs. There is good indication that State and local health departments would be prepared to engage in the public health assault against chronic disease and in the effort to maintain the health of the aging which is so very badly needed, if enough Federal funds were available.

The organization of health services, especially for the chronically ill and the aged, and particularly in the area of out-of-hospital care, is extremely inadequate in most communities. There is a great need for demonstrations on the local level of how the organization and quality of services can be improved, in the areas of prevention of disease, curative treatment, and prevention of disability. A great deal could be achieved through demonstration projects which could, for example, provide organized home care under hospital supervision; establish home-nursing and homemaker services; experiment with facilities to provide day care to some, and night care to others; or show what can be done through the use of rational methods of hospital organization such as progressive patient care and allied techniques.

Experience shows that the development of these urgently needed services could be effectively encouraged and expanded through the use of increased Federal funds.

No appropriation less than the maximum authorized for assistance to the States under the basic legislation is reasonable under the circumstances. We believe that $30 million should be appropriated for "Assistance to States, general," and that a substantial portion of this should go to stimulate the creation of projects and services for the aged and those with chronic illness.

*Environmental health activities*

The Congress in 1956 authorized $50 million annually for grants-in-aid to localities for construction of sewage treatment facilities. In the bill which the President has just vetoed, H.R. 3610, this amount would have been raised to $90 million a year for a 10-year period. In the face of this minimum need as expressed by the Congress, the administration has requested only $20 million for this purpose for fiscal 1961.

This is a completely inadequate amount which should be substantially increased. It is well known that the localities simply do not have the financial capacity to deal with this growing menace to the Nation's health. While the program under the 1956 act has stimulated construction of sewage treatment facilities, even the administration acknowledges that there is still a tremendous backlog of needs for additional plants. Thus, Maj. Gen. J. S. Bragdon, the adviser to the President on public works, has said: "We need almost 8,000 municipal plants alone, and in all, some 17,000 facilities, public and private, to insure that all of the potential sources of pollution are adequately controlled."

In addition to increasing the appropriation to carry out the 1956 act, we also believe that the $12.5 million requested for the Department's own program of environmental health activities, including water and air pollution and radiological health, is probably inadequate. We question whether the $4.9 million requested for the air pollution control program is enough in view of the magnitude of the problem. We are also concerned that the $6.1 million appropriated for radiological health will probably be inadequate. As you know, the Secretary of Health, Education, and Welfare has largely accepted the recommendation of the Radiation Study Subcommittee, of the National Committee on Radiation Protection and Measurement for lowering the permissible limits for radiation in food and water. This makes all the more important the work of the Public Health Service in this field and will also increase the complexity in size of its program. We therefore urge that sufficient funds be appropriated to assure that this vital problem affecting the Nation's health and welfare will be adequately met.

NATIONAL HEALTH SURVEY

We welcome the President's request for an increase of $681,000 for the Office of the Surgeon General to support the national health survey. As indicated in the budget message, such funds would be used to (1) obtain information on the amount, distribution, and effects of illness and disability in the United States and the services received for such conditions, and (2) study techniques for obtaining such statistical information with a view toward their continuing improvement.

With the total health budget running into the hundreds of millions of dollars, certainly this expenditure of about two-thirds of $1 million to keep fully informed on the nature of the health problem in a modest and desirable one. We urge its approval.

---

STATEMENT OF THE AFL–CIO EXECUTIVE COUNCIL ON THE ECONOMIC SITUATION

America must choose dynamic, up-to-date programs for sustaining economic growth in the 1960's or face more crippling recessions from repeating the mistakes of the past 7 years of stagnation. Only a balanced economy with a sustained growth rate of 5 percent a year can provide a healthy relationship between a fast-growing labor force and rapid increases in productivity and productive capacity. Policymakers must choose between an America with more jobs for more people who can buy more goods produced more efficiently by greater plant capacity and an America with limited job opportunities, high levels of unemployment, tight money, economic restrictions, and repeated recessions.

As 1960 begins, policymakers seem intent on repeating past errors. Despite the prosperous beginning of this year, many academic and business economists are already predicting a recession in 1961. Facts support this possibility. Administration and business policymakers must, therefore, take immediate action. They must discard the negative, growth-stunting, lopsided, recession-producing policies of the last 7 years or face the possibility of a repetition of the recession years 1953–54 and 1957–58; only this time, the losses could be greater.

Policy changes must be immediate: Monetary policy designed to foster growth must replace the tight-money policy that has helped squeeze the economy into

recession twice in the last decade. This squeeze recently has in some ways become as tight as 1929. Budget policy based on America's need for defense and for the growing needs of its increasing population must replace the 19th century budget policy based on the pennypinching obsession with seeking budget surpluses regardless of the cost to national well-being.

Business and Government must both recognize that increased plant and equipment expenditure is dependent upon high levels of consumer buying power. The growing number of products produced by the Nation's factories cannot be sold unless wage and salary income is rising. Tax policy must include revisions in the tax structure to help support this balance between consumption and investment Tax inequities and discrimination against low- and middle-income taxpayers must be replaced by a fair method of getting enough revenue to meet national needs.

At the same time, counterrecessionary measures should be put on the statute books, enacted now and to be saved for use in case a downward cycle arrives.

### OUTLOOK FOR 1609

Support for the prediction of a recession in 1961 comes from the following analysis: During the first quarter of 1960, economic activity will be at a high level. Business is rebuilding inventories of steel, steel products, and automobiles. Production, sales, and employment are rising.

By midyear, the rebuilding of business inventories can be expected to ease and a considerable slowdown in economic activity will follow.

The rise of consumer sales in the past year has been bolstered by a $5.4 billion increase in installment credit, one of the sharpest rises on record. A similar sharp rise of installment buying cannot be expected to continue through 1960. If the buying power of American families fails to rise substantially in the months ahead—through wage and salary increases, as well as rising employment—the increase of consumer sales may slow down at about the same time that the inventory buildup eases.

Unless present policies are reversed, the economy's forward advance, marked in the first half of 1960, will start to slacken by mid-1960. Most lines of economic activity will be slowing down or declining by the end of the year. One possible exception to the decline in activities may be large corporations' investment in new plant and equipment. Productive and more efficient capacity, therefore, will be available, while sales of most goods may be leveling off or falling. This combination of factors make a recession some time in 1961 a very great possibility

### FORCES SLOWING DOWN RATE OF ECONOMIC GROWTH

What are the forces that are working for a slowdown in the rate of economic growth? (1) Tight-money policy has brought on interest rates that are the highest in over a quarter of a century; (2) Government budget policy designed to stifle the building of schools, hospitals, homes, and community facilities that are so vital for a growing and expanding economy; (3) preoccupation with fighting inflation, coupled with a fear of growth. Nineteenth century economic policies do not fit the dynamics of today's problems.

*(1) The tight-money squeeze*

The continued application of the tight-money choke every time the economy moves upward has finally caused the tightest squeeze in more than a generation. The Government's tight-money policy has squeezed the money supply downward until it is almost smaller in relation to total output than it has been since befor the great depression of 1929. The tight-money policy has contributed to a rise of over 40 percent in interest payments on the national debt since 1953, although the debt has increased less than 8 percent. It threatens the economy's forward momentum, as it drastically restricts certain kinds of necessary economic activity.

The interest rates on FHA mortgages is now 5¾ percent. But that isn't all. There is another one-half percent that must be added for insurance. Untold additional payments have to be made in order to even get a mortgage. This combination of tight-money policies and practices has already brought a slump in homebuilding. Construction programs of State and local governments are being curtailed or postponed, because borrowing has become too expensive. If the tight-money squeeze continues, it will curb the purchases of small businesses,

farmers, and consumers. An increasing number of economic activities will be choked as tight money takes hold during the course of the year.

The large corporations, however, have huge financial resources that make them immune to early effects of the tight-money squeeze. Their investments in new plant and equipment—particularly labor-displacing automation machinery—are expected to rise through the year. Industry's capacity to produce will be increasing in the second half of 1960, when the economy's ability to buy may be slowing down considerably. It was such a lack of balance between the economy's capacity to produce and its ability to buy that brought on the recession of 1957–58.

*(2) The budget cudgel*

In the name of fighting inflation, the administration has assumed that a budget surplus, regardless of its consequences, is a necessity. The administration's budget proposals threaten the expansion of our economy, as they restrict necessary and economy-boosting activities. Defense expenditures are to be held to last year's level, and public service programs are to be curbed or maintained as mere token gestures. The Federal Government's aim is to create a $4.2 billion surplus in the budget, placing greater emphasis on a balanced budget than upon economic growth.

*(3) "Inflation" fight has caused 7 years of stagnation*

A snail's pace growth of the economy in relation to population has resulted from 7 years of dangerously cutting down the pace of balanced economic growth in the name of fighting inflation. The tight-money squeeze and the budget-balancing efforts have combined to make a sustained high average growth rate impossible. Instead, America's rate of output per person between 1953 and 1959 was squeezed to a yearly average rate of six-tenths of 1 percent, only one-seventh the rate of Soviet economic expansion. During this period, unemployment as a percent of the labor force rose from 2.9 percent to over 5 percent. Yet the current policies of Government seem designed to reduce even the snail's pace of growth and to lead to ever higher levels of joblessness.

As 1960 begins with a boom that includes a high rate of joblessness and a large percentage of idle industrial capacity, therefore, prospects for the future, based on current policies, are frightening. For the population is growing rapidly. The labor force—the number of people who need jobs—is also growing. Large corporations continue to pour funds into new plant and equipment of a kind that will cause sharp rises in productivity.

## CONCLUSION

Obviously the 19th century economic policies practiced in the last decade have not, therefore, even in a moment of boom produced an economy with maximum employment, production and purchasing power. Restricting economic growth by budget balancing and preoccupation with a nonexistent kind of inflation obviously will not attain the objectives of the Employment Act of 1946. Action to reverse these current policies cannot come too soon.

The weak and backward-looking actions of the last 7 years of stagnation with its restricted and distorted policies must be reversed. A bold dynamic program along the lines of the following six points must be substituted.

(1) The tight-money squeeze must be reversed. The administration's attempt to remove the 4¼ percent ceiling on long-term bonds must be repulsed. Any effort to tighten the money supply and raise interest rates even further must be defeated. The current economic problem is just the opposite of the one now dictating tight-money decisions. Today, the United States is faced with an inadequate supply of money to accomplish its goal of sustained 5 percent annual rate of growth.

(2) Government programs for public services such as schools, hospitals, community facilities, and homes must be expanded, not restricted.

(3) The defense needs of this country must be adequately met. Expenditures in this area should be stepped up wherever and whenever necessary. Consideration of a balanced budget should be secondary to the military security of the United States.

(4) Economic balance between business investment and consumer markets must be achieved. We cannot permit a repetition of the 1955–57 experience when the country's economic ability to produce outpaced its ability to consume.

(5) Increases in wages and salaries, along with special efforts to raise the buying power of low-wage workers through minimum-wage legislation, must be encouraged and achieved. The Fair Labor Standards Act should be amended to extend the law's coverage to workers in retail and wholesale trade, service, and large-scale farms and to raise the minimum wage to $1.25 an hour.

(6) A revision in the tax structure designed to provide a more equitable basis for raising Federal revenues is essential to meet the needs of an expanding Government budget.

Since realism dictates an awareness that the administration does not intend to reverse its policies quickly, we must, therefore, be prepared to fight another recession, aggressively and quickly.

We should adopt immediate counterrecessionary policies to be put into effect as soon as a decline in the economy develops. In this way, any recession that may develop can be minimized and its effects reduced.

First, the unemployment insurance system should be improved. The rise in unemployment insurance payments during the 1957–58 recession, offset one-fourth to one-fifth of the drop in total wages and salaries. The adoption of a Federal standards system for unemployment insurance designed to increase benefit levels as well as duration of payments would substantially improve the counterrecessionary measures now avialable.

Second, a detailed shelf of public works programs should be prepared at once. All public works programs should be examined to determine which of them could be made ready and available for immediate action at the first signs of a recession. Detailed planning, blueprinting, and land purchases should be made well in advance of a recession. A comprehensive program of this type would include Federal technical aid and long-term loans to make possible State and local government planning. Such a program is essential for the development of a Federal shelf of public works.

Third, the Social Security Act should be amended to provide increased benefits and medical care provision to those who are eligible for old-age and survivors insurance.

These things must be done regardless of whether a recession will actually occur. Our economy should always be prepared to react quickly in case of economic decline. It is our fervent hope that the economic policies of this administration can be reversed, thus enabling us to maintain maximum employment, production, and purchasing power.

The AFL–CIO is convinced that the present policies that are now leading us toward another recession can and should be reversed. But if they are not, we repeat, we must be prepared, better than we have been in the past, with the necessary kinds of action programs designed to quickly counteract the effects of a recession.

Mr. Bookbinder. I shall take just a few moments to highlight several of our specific recommendations.

On the whole, as in previous years, as you know, we support the work of these two major departments of Government. These are two departments which have a major responsibility for the health, welfare, and well-being of working people in addition to all men and women of the country.

I want to point out that in the resolution which is appended to the statement and which we quote on the first page, the AFL–CIO has stated a basic concept which may merit repetition here. Although we obviously do not seek to increase the budget for the sake of increasing the budget—we would just as soon see a balanced budget as anybody—we do think a balanced budget is a No. 2 priority and that the No. 1 priority is the welfare of the American people. We note with concern that there are some needs of the American people which are not met adequately by this particular budget submitted by the President.

Now for a few specific recommendations.

In the case of the wage-hour administration, in light of the record of great violations, we would hope that the request made by the Wage-Hour Division which was turned down by the Budget Bureau, for $900,000 to permit the employment of 100 additional field inspectors,

be granted to the Division. Many millions of dollars in wages are now known to be lost, as determined by the sample checks made. Many, many additional millions are presumably lost which are not even known about.

For the Bureau of Labor Standards, we would recommend specifically a $50,000 increase to permit some detailed study and analysis of the reports which have now come in in such large numbers under the Welfare and Pension Plan Disclosure Act. It seems to us rather silly to have invested all these funds, to have had many thousands of people produce these reports, and then to find that a gold mine of really useful information lies untapped in the Bureau of Labor Standards. This modest amount of money would make possible a very useful appraisal of those data.

Also we would endorse very heartily the $65,000 which has been requested by the Bureau of Labor Standards for the work in the improvement of domestic migratory workers' conditions.

A few quick observations on the Bureau of Labor Statistics. First, I am very happy to be able to say to the committee for the record how pleased we are that the committee's work is being fruit in the case of the city worker's family budget. After several years' reminders from this committee, the work has proceeded to the point that we are told within a few months figures for 6 cities will be available, and shortly thereafter some additional 14 cities.

We also want to express pleasure at the fact that although our request for additional moneys for wage statistics was not granted in the initial appropriation, a supplemental appropriation soon thereafter did provide very much needed funds for more work in the field of wages.

We renew our support for some more funds for collective bargaining and for productivity. These are two areas that require more progress.

A modest amount of money is now being requested, some $40,000, for a study of the labor aspects of world markets. You will recall that we have supported this type of study in previous years, and we hope this $40,000 will be available.

I had hoped to have with me a delegate from our Metal Trades Department to say just a few words about the need for additional moneys in the apprenticeship and training program. We have a detailed section in the full statement which has been submitted. I would just comment here that we would recommend some three-quarters of a million dollars more, in addition to the $4 million requested, which would permit the employment of some 100 additional field staff people to do work in this rapidly increasing field, because of the increased need.

Finally, just a word or two on public health and related matters.

Once again the administration does no more than to say, "OK" for what you do the previous year, but one of these days you may see them say, "OK and do a little more, too." As you know from many weeks of detailed testimony, the administration is willing to have the same amount for the NIH activities, but by limiting it to the same overall amount they actually have to cut important activities: cancer research, mental health, neurology, and blindness. We look forward again to reading with pleasure that the committee has not been held

back by the administration's recommendations, but that you will make recommendations based only on what the needs are.

In the field of hospital construction, unfortunately, the administration has gone down some $60 million. Through their convenient sleight of hand, they make this recommendation appear as if they are continuing the program at the same level when, as a matter of fact, it means sustaining the inadequate rate of actual expenditures, but not meeting the needed goals that you have set through your appropriations.

Although the Congress has indicated that $50 million is not enough for sewage treatment facilities—that $90 million is the actual need—the administration would appropriate only $20 million out of the authorized $50 million, and we trust that that will not remain that way.

This completes my own recommendations. I have Mr. Bert Seidman, economist of the AFL–CIO, who helped prepare the statement, and we are ready for any questions you may have.

Mr. Fogarty. Mr. Seidman, have you anything to add?

Thank you very much.

---

Thursday, March 3, 1960.

## Library Services

### WITNESS

### MISS SALLY BUTLER, DIRECTOR OF LEGISLATION, GENERAL FEDERATION OF WOMEN'S CLUBS

Mr. Fogarty. Next we have Miss Sally Butler representing the General Federation of Women's Clubs.

Miss Butler.

Miss Butler. Mr. Chairman and members of the committee, I am Sally Butler, director of legislation for the General Federation of Women's Clubs. The general federation was chartered by the U.S. Congress in 1901. The purpose as defined in the charter of the organization is to unite the women's clubs and like organizations throughout the world for the purpose of mutual benefit, and for the promotion of their common interest, education, moral values, and fine arts.

The general federation has a membership of approximately 5 million women in the United States of America. Education is a necessary requisite for the preservation of the democratic way of life. All people in every community must have the opportunity to acquire all the education that is offered in our public schools and the additional opportunities that can only be given through the library services. The Library Services Act sets up machinery by which the facilities of libraries can reach a broader base than it has in the past. However, no matter how much machinery is set up for this or any purpose it is of little service unless there are sufficient appropriations granted so the job can be done.

Since the president of the General Federation of Women's Clubs, Miss Chloe Gifford—who, incidentally, is of the staff of the University of Kentucky, off 2 years to do this job—repeatedly says that edu-

cation is the first line of defense for our Nation, we believe library services to the States and communities must not be curtailed. The resolutions of the General Federation of Women's Clubs form the policy of the organization. We do have a resolution that urges economy in government but we feel it is false economy to jeopardize the education, health, and welfare of the people. We urge you gentlemen, of this committee, to recommend that the full appropriations as authorized by the Library Services Act be granted.

Mr. FOGARTY. That is a very fine statement, Miss Butler.

We have resolutions urging economy, but you do not urge economy in the field of education and welfare.

Miss BUTLER. When it will affect the welfare of the people. As our president has said, she is very emphatic that education is the first line of defense.

Mr. FOGARTY. But in the President's budget we have before us, he and Mr. Flemming, the Secretary of Health, Education, and Welfare, have cut several of the going programs, like vocational education, which he cut $2 million; and aid to federally impacted areas for maintenance and operation of schools, and construction of schools, which was cut by $80 million; hospital construction, which was cut $60 million; and medical research facilities program, which was cut $5 million.

There is also the program to clean up our streams. I am sure your federation is for that.

Miss BUTLER. We support the idea that we must not economize in that area.

Mr. FOGARTY. That was cut $25 million this year, though.

Miss BUTLER. When you economize in that area you are jeopardizing not only the health but we feel, and have said in the statement, that you are jeopardizing the security of the Nation.

Mr. FOGARTY. It is false economy, too, is it not, to cut back on programs like this which involve the health and welfare and education of our people?

Miss BUTLER. That is true.

Mr. FOGARTY. We should live up to our responsibility to give our children good education.

Miss BUTLER. Indeed so. Frankly, we have resolutions which cover almost everything you mentioned. We figure it is false economy to reduce such appropriations.

Mr. FOGARTY. I agree with you in that.

You say you have 5 million members. How many members do you have in Rhode Island?

Miss BUTLER. I wish I had looked that figure up. We have a very active group in Rhode Island.

Mr. FOGARTY. I was just wondering how many members.

Miss BUTLER. I will drop you a note to your office and let you know. We have a very active group there.

We have groups in every State, including the two new ones. Our organization is very active, sir. The women of this country, particularly the women of this organization, I think are becoming more and more interested and are doing a great deal of adult education.

They are studying the problems. They are trying to see if they cannot have a little influence in those areas. I believe they are being effective.

Mr. FOGARTY. What do you think about the Parent-Teachers?

Miss BUTLER. They are fine but you can let somebody else tell you about that since their representative is here to testify. We have many members who belong both to parents and to teachers.

Mr. FOGARTY. It is a pretty good group, is it not?

Miss BUTLER. I think it is wonderful.

Mr. FOGARTY. Mr. Denton.

Mr. DENTON. Miss Butler, as one Hoosier lawyer to another, I was very pleased to hear you talk about adequate appropriations for library service, because we know as Hoosiers how embarrassing that situation is.

Miss BUTLER. Yes.

Mr. DENTON. The full authorization is $7,500,000, but the budget is for only $7,300,000 this year because Indiana is the only State in the Union which does not participate in that program. The Governor has been reported as saying he was afraid to have this service because he was afraid it would brainwash the people of Indiana. He said he was misquoted on that; that he did not make that statement.

When you want the full appropriation, I am afraid you are talking to the wrong people. I know you have much more influence with the Governor than I have. If you would use your influence with the Governor to put this library service program in effect in Indiana, I am sure this committee would give the full amount for that purpose.

Miss BUTLER. I do not mind talking to the Governor, but of course my assignment here was to talk to the committee. I am quite vocal when I am back in Indiana, and I shall be back March 14. I shall try to call on the Governor.

Mr. DENTON. Several Members of Congress are very much disturbed about that. Of course, we are hopeful that the new Governor we shall have next year will take Indiana back into the Union on libarary services and we will not be the only State which thinks the service is not safe. I think it is a splendid service.

Miss BUTLER. We think it is a necessary one.

Mr. DENTON. I think it is a crime that the people of our State are deprived of it. We pay taxes the same as anybody else. I cannot think of any subject I would rather hear a Hoosier talk on than that subject. Knowing you and your ability to get things done, I believe you should try to convince our Governor that this is not a dangerous program.

Miss BUTLER. Do you think it might help if I should take a copy of our statement and go call on him when I get there next week?

Mr. DENTON. Of course, he has had a number of people call on him since he has been in the statehouse. I think the ladies' clubs would have some influence with him.

Miss BUTLER. I shall be glad to do what I can, because I truly believe this is a necessary thing for the welfare of our country.

Mr. DENTON. I thank you very much.

Miss BUTLER. You are welcome.

THURSDAY, MARCH 3, 1960.

## CHILDREN'S BUREAU, LIBRARY SERVICES ACT, PAYMENTS TO SCHOOL DISTRICTS IN FEDERALLY IMPACTED AREAS

### WITNESS

### MRS. RICHARD G. RADUE, CHAIRMAN, WASHINGTON LEGISLATION COMMITTEE, NATIONAL CONGRESS OF PARENTS AND TEACHERS

Mr. DENTON. We have before us now Mrs. Richard G. Radue representing the National Congress of Parents and Teachers.

Mrs. Radue.

Mrs. RADUE. It is always a pleasure and a privilege to bring to the members of this committee the statement of my organization's position on some of the items of the budget before you. So many of the programs which represent a partnership between the citizenry and the Federal Government are reviewed by the members of this committee that you gentlemen serve as the trustees and the guardians of our people's needs.

In the budget before you there are three specific programs for which we should like to speak.

#### PAYMENTS TO SCHOOL DISTRICTS IN FEDERALLY IMPACTED AREAS

We regret that the 1961 budget carries a decrease of $37 million for operation and maintenance and a $16,700,000 decrease for construction costs for schools in federally impacted areas. Such a cutback would disrupt educational activities which have either been started or planned under the assumption that previously furnished funds would be forthcoming.

Last year a subcommittee of the House Committee on Education and Labor held extended hearings on another administration proposal to limit such payments for school assistance. More than 100 Members of Congress testified against it. After the hearings, the subcommittee issued this report:

> As a result of the hearings held thus far, the subcommittee is in full agreement that both these programs (for maintenance and school construction) have proven their worth and that no drastic curtailment of either program is advisable.

We urge a restoration of funds to last year's level, in order that these programs may be carried out in accordance with the expressed intent of the Congress.

#### APPROPRIATIONS FOR THE LIBRARY SERVICES ACT

We urge your support for a program which has been a heartwarming example of partnership between the Federal Government and the people—the Library Services Act. In 1956 there were 26 million people without any public library service; 50 million more with inadequate services; and 319 rural counties without any public library service. In the last 3 years, under the Library Services Act, State funds for rural library services have increased 54 percent. Public library service has come, for the first time, to over 1 million rural children and adults, and 7.6 million more have received substantially increased services. There are about 200 new bookmobiles in operation, and more than 5 million books in rural communities. States

have learned what good public library service is, how much it costs, and how important it is to the economic as well as the cultural welfare of the community. Studies of the effect of the Library Services Act upon children are emphasizing what book-loving parents have always urged—that the surest way, the most effective way, to build up in children the sound values which are a defense against trash and obscenity is to steep the children in good reading.

But there is still a job to be done. There are still 25 million people without any library service and 21 million more whose services are still inadequate. They are not all in Indiana, Mr. Denton.

Mr. DENTON. Of course, that is the only place where the program is not operating.

Mrs. RADUE. I know it, and we are disturbed about it.

We urge your support of the full amount authorized, $7,500,000.

GRANTS TO THE STATES FOR MATERNAL AND CHILD HEALTH AND WELFARE

We urge the appropriation of the full amounts authorized for grants to the States for maternal and child health and welfare:

| | |
|---|---|
| Maternal and child health | $21,500,000 |
| Crippled children services | 20,000,000 |
| Child welfare services | 17,000,000 |

When the Congress increased the authorization for these grants a year ago, it was in recognition of urgent need. In the words of H.R. 2288, 85th Congress:

> The unprecedented increase in the child population, the rising costs of care and services, the development of new techniques and measures for helping children, and the great inequality of the basic child health and welfare services are factors which combine to produce an urgent need for increased Federal funds for all of these programs.

The needs continue. Increased funds would be used to provide more well-baby clinics, new or expanded services for children with mental retardation, and more polio immunization. We may remember regretfully that 50 percent of the cases of paralytic polio last year occurred in children under 5, and that the outbreaks were in areas without free vaccination. Members of our organization are proud of the work being done in medical research, and of this committee for its vision and leadership in stimulating and supporting research. But it is in programs like this that the fruits of research are made available to the Nation's children.

Thank you, Mr. Chairman for the privilege of appearing before you.

Mr. DENTON. Thank you very much. I believe you would be interested to know that the Secretary of HEW stated that he could not find any support on either side of the aisle for his proposed legislation, yet we are sent a budget on the federally impacted areas based on a law which has only been recommended and has no prospect of passing. I just do not know what to think of sending a budget up that way or what is back of it.

As you say, we have a moral commitment, and the schools have set up their budgets on the theory they are going to receive that money, and of course they expect to receive it and should receive it.

What do you think about cutting a budget like that? You certainly do not think economy stands before keeping your obligation, do you?

Mrs. RADUE. I listened to the hearings last year before Mr. Bailey's subcommittee, which were quite extended. It seemed to me a case was made, without any question, for the need of the commitment. It is not a gift to the people, but a part of this partnership, and a necessary part. I think the members of the committee were fully convinced.

Mr. DENTON. Of course, the Government is just being a good citizen and paying its part of the obligation.

Mrs. RADUE. And it is not a large share.

Mr. DENTON. Of course, in small communities, such as I have in my district, it is a very important contribution to the schools. They would have a hard time operating without it.

About the library service, I am very glad you want all the people in the country to enjoy that. I wish you would use your influence with your constituent members in Indiana to see if they would not try to prevail on the Governor to take that service for Indiana. They might convince him it has been tried in 49 other States and all found it safe. It has not been a bit dangerous.

Mrs. RADUE. Our people try.

Mr. DENTON. As I told Miss Butler, you are talking to the wrong people in trying to get the full appropriation. You need the help of the Governor of Indiana on that because if Indiana participates we will appropriate the full amount.

Mr. FOGARTY. I think you heard what I just mentioned to Miss Butler about all these other needs in addition to the many you have mentioned, but I did not talk about the grants to States for maternal and child welfare. I cannot understand, when Congress raises the authorization, especially in the crippled children's services, why the administration would not go up to the full authorization, can you?

Mrs. RADUE. No.

Mr. FOGARTY. It is false economy, is it not, to prevent some of these things being accomplished which can be done now for these children?

Mrs. RADUE. Funds spent like this are an investment in the future of the country.

Mr. FOGARTY. That is what I believe. Sometimes it is difficult for us to convince Members of Congress and others who think more of a balanced budget than they do about some of these programs.

Has your national group taken a stand on the Metcalf bill for aid to schools? I am getting quite a few letters now from local parents' and teachers' groups in the State, supporting it.

Mrs. RADUE. We have urged them to support it. We have urged them to state the needs of their State. If the greatest need is for teachers' salaries, we have asked them to say so.

Mr. FOGARTY. You left it up to the States.

Mrs. RADUE. Yes. We are supporting a good school-support bill.

Mr. FOGARTY. How is it making out?

Mrs. RADUE. I am sure you know better than I do, but they seem rather hopeful.

Mr. FOGARTY. It is still in the Education and Labor Committee of the House, is it not?

Mrs. RADUE. It has not been reported out.

Mr. FOGARTY. They had a meeting yesterday on it, and there was no action taken. Are you hopeful that you will get action this year?

Mrs. RADUE. Very hopeful. We are working as hard as we can for it. I am delighted to hear that you are receiving letters from people in Rhode Island.

Mr. FOGARTY. I have been speaking to some of the Rhode Island PTA's during the past years on these programs. They are very good groups to talk to, I find, very much interested in all of the programs of health and education and welfare.

Mrs. RADUE. That is our immediate business.

Mr. FOGARTY. We want to make sure we do the right thing for our children.

What about the White House Conference on Children and Youth? Are you taking any part in that? That is to be at the end of this month, is it not?

Mrs. RADUE. At the end of this month. As a matter of fact, I believe about 175 of the delegates are PTA people in one way or another. The organization as such has 10 or 15, but because PTA people are interested in such a program, that many are being sent by the States. I do not know just how many people we do have in Rhode Island, but I do know they are one of our best groups.

Mr. FOGARTY. I know you have quite a few members. I do not know the exact membership, but I know it is considerable, and the local meetings are well attended.

Mrs. RADUE. I know they are all delighted when you come to speak to them.

Mr. FOGARTY. I enjoy it, too. Have you anything else to add?

Mrs. RADUE. No, Mr. Chairman.

Mr. FOGARTY. It is good to listen to you again. I am glad to see that you are for these things. At least the majority of this subcommittee agrees with you.

Mr. DENTON. She is going to help me get the Governor of Indiana to accept the library services.

Mr. FOGARTY. Good. Is it not a terrible thing to have a program like that available and not accept it?

Mr. DENTON. And be denied the benefit of it, when they have paid for it through their Federal taxes.

Mr. FOGARTY. It is one of the best programs we have ever had, especially in the rural areas. It has been of tremendous help.

Thank you very much, Mrs. Radue.

THURSDAY, MARCH 3, 1960.

DIVISION OF INDIAN HEALTH, PUBLIC HEALTH SERVICE

WITNESS

MRS. HELEN L. PETERSON, EXECUTIVE DIRECTOR, NATIONAL CONGRESS OF AMERICAN INDIANS

Mr. FOGARTY. Next we shall hear Mrs. Helen L. Peterson, of the National Congress of American Indians.

Mrs. Peterson.

Mrs. PETERSON. Mr. Chairman, partly because of the weather I could not get to the finally typed copies and, if I may, I would like to summarize my remarks and then have your permission to submit my statement later, which will not be very long.

Mr. FOGARTY. You go right ahead, Mrs. Peterson.

Mrs. PETERSON. My name is Mrs. Helen L. Peterson, executive director of the National Congress of American Indians. Ours is the only national organization of the Indians themselves limited to the Indians.

My testimony today is in support of the Division of Indian Health 1961 appropriations and in behalf of increases. This branch of the U.S. Public Health Service has formally administered the Indian health program since July 1, 1955, when it was transferred from the Bureau of Indian Affairs. Even though the Division of Indian Health had a good deal of responsibility before that, the whole responsibility we have to regard as being theirs since that time.

Some of the things I will need for the formal statement concern the record of Indian health, but the thing we feel so very strongly about is that even though Congress has generously given some appropriations in recent years, still those appropriations do little more than meet the mandatory pay increases, so we continue with a very serious health problem and there is not really an increase in service that is so badly needed if we are to make real strides, because cost increases each year and the mandatory pay increases absorb some of those increased appropriations, and we continue to end up with far too little to make real headway in improving the health of Indians.

Of course, in Indian education that is handicapped; Indian economic improvement, stability in jobs, community health, all of these problems are intensified by the fact that Indian health is still lagging, so our plea to you and your committee is that while we continue to try to do everything we can toward all of those programs, that we can to prevent disease, and to encourage the tribes as we do to spend their own funds and do what they can without appropriations, we have to look to the Congress of the United States for the professional services and the construction funds that have to be made available if we are really going to catch up on this problem of lagging Indian health.

At our last convention in Phoenix, Ariz., last December, where about 75 tribes were officially represented, our membership asked for a total Indian health appropriation of $60 million, and roughly $10 million of this for construction and a little over $50 million for Indian health programs.

I have some suggestions as to the specific categories, but the one I would like especially to call your attention to is the contract patient care.

In that category it would take at least another million dollars just to provide better quality care for those Indian people now eligible, but there are a great many people under the present eligibility requirements, which incidentally we find fault with; there are many Indians in addition to those presently eligible, who also need health care and who live in communities that still can be called Indian communities and are part of a problem that we still have to look upon as a group Indian health problem, so that we respectfully and urgently ask your committee to consider at least another million dollars in contract patient care to take care of those now eligible and at least another million dollars for additional people who should be eligible and who badly need medical care under the present program.

I would be happy to try to make any other comment and I would appreciate it if my three-page statement could be made part of the record.

Mr. FOGARTY. It may be.

(The statement referred to had not been submitted at the time of printing these hearings.)

Mr. DENTON. I thought we had made quite a bit of improvement in the last 4 or 5 years, though I know there is a long way to go.

Mrs. PETERSON. We appreciate the more generous appropriation, but it is true they are almost eaten up in the mandatory pay increases so that there is not really the increase in services.

Mr. DENTON. The records show we have made great strides in tuberculosis control.

Mrs. PETERSON. That is true. While we appreciate the efforts of the Division of Indian Health, actually the methods of treatment——

Mr. DENTON. We thought if we could integrate the Indian hospitals with Government hospitals and Hill-Burton hospitals it would be very helpful. There are places where there is too small a group of Indians to have a hospital.

Mrs. PETERSON. We understand that.

Mr. DENTON. That is the problem.

Mrs. PETERSON. We appreciate those problems, sir. It has been extremely difficult to persuade our older people, in particular, to go to the larger hospitals. When they do send them away some of us appreciate this constitutes better and more specialized medical care, and there is where we hope our organization is of some help, when we try to explain why we have to go greater distances.

But in addition there are really Indian people who are not now under present regulations considered eligible, and yet they are still part of an Indian community health problem.

Mr. DENTON. Of course, if they live on the reservation they are eligible.

Mrs. PETERSON. Not if the regulation is strictly interpreted, but we are trying——

Mr. DENTON. I thought they were if they lived on a reservation.

Mrs. PETERSON. No. As a matter of fact, this has been one of our chief complaints.

The present policy is to give first priority on eligibility to those who actually reside on a piece of trust land.

Mr. DENTON. Oklahoma.

Mrs. PETERSON. Montana, the Dakotas, Nebraska, Idaho, and we do actually have cases where people living on deeded land right next to Indians living on trust land within the reservation boundaries are told they are not eligible.

We think this does not make medical sense.

Mr. DENTON. Of course, when they leave the reservation they are given a year's hospital insurance.

Mrs. PETERSON. Those on relocation. Yet there are heavy concentrations of Indians in places such as Phoenix, Great Falls, Mont., Rapid City, S. Dak., bordering towns near the reservation, where if they are not on relocation they are not considered eligible. They lose residence at home and do not live on trust land.

I didn't mention this because we have assumed it was more a matter of policy in regard to something else, and we are always told this is because limited services and limited appropriations mean they cannot serve everyone.

It has been our understanding in years past that services were available to people in the discretion of the professional judgment of the people in the Department on or near Indian reservations or Indian communities.

If something is a community health problem obviously it is title to the land. Actually if they were just 1 year off the reservation does not change the health problem.

We objected to those regulations which, frankly, we believe emanate from the Department of the Interior and are followed as a matter of policy by the Division of Indian Health.

This matter of contract patient care is extremely serious, particularly with the closing of these small hospitals.

You see, it throws out a heavier burden.

Mr. DENTON. You could not put a Public Health doctor in many of those small communities.

Mrs. PETERSON. That is true. In view of this suggestion it really calls for considerably stepped up contract patient care.

Mr. DENTON. That is a difficult problem.

Mrs. PETERSON. Yes. At the same time we have many smaller hospitals closing. So I would especially like to make a specific plea in the oral testimony for serious attention to another $2 million which we understand would be broken down to at least $1 million to take care of gallbladders, really serious problems for those now eligible.

It does not make medical sense to deprive a person of care who is a half mile away from another person where they have exactly the same problem.

We do want you to know how much we appreciate the increases in the appropriations, but in terms of rising medical costs and in terms of these mandatory pay increases we really are not pushing ahead too fast except in an area like tuberculosis where it is really the modern method of treatment which has brought about such startling results.

We do not have improvements where we are not able to take the forward steps in sanitation which would prevent so many of these things.

We also want you to know we will continue to do everything we can by way of education and teaching our people to cooperate and trying to do the things that a little education would help.

Occasionally we devote an entire publication to matters of health education and matters of encouraging through our tribes citizens groups and health committees. We think this saves some money and brings about more intelligent and more efficient use of the funds you do appropriate.

Thank you, Mr. Chairman.

Mr. FOGARTY. Thank you very much, Mrs. Peterson.

## WATER POLLUTION CONTROL

### WITNESS

### BERNARD F. HILLENBRAND, EXECUTIVE DIRECTOR OF THE NATIONAL ASSOCIATION OF COUNTY OFFICIALS

Mr. FOGARTY. Next we have before us Mr. Bernard F. Hillenbrand, representing the National Association of County Officials.

You may proceed.

Mr. HILLENBRAND. My name is Bernard F. Hillenbrand. I am the executive director of the National Association of County Officials. I am testifying today in behalf of the association.

We had originally expected to have Commissioner M. James Gleason of Multnomah County, Oreg., testify for us but he is out of the country and could not make it. He is chairman of our natural resources committee.

Mr. Chairman, I am sorry we do not have a prepared statement. Because of the storm we had a disruption in the office. If it meets with your approval we would like to put a very brief written statement into the record later.

Mr. FOGARTY. Very well.

(The statement referred to follows:)

My name is Bernard F. Hillenbrand, executive director of the National Association of County Officials. I have a very brief statement which I should like to present for the association at this time. This statement refers to the water pollution control program of the Department of Health, Education, and Welfare. The association appreciates this opportunity to appear before your committee on behalf of the nearly 6,000[1] elected and appointed county officials from 47 States, who comprise the membership of the NACO. This association speaks essentially for counties and their citizens. I appear before you today to urge that the appropriation of $20 million requested in the President's 1961 budget message for Federal incentive grants to aid communities in the construction of sewage-treatment plants be increased to the $50 million authorized in the legislation. The NACO supported the bill (H.R. 3610) which, had it not vetoed by the President, would double the present program for the construction of waste-treatment facilities. County governments are finding it increasingly difficult to provide necessary services within the present tax structure. The sewage-treatment plant construction-grant program has during the last 3½ years have been very beneficial in aiding county governments in constructing 256 sewage-treatment plants. The total estimated cost of these 256 plants is $164 million while the total Federal funds amounts to only $27.7 million. In other words 5 local dollars have been expended for each Federal-grant dollar in building these much-needed sewage-treatment plants. While only 10 percent of the 2,000 projects which have received Federal aid to date have been financed through county governments, nearly all of these 256 plants were direly needed to reduce pollution and protect the health and welfare of county citizens; and, furthermore, most of these plants could not have been financed at this time without the Federal incentive assistance received under Public Law 660.

---

[1] 3,610 figure.

In addition to supporting the present level of $50 million as provided by law for the construction grant program, the National Association of County Officials wants to go on record in support of the entire appropriation for the DHEW water pollution control program. We are very much concerned with all facets of the national water pollution control because in the final analysis county officials are the ones who have to face the problem at the local level. Our officials are faced with urgent problems affecting not only the economy but also the health and welfare of their people. Furthermore, we should like the record to show that we support a separate appropriation item for administering the national water pollution control program. Interested local county officials find it difficult to understand exactly what funds are used to administer the Federal program under the present budget system wherein water pollution control is lumped with many other programs under the heading "Environmental sanitation."

Mr. HILLENBRAND. We are testifying in behalf of the appropriation for the water-pollution-control program, the construction-grant program. We urge Congress to appropriate the full $50 million authorized in the original 1956 Water Pollution Control Act.

Mr. FOGARTY. You do not agree with the President, then?

Mr. HILLENBRAND. No; we do not.

Mr. FOGARTY. What do you think will happen if the President has his way in cutting this program in half?

Mr. HILLENBRAND. It will certainly decrease the amount of construction of sewage-treatment plants. I think it would act as a general depressant on all treatment plant construction.

Mr. FOGARTY. You think the President is making a big mistake, then?

Mr. HILLENBRAND. Yes. We have backed the larger bill which narrowly missed passing over the President's veto.

We felt, and have felt from the beginning, since 1956, that the actual amount of money that is needed each year is $100 million of Federal funds, and we have so testified.

We were actively supporting the larger bill which was vetoed by the President.

Mr. FOGARTY. Sixty-one percent of the Members of Congress thought the same way.

Mr. HILLENBRAND. I think it failed by 22 votes. I think the original vote in the Senate would have been enough to override the veto.

Mr. FOGARTY. What did you think of the President's veto message?

Mr. HILLENBRAND. I am not familiar enough with the details of it.

Our general reaction was that the President seemed to consider these as expenditures whereas we consider them to be more in the nature of an investment. A water-pollution-control facility helping to purify the Nation's water supply is a stimulus to industrial development, a stimulus for use of streams for recreational purposes, and we think that the Federal portion of the costs is recaptured by increased industrialization. This brings increased Federal taxes from industry, the building of cabins, and so on. All of these things are eventually recaptured.

Mr. FOGARTY. We had the Izaak Walton League testify, the American Municipal Association, Sport Fishing Institute, the National Wildlife Federation, your group, and many others. None of them agrees with the President.

Mr. HILLENBRAND. As you know, we represent county governments with all shades of political opinions from all sections of the Nation. We are organized with State associations of county officials in 45

States, and this Federal pollution program has been before our group on three separate occasions and it passed unanimously.

As you know, the counties are increasingly being called upon to provide these sewage-treatment facilities because of the movement of people to the suburbs. The great population growth in the United States now is being out in our county area outside of incorporated municipalities.

There is a great national trend now toward solving these water-pollution-control problems on an areawide basis, so our counties are getting increasingly involved.

I do not have the figures here but we will submit them for the record.

I think about 10 percent of these projects already are county projects. Money is going to counties to construct these facilities.

There was a provision in this bill which was just vetoed by the President which would have stimulated this areawide construction. It would have allowed several communities to band together to construct one areawide treatment facility.

Under the present law, as you know, each community is entitled to $250,000 maximum per project.

If several band together that quarter of a million dollars still applies.

We were in favor of the law being adjusted so if 10 communities combine at the county level they can get a total of $2½ million for the project.

Mr. Fogarty. The State and territorial health officers made a recommendation that Congress be petitioned to amend Public Law 660 with a view to increasing the effectiveness of construction grants for the sewage treatment works program through:

(*a*) Increasing maximum grant provisions.

(*b*) Increasing the total appropriation authorization and the appropriation so authorized.

(*c*) Authorizing municipalities as individual applicants to band together in construction of joint projects.

(*d*) Permitting reallocation among the States of funds unobligated 6 months after the beginning of the second fiscal year for which the funds were appropriated.

Do you agree with that?

Mr. Hillenbrand. We certainly do. It is very interesting that the State and territorial directors make this statement.

When the 1956 act was up they were not at all sure this program would do the things that we who were advocating it testified that it would do.

I remember they had some negative testimony back when the original act was considered in 1956.

Mr. Fogarty. So here we have organizations representing the States and municipalities and the counties all supporting it, and everybody else interested in conservation. They are all for this new bill and we could not get enough votes in Congress to override the President's veto.

Mr. Hillenbrand. It is interesting to know that the National Association of County Officials representing the policymaking officials rather than the technicians, are in support. It indicates a broad

concept of the need for Federal assistance at the grassroots. We are quite solidly behind this.

What has happened is that we have fallen way behind in construction of these sewage treatment plants and it is not solely our fault.

We had a long depression, as you members of the committee know, and we had a war. We got such a great backlog of projects, and at the same time we were accumulating a backlog of school needs, road needs, public buildings, and so on, all of which are vying for the precious few local dollars we have to finance these things.

We are firmly of the opinion that the only way we will meet this backlog is through this temporary program. This is a 10-year program, not a permanent program. This will help us catch up.

We are solidly behind the Congress appropriating the full $50 million. We think even this is inadequate.

We think the appropriation should be about $100 million.

Mr. FOGARTY. We cannot do that unless you can get Congress to pass a bill authorizing that.

Mr. HILLENBRAND. I appreciate that. As I say, we were extremely disappointed that that was vetoed by the President.

We notice another thing—we are gaining very broad support for this program now. The rash of articles in national magazines about this crisis developing in water pollution is helping.

We are also of the opinion that we have to stay on top of this day by day. This is not something you can start a crash program on and in 2 years build all the sewage treatment plants you need. That is not the kind of problem it is.

If we do not keep up with our backlog as we go along, at least we ought to meet our new needs.

The population is expanding 3 or 4 million a year, and they are building about 1,250,000 new houses a year, and we have this industrial development, so we ought to at least keep up with the new demand even if we do not make a dent in the backlog of inadequate plants, plants too small, or obsolete because of technological changes.

Mr. DENTON. I read some place where the bonded indebtedness of local governments went up in one case 200 percent and in another 400 percent, while during the same period of time the Government's had gone up 10 percent.

The National Planning Association had some figures to show that in nondefense spending the Government's expenditure has gone down and the local and State Government's have doubled.

When the President vetoed that bill I wonder if he knew the problem local governments are having. I am sure he did not want people to have dirty water and our streams polluted.

Mr. HILLENBRAND. Our observation in this is that we have just about reached the limit under our present resources to finance these things.

Mr. DENTON. Many areas are bonded to the limit?

Mr. HILLENBRAND. That is right. We have constitutional limits established for our indebtedness and we are trying desperately to keep up with the school problem. This is where a tremendous portion of our bonds are being issued.

We need the additional help we get from this water pollution control program to try to keep up with the sewage.

Mr. DENTON. Where do you live?

Mr. HILLENBRAND. In Montgomery County, Md. We have a bi-county suburban sanitary sewage district. They have been doing a very good job of keeping abreast of this water pollution problem, but it is a problem even there.

Mr. FOGARTY. Thank you very much, Mr. Hillenbrand.

## CRIPPLED CHILDREN'S PROGRAMS

### WITNESS

### MRS. ADA B. STOUGH, EXECUTIVE DIRECTOR, AMERICAN PARENTS COMMITTEE

Mr. FOGARTY. We have now Mrs. Ada B. Stough of the American Parents Committee. Proceed, Mrs. Stough.

Mrs. STOUGH. Thank you, Mr. Fogarty.

I have a rather short statement. I think I would rather sketch over it informally.

There are many things we could talk about. This year I am looking for an increase in the crippled children's program.

As you know this is one of the many children's programs which requires any increase.

Mr. FOGARTY. Go right ahead.

Mrs. STOUGH. I notice that Mr. Flemming after the President's budget came out made a great point of saying that he was asking for increases in the three grants in aid under the Children's Bureau. He gave three reasons.

Mr. FOGARTY. But the budget does not bear out what he said.

Mrs. STOUGH. You anticipated my words. First he said populations had increased, hospital costs and other costs were rising and we had to have other adequate services.

Then he advocates $666,000 of increase in each of the programs.

You spread $666,000 over 50 States and you realize no one of them gets very much.

Mr. FOGARTY. He thinks that is pretty good because he said they have to balance the budget.

Mrs. STOUGH. I know he says that.

Mr. FOGARTY. What do you say about it?

Mrs. STOUGH. At the very end of my testimony I say that the money you will put in for children today, to rehabilitate them, to save their lives, to make them normal human beings, the services you give them today will mean that these people can be economically self-supporting and contribute to the Nation's budget in the future. It is an investment.

I do not see how in the world you can look at it any other way.

Mr. FOGARTY. I agree. Go ahead.

Mrs. STOUGH. The child population of the country today is the highest in our history. There has been an increase of over 10 million children in the last 5 years. (1955 civilian population under 21, 62,834,000, source, Joint Financial Report, form 11.1; 1960 estimated civilian population under 21, U.S. Census Bureau, February 1960.) Yet in that time the Federal share of the crippled children's program has been increased by only $1 million.

About 40 percent of the expenditures under the crippled children's program goes for hospitalization. In the last 5 years, hospital costs per patient will have risen from approximately $24 a day to $30 a day—or an increase of almost 26 percent. The costs of doctors, orthopedic devices, drugs, and other necessities have increased in about the same proportion.

Attached to this testimony is a summary of the information received from the crippled children's directors of 41 States. A glance at it will reveal that amazing work is being done to restore health and mobility to handicapped children, but that the program isn't beginning to meet the need. The one theme that seemed to run through all the letters received was that parents today seem able to take care of the minor defects of their children, but are unable to meet the total costs of chronic and congenital cases which are expensive and long lasting. As an example, 30,000 to 40,000 children are born each year with congenital heart defects. Before the development of open heart surgery, a large percentage of them died. Now they can be saved. Less than half the States, however, are equipped and staffed to provide this needed surgery. The regional surgical services which are available were developed under the crippled children's program.

As hospital and medical prices mount higher and higher, State programs must bear more and more of the expense if a child is to live or be returned to normal living.

You will see in reading this summary that the increase in child population has brought a proportionately larger number of children who need help. In some States the number of cases has increased 50 percent in the past year. Many States limit their services to only a few categories of crippling conditions, and often nothing is done for children who have epilepsy, speech and hearing defects, cleft palate, cystic fibrosis and other conditions.

Several States reported an unusual drain on their State budgets for braces and treatment of polio victims brought about by the discontinuance of funds from the organization formerly known as the National Foundation for Infantile Paralysis.

Mr. Fogarty. Several letters I have received indicate that many of the States find their budgets cramped because they have had to take over the treatment of polio victims formerly taken care of by the National Polio Foundation. This has made quote a dent in the crippled children's program because they cannot leave the children unattended. Without the polio fund this has had to come out of the crippled children's fund.

Mrs. Stough. This is one point (not mentioned by Mr. Flemming) we believe needs emphasizing. This research has developed extremely effective drugs for control of epilepsy, miraculous techniques of open heart surgery, and functional artificial hands for children. None of these accomplishments can mean much, however, unless they can be brought to the children who need them.

In 1955 Congress raised the fund for crippled children by some $5 million. Out of these funds this artificial hand was developed.

As an illustration of this last point, I would like to show you this artificial hand. The development of this hand for children has been going on for the past 4 years through the cooperative efforts of the Children's Bureau and the Children's Prosthetic Committee of the

National Academy of Science. The Veterans' Administration had long ago made possible the production of such a hand for adults but there was no functional cosmetic artificial hand for children. There were many technical and engineering problems involved in adjusting and reducing the mechanics of the adult hand to a child's size. In order to accomplish this, the Children's Bureau made a special project grant to the Michigan Crippled Children's Commission which contracted with engineering companies for the production of the hand. This right hand which I have here to show you is the smallest child's size for ages about 5 to 8. It is now being tested in 12 of the largest child's amputee centers. It is already clear that this is a highly efficient hand. Very soon the company, (as a part of its original contract) will deliver 50 hands. After that the hand may be purchased by organizations or individuals, including the State crippled children's agencies. A left hand is now also in the process of production and will be available for testing soon. It is now planned to get into production a child's hand in larger sizes including one for teenage boys and girls.

In the light of this need, and the three needs outlined by Mr. Flemming, we cannot understand why the Department's budget asks for only $666,000 additional this year for the crippled children's program. We believe that if the needs are to be even partially met, the full authorization of $20 million should be appropriated. If they follow their previous pattern, the States and localities will match this sum by about 3 to 1. Such a total represents only a very small investment in the Nation's future. Every child snatched from death by open heart surgery, rehabilitated from epilepsy or polio, becomes an economic asset instead of a social liability to his community and Nation. Each dollar spent for a crippled child today, will bring a large return to the Nation's budget of the future.

This is not money wasted. These children who can be functionally operative, normal taxpaying citizens, are going to be an asset to this country and not a liability. I do not see how in the world we can get along with $666,000 in the way of an increase in each of these programs.

We think in the crippled children's program we should have the full $20 million. It should be matched by the States who have done as well as they have in the past. It will be matched 3 to 1.

(The following was submitted for the record:)

SUMMARY OF NEEDS IN THE FEDERAL GRANT-IN-AID PROGRAM FOR CRIPPLED CHILDREN

(Compiled by the American Parents Committee, Inc., Washington, D.C.)

At the end of October 1959, the American Parents Committee sent a letter to each of the State directors of the crippled children's program to ask them a number of questions, such as: Is the demand for service for crippled children increasing or decreasing? How long does an applicant have to wait on the clinic's list before they can get service? Are your funds adequate? In what fields are the needs most acute?

Each of the 41 States responding (except California, Indiana, Kansas, and Utah) stated that their funds for crippled children's services were inadequate to meet the demand. However, those States do not help all crippled children. Certain categories are excluded in each of these States.

Everywhere there seems to be the problem of maintaining the stability of the program in the face of increasing costs of service. There has been a large increase in the child population, with a proportionately larger number of crippled

children in need of services. There seems to be fewer minor defects and many more serious chronic or congenital cases coming to the clinics. The latter are more expensive and long lasting. Congenital heart conditions, epilepsy, diabetes, and speech and hearing defects are some of the categories of service for which the States report insufficient funds.

The States were asked if they thought increased demands could be traced to an increasing dependence of the population on help from the Government. Not one answered in the affirmative. One State summed up the situation in this way: "The increasing costs of medical care have caused people in the middle income group to apply for partial assistance because they are no longer able to meet all of the cost of care."

Following are brief summaries of the needs of the various States as reported in answers to the recent inquiries from the American Parents Committee:

*Alabama.*—Because of shortage of funds, only emergency and critical amputee and congenital heart cases can be taken. Cost of appliances and hospital services have increased more than appropriations.

*Alaska.*—Available funds are inadequate. Congenital heart cases are increasing and the children must be sent to the regional heart center in San Francisco. Transportation is a big expense. Complications of upper respiratory disease is a major problem with perhaps as many as 2,000 children who need mastoidectomies. Because of the low economic situation among the natives, a large percentage must depend on the crippled children's program if their condition is to be remedied.

*California.*—State appropriations are exceptionally adequate. Counties must assess a tenth of a mill of assessed valuation for this purpose, and the State responds with an open-end appropriation. The Federal appropriation of $400,000 is only a small part of the more than $6 million budget spent by California for diagnosis and treatment. However, service is limited to certain categorical handicapping conditions.

Dr. Charles R. Gardipee notes in his response: "I would like to see an increase in the Federal appropriation because I have indications from the other States, principally through the experience we gathered from our operating the regional congenital heart program, that the Federal money is the major source of funds in many State crippled children services program and that any increase in this money will definitely be of benefit to increase their level of the program."

*Colorado.*—Number of children served increased 50 percent in last 5 years. At present there is a waiting list of children for whom service must be deferred. Particularly, need for more generous provision for artificial limbs and other appliances, and an acute need for enough money to be able to give comprehensive care to very seriously injured children over a long period and to carry them toward physical rehabilitation.

*Delaware.*—Services are greatly increased through facilities of the E. I. du Pont Institute, but present funds are inadequate to meet the demands of the program. More demand for service to severely handicapped children. Waiting lists of children awaiting speech diagnostic work and speech therapy. Need funds to cover hospitalization of neurosurgical cases and for diagnostic work in cystic fibrosis, nephrosis, and other conditions which require long-term care.

*Florida.*—Last 2 years have brought many more children who need services but no increase in funds. Can do very little in speech and hearing, epilepsy, cystic fibrosis, and certain other fields. In our program, the ratio of Federal funds to State funds is about 1 to 6. On the other hand, certain programs relating to vocational rehabilitation and welfare enjoy nearly a 1 to 1 ratio. It is difficult for us to understand these wide differences in Federal support. Health programs serving children seem to receive less and less attention while programs for adults are rapidly expanding.

*Georgia.*—Acute need of funds for cardiac surgery work and epilepsy, and services for children with severe personality disorders. Have no services for cystic fibrosis, diabetic children, and need more money for home beds for rheumatic heart patients.

*Hawaii.*—Operating in the red and still not meeting demands. Have no services for children with sepech and hearing defects, very little in epilepsy. Demands for congenital heart surgery have greatly increased.

*Idaho.*—Hearing and speech defects receive no attention due to lack of funds and personnel. There are waiting lists for congenital heart surgery because there are no funds.

*Illinois.*—Patients with polio, formerly cared for by the National Foundation for Infantile Paralysis, have put an unexpected strain on the crippled children's budget. Federal funds play a significantly smaller role in this large program than do funds from the State. On the whole there are no acute unmet needs.

*Indiana.*—The needs of the crippled children in this State are being met with current available funds, according to Frank M. Hall, acting director, and he sees no need for an increase in the Federal appropriation.

*Iowa.*—Greatest current need and backlog of cases are: children with congenital heart disease, children suspected of mental and development retardation, and continuing need of a penicillin program for the prevention of rheumatic fever. Increased Federal appropriation of 20 to 25 percent would make a considerable difference in service Iowa is able to offer.

*Kansas.*—Current needs are being met. No children on waiting list.

*Louisiana.*—Acute need for service for conditions not now eligible. Nothing being done for children with epilepsy, mental retardation, hearing, visual, and speech handicaps.

*Maine.*—Demands have increased considerably over past 5 years. Birth rate has increased from 23.2 in 1950 to 24.3 in 1958. Applicant waits from 2 to 3 months to get a clinic appointment. Acute needs are for more clinics and for more surgery for congenital heart conditions.

*Maryland.*—The main diagnostic and treatment services are being met but there is a lag in followup rehabilitation services in the local communities.

*Massachusetts.*—As of October 30, $37,000 was needed for remainder of fiscal year or State would be forced to discontinue hospital care for all programs except congenital heart cases, and would discontinue service in epilepsy and payments for artificial limbs. Massachusetts (like other States) is suffering from the discontinuance of funds from the National Foundation of Infantile Paralysis. About 300 are on waiting list and they must wait from 1 to 5 months. Approximately 2,000 to 3,000 children would be eligible for crippled children's services if funds and personnel were available. Urgent needs are for funds for orthopedically handicapped, for artificial limbs, and for epilepsy.

*Minnesota.*—Needs additional funds for heart surgery, orthodontia for cleft palate cases, diagnosis and treatment in hearing and speech.

*Mississippi.*—Needs more personnel. Waiting lists in cardiac cases. Nothing done in hearing and speech or sight defects because there are no funds.

*Missouri.*—A budget twice the size would be necessary to meet the current need. Waiting list of 200 children. Those needing elective surgery must wait a year or more. Acute needs are in plastic surgery, epilepsy, cerebral palsy.

*Nevada.*—Program growing as fast as it can with present available funds. An increase in Federal funds would be an incentive for more State funds and therefore make possible more services to crippled children of the State.

*New Hampshire.*—More State funds are needed: not sure about need for increased Federal funds. Needs lie in lack of personnel, and services in the field of hearing and speech services, controlled observation of children with seizures, and better rehabilitation services for handicapped children.

*New Jersey.*—Need funds for some demonstrations and pilot projects. Increased services are needed for children with speech and hearing defects, congenital cardiac conditions, gastrointestinal conditions, and urinary defects. "* * * the increased cost of hospitalization and services have reached a point by which many families must request services on the part of the crippled children program if they are to receive care." "* * * there is an increased dependence of the population on governmental resources. I do not believe this is by choice, but by necessity as a result of the increased cost of medical care."

*New Mexico.*—No services in several categories of crippling conditions. Shortage of funds is felt in field of cardiac surgery. Withdrawal of help from National Foundation of Infantile Paralysis is being felt.

*North Carolina.*—Cannot give even limited services to children with epilepsy because of lack of funds. Need more money just to maintain present level because of increased hospital costs. Greater demands have risen for help in rheumatic heart cases, for speech and hearing defects, and for heart surgery. Sometimes waiting list reaches 300.

*Ohio.*—Need funds for increased personnel and to expand services to meet crippling conditions not now eligible. No services now in orthodontia for cleft palate, epilepsy, cystic fibrosis, and several others.

*Oklahoma.*—Greatest needs are conditions of epilepsy, speech and hearing defects, brain disfunctions, and ophthalmology, which are not cared for because of lack of funds. Demands have greatly increased due to increased birthrate, decreased infant mortality rate, and high incidence of highway and other accidents.

*Oregon.*—Find need for increased funds to meet the needs of children with multiple handicaps. These children present "so many new problems which demand personnel trained in paramedical specialties to provide well-rounded treatment. The demands on the crippled children's program have decreased in total numbers; however, it has increased in patients requiring extensive hospital and prolonged rehabilitation treatment. This can be attributed to the fact that the Oregon program is no longer primarily an orthopedic program but is interested in handicapping conditions in children."

*South Carolina.*—Additional funds are needed. Demands have increased steadily and progressively without a corresponding increase in funds. Need is particularly acute for children who need artificial limbs (sometimes children must be fitted with pylons instead of artificial limbs), more adequate service to children with severe burns, cleft lip and palate, more funds to meet diagnostic and therapeutic procedures necessary in cases of epilepsy.

*South Dakota.*—Many categories are not included because of lack of funds. There is no service for children with epilepsy and rheumatic fever. Would need 20 percent more funds to do the job that needs to be done.

*Tennessee.*—The cases given service increased from 4,200 in 1954 to 7,300 in 1958. There is need for more funds particularly for children suffering from epilepsy, cerebral palsy, and rehabilitation for children who have suffered polio. Severe burns, cleft palate are also high on the list of cases which must be treated.

*Texas.*—Acute need for funds to hospitalize patients suffering from chronic crippling conditions, for braces, appliances, and prosthesis.

*Utah.*—Needs are for well-trained staff. No need for increase in Federal funds. Demands have increased in children requiring cardiac surgery, emotionally disturbed, and mentally retarder. Greatest need is for congential heart surgery.

*Vermont.*—The only service given in this State is service to orthopedically handicapped children. Needs are acute in other fields such as epilepsy, speech and hearing defects, and metabolic disorders.

*Virginia.*—Has requested an additional $270,932 from the State. Needs it badly to meet increased costs, and to broaden program to include, especially, some services for speech and hearing defects.

*Washington.*—Greatest need is for services to children with congenital heart disease; approximately $300,000 would be needed to meet present demands.

*West Virginia.*—Present program inadequate because of lack of funds. "Clinics are understaffed; need more nurses—more cardiac clinics—more seizure clinics—more physical therapy treatment centers. New programs of services should be provided for children with rheumatic heart disease, children with hearing defects, and children with speech defects."

*Wisconsin.*—Need increased appropriation for service to children with neurological disorders. There are waiting lists for services in all areas. Post-polio patients demand more expenditures now that the NFIP has discontinued help to local chapters.

*Wyoming.*—There are public health nurses in less than half the counties, so there is great need for more nurses. Demands on the State crippled children's program have increased. The conditions for which increased funds are most needed are congenital heart defects, and handicapping speech and hearing defects.

ADDENDA (FEBRUARY 1960)

*Connecticut.*—Fifty-nine emergency congential heart cases now in need of surgery. The State's share of the Federal supplemental (voted 1959) will provide open-heart surgery for only 15 to 20 of them.

"We are having to remove children we had planned to help on a high priority list because higher priorities came up as emergencies." Inadequate service to 100 child amputees. Only one clinic in the State for children with epilepsy, and only one for children with hearing loss; more are needed. The 59 percent of Connecticut children now living in urban areas have few services for orthopedic and paralytic conditions because there has not been money to extend this work into the major cities.

*North Dakota.*—Children with epilepsy, those with hearing loss, and children severly burned and requiring long-term medical care are not being cared for. Demands and costs have increased in past 5 years, but appropriations have not kept pace.

Mr. FOGARTY. I do not see Rhode Island here.

Mrs. STOUGH. I hate to tell you but that was one of the places from which I could get no answer. Perhaps you can tell me why.

I got answers from 41 States, which is quite good.

Mr. FOGARTY. That is quite good. I am just surprised they have not answered.

What do you think is the trouble?

Mrs. STOUGH. I am afraid you will have to answer that question. I don't know.

Mr. FOGARTY. Are they running short of funds there?

Mrs. STOUGH. I didn't check with the Children's Bureau. I don't know whether or not they are running short of funds.

As much of a champion as they have in you they should make good use of it.

I sent the original letter out in November, followed it up the latter part of December.

Mr. FOGARTY. You have written two letters and never received an answer?

Mrs. STOUGH. No.

Mr. FOGARTY. It doesn't speak very well of Rhode Island's office, does it?

Mrs. STOUGH. Not if they are interested in Federal appropriations.

I didn't know what else to do. I sent them two polite letters.

Mr. FOGARTY. I am surprised that they haven't even replied. How much will that hand sell for?

Mrs. STOUGH. I do not know exactly. I asked the crippled children's people at HEW, and they said around $200, but they did not know.

Of course, this is one of the first 12 produced now which is being tested.

Mr. DENTON. As Mr. Fogarty, I looked for my own State. I find 39 States are here and Indiana is also left out.

Mrs. STOUGH. Indiana, Kansas, and Utah say, "We don't care whether or not you get any more Federal funds."

How do you account for that?

Mr. DENTON. No wonder my taxes are so high. We pay for some of these things twice. We pay for them in taxes to the Federal Government, and do not get the benefit of it, and then pay for local programs too.

That is all.

Mr. FOGARTY. Thank you very much, Mrs. Stough.

## SOCIAL SECURITY PROGRAMS

Mr. FOGARTY. We have received a letter and attachment from the American Public Welfare Association and from State government agencies concerning funds for various social security programs, which we will insert in the record at this point. I have received many more from local organizations and individuals but these will serve to indicate the interest.

(The letters referred to follow:)

AMERICAN PUBLIC WELFARE ASSOCIATION,
*Chicago, Ill., February 15, 1960.*

Hon. JOHN E. FOGARTY,
*Chairman, Subcommittee of the House Committee on Appropriations for Labor-DHEW, House Office Building, Washington, D.C.*

DEAR CONGRESSMAN FOGARTY: The American Public Welfare Association wishes to express its support of the request of the Department of Health, Education, and Welfare for appropriations for the social security programs for the fiscal year 1961.

This association is a national nonpartisan organization of State and local public welfare agencies and of individuals engaged in public welfare at all levels of government. Our members, therefore, are responsible for the administration of the public assistance and child welfare programs.

Enclosed is a copy of our "Federal Legislative Objectives for 1960." In connection with the committee's consideration of the appropriation requested, I would like to call special attention to objectives Nos. 19 and 20, which emphasize the need for Federal funds for training of personnel in public welfare. We endorse the Department's proposed extension of the training activities for State and local public assistance staff through short-term workshops focused on furthering the program objectives of self-support, self-care, and strengthened family life. We believe, however, that it is essential for the funds authorized in 1956 for full professional training of staff to be appropriated.

In accordance with objective No. 32, we endorse the request for funds for research and demonstration projects which would investigate the causes of dependency and more effective ways of dealing with this problem. More knowledge in this area should result in a reduction in the need for public assistance.

We note that the Department's request for funds for child welfare services is slightly higher than the amount appropriated for 1960. We believe that, in view of the growing need for such services, it is urgent that the full amount authorized by Congress, $17 million be appropriated.

As I indicated above, we support the appropriate requests of the Department as submitted. I wanted to bring to your attention, however, our special concern about the items on which I have commented specifically.

We would appreciate your making this letter a part of the record of the committee's hearings.

Sincerely yours,

LOULA DUNN, *Director.*

FEDERAL LEGISLATIVE OBJECTIVES, 1960, AMERICAN PUBLIC WELFARE ASSOCIATION

(Prepared by Committee on Welfare Policy, approved by the board of directors, November 30, 1959)

The American Public Welfare Association believes that the States and their political subdivisions have the primary responsibility for developing and administering effective public welfare services in the United States. The Federal Government has the obligation to develop nationwide goals and to use its constitutional taxing power to equalize the financing of public welfare so that public welfare services may be available on a reasonably equitable basis throughout the country. The States, their political subdivisions, and the Federal Government, in cooperation, must provide the leadership and the professional and technical personnel to carry out these obligations. The association's legislative objectives are based on these premises and on the recognition of the importance of preserving and strengthening family life, encouraging self-responsibility, and assuring humanitarian concern for individuals and families.

To accomplish these purposes the association believes that—

Contributory social insurance is a preferable governmental method of protecting individuals and their families against loss of income due to unemployment, sickness, disability, death of the family breadwinner, and retirement in old age;

Public welfare programs should provide effective services to all who require them including financial assistance and preventive, protective, and rehabilitative services, and these services should be available to all persons without regard to residence, settlement, or citizenship requirements;

The benefits of modern medical science should be available to all; and to the extent that individuals cannot secure them for themselves governmental or other social measures should assure their availability;

Democracy has a special obligation to assure to all the Nation's children full and equitable opportunity for family life, healthy growth, and maximum utilization of their potentialities.

These general principles are amplified in other policy statements approved by the board of directors of the association. The welfare policy committee of the association has reviewed all of these statements in the light of current needs and has developed specific legislative objectives for 1960. While the following list does not include all of the association's policy positions, it presents in condensed form those immediate and longer range legislative objectives which are most likely to be of current significance in improving public welfare services.

PUBLIC WELFARE PROGRAMS

*Scope of program*

1. The comprehensive nature of public welfare responsibility should be recognized through Federal grants-in-aid which will enable the States to provide not only financial assistance (including medical care) and other services for the aged, the blind, the disabled, and dependent children, but also general assistance and services for all other needy persons.

2. Federal financial aid should be available to assist States in carrying out public welfare responsibility for preventive, protective, and rehabilitative services to all who require them, irrespective of financial need.

The Federal Government should participate financially in State and local projects which would encourage, extend, or establish problems for self-support, self-care, or the rehabilitation of persons receiving or likely to need public assistance.

3. The Federal Government should participate financially only in those assistance and other welfare programs which are available to all persons within the State who are otherwise eligible without regard to residence, settlement, or citizenship requirements.

4. In order to strengthen family life, the aid-to-dependent-children program should provide Federal aid to the States for any needy child living in the home of any relative.

5. Specific provisions should be made for Federal financial participation in the maintenance of children in foster care.

6. Child welfare services in the Social Security Act should be broadened in scope, should specifically include child welfare services for the delinquent child, and the funds authorized and appropriated should be increased in all States sufficiently to extend and improve their programs compatible with the growing child population and the continuing advances in knowledge which make more effective services attainable.

Specific provision should be made for Federal financial assistance to States to stimulate and support programs for the prevention and control of juvenile delinquency. This should include research and the training of personnel.

7. The category of aid to the permanently and totally disabled should be modified by eliminating the Federal restriction requiring a disability to be permanent and total and by eliminating the age requirement so that all needy disabled persons may be aided under the program.

8. The Federal Government should participate financially in the development of specialized services for the aged, irrespective of financial need.

9. The Federal Government, in cooperation with the States, should study the restriction on Federal financial participation in assistance payments to adults living in public nonmedical institutions.

*Methods of financing programs*

10. The continuation of the Federal open-end appropriation is essential to a sound State-Federal fiscal partnership in all aspects of public assistance. Since it is not possible to predict accurately the incidence and areas of need, flexibility, and comprehensiveness are necessary in financing public assistance programs.

11. Federal financial participation should be on an equalization grant basis provided by law and applicable to financial assistance (including medical care) for all needy persons, welfare services (including child welfare), and administration.

12. Any maximums on Federal participation in public assistance (including medical care) should continue to be related to the average payment per recipient and should be increased sufficiently to assure reasonable standards of maintenance, comprehensive medical care of high quality and appropriate quantity, and the preservation and strengthening of family life.

Federal participation in aid to dependent children should be increased to a level which will assure treatment of children equitable with that accorded other public assistance recipients.

13. There should be no reduction in the overall Federal proportion of assistance and service expenditures unless and until changes in the scope and adequacy of Federal legislation affecting public assistance and social insurance enable the States to meet needs more effectively.

14. No change should be made in the Federal matching formulas which would result in a reduction in the Federal share of State and local administrative costs.

15. Federal aid for public assistance should be on the same basis for Puerto Rico, the Virgin Islands, and Guam as for other jurisdictions. In particular, the annual dollar limitations on Federal participation should be removed.

16. The Federal Government should participate financially in the costs of any State and local civil defense welfare services.

17. Federal legislation should provide funds for American nationals in need of assistance and other services who are repatriated from abroad.

*Administration*

18. States should have the option to administer Federal funds for assistance and services by categories or by a single comprehensive program covering all needy persons.

19. Adequate and qualified personnel is essential in the administration of public welfare programs. Federal financial participation in administrative costs of State welfare programs should be sufficient to enable States to provide for the adequate administration of all welfare programs.

20. Adequate Federal funds should be authorized on a permanent basis to assist States in training staff for State and local public welfare programs and moneys should be appropriated for this purpose.

21. All public welfare programs in which the Federal Government participates financially should be administered by a single agency at the local, State, and Federal level.

22. Federal, State, and local public welfare agencies should participate in and assist in the administrative coordination of all related programs in which there is Federal financial participation.

23. The administration of the Children's Bureau should be maintained within the Social Security Administration.

## SOCIAL INSURANCE PROGRAMS

*OASDI*

24. The contributory old-age, survivors, and disability insurance program, as a preferable means of meeting the income-maintenance needs of people and as a means of keeping the need for public assistance to a minimum, should be strengthened. Among the needed improvements are: Making benefit payments more adequate; increasing the amount of earnings creditable for contribution and benefit purposes in line with current conditions; providing benefits for disabled insured persons of any age and for their dependents; extending coverage to earners still excluded.

25. Health costs of old-age, survivors, and disability insurance beneficiaries should be financed through the OASDI program. Arrangements for achieving this objective should take into account the priority needs of the groups to be served; availability of facilities, personnel, and services; and protection and encouragement of high quality of care, including the organization of health and related services to effect appropriate utilization of services and facilities.

26. The funds of the insurance program should be available to help restore persons on the OASDI disability rolls to gainful employment since such expenditures would result in a net saving to the fund and increase the number of persons rehabilitated.

27. To the extent that changes to improve the OASDI program increase the cost of the program, contributions should be increased to insure the financial stability of the program.

28. The membership of the Advisory Council on Social Security Financing, established by the 1956 amendments, should include representation from public welfare and its functions should be broadened to include responsibility for recommending improvements in all aspects of old-age, survivors, and disability insurance, with particular emphasis on methods of keeping the program in line with current economic conditions and with changes in levels of living, and as a means of keeping the need for public assistance to a minimum.

29. Adequate and qualified personnel are essential in the administration of the old-age, survivors, and disability insurance program. Federal funds should be utilized for the professional training of staff in institutions of higher learning.

*Unemployment insurance*

30. The unemployment insurance program, as a preferable means of meeting the income-maintenance needs of unemployed people and as a means of keeping the need for public assistance to a minimum, should be strengthened. Among the needed inmprovements are: Establishing Federal standards which would assure more adequate benefit payments including benefits for dependents; extension of coverage to earners still excluded; provision for a minimum duration of benefits and appropriate extension of the duration during any period of extended unemployment; provision for more equitable eligibility conditions; provisions for less restrictive disqualification requirements; and an increase in the amount of earnings creditable for contribution and benefit purposes in the line with current conditions.

*Other social insurance*

31. Study should be given to ways of improving and extending, on a sound social insurance basis, temporary disability insurance benefits and workmen's compensation programs, with emphasis on planning for effective medical care and vocational rehabilitation.

RESEARCH AND DEMONSTRATION PROJECTS

32. Federal funds should be authorized and appropriated for research and demonstration projects in all aspects of social security and public welfare.

RELATED PROGRAMS

33. The Federal Government should provide leadership, funds and research for the promotion of health and the prevention of sickness and disability contributing to dependency. Federal health programs should encourage and enable State and local health departments to make a more effective contribution to broad programs of physical restoration. In view of the increasing number of children and the increasing cost of medical service, the amounts authorized and appropriated for maternal and child health and crippled children's services in the Social Security Act should be increased.

34. Public welfare has a responsibility to assure that comprehensive rehabilitative services are made available to persons who require them. In carrying out this objective, public welfare programs have the responsibility to restore individuals to self-care and independent living and to strengthen family life. As part of this responsibility, public welfare agencies are concerned with the availability of adequate vocational rehabilitation services for individuals who can benefit from them.

Since many eligible individuals in the United States still are deprived of vocational rehabilitation services, such services should be strengthened so that all vocationally handicapped persons who present reasonable possibilities of attaining a vocational objective would be served. The vocational rehabilitation program also should be strengthened by permitting States to designate the State agency which can most effectively administer this program.

35. Federal programs should provide more effective aid to help meet the needs of mentally retarded and other handicapped children.

36. The nonquota entry of foreign-born orphans should be limited to children who are placed for adoption in the United States with the approval of authorized social agencies, and to children who are adopted abroad by U.S. citizens residing in the country where the adoption takes place.

37. The Federal Fair Labor Standards Act should be amended to extend coverage and to increase the minimum wage in line with current conditions.

38. Federal programs should provide more effective aid to help meet the needs of migratory workers and their families.

52692—60——31

STATE DEPARTMENT OF PUBLIC ASSISTANCE,
*Charleston, W. Va.*

Mr. JOHN FOGARTY,
*Chairman, Labor-HEW Subcommittee,*
*House Appropriations Committee,*
*Washington, D.C.*

DEAR MR. FOGARTY: We respectfully solicit your interest and support in urging the appropriation of $20 million for crippled children's services in 1961, the full amount authorized by law.

In West Virginia we have many unmet needs so far as handicapped children are concerned, needs unmet because of insufficient funds.

Our program of services for children with congenital heart deformities has increased enormously: in 1948, 2 children were treated; in 1959, 233 were provided treatment. These cases are urgent and expensive. The State needs more funds for additional diagnostic cardiac clinics and for medical care and hospitalization.

In our State there is no adequate program of services for children with rheumatic heart disease; if these children could be treated in the acute stage, perhaps much cardiac crippling could be prevented.

The child with seizures has long been neglected; but it is now known that in cost cases seizures can be controlled with proper treatment and these children so enabled to attend school and to become self-supporting instead of public charges. Our State has one seizure clinic covering only a few counties in one area; this program should be expanded to cover the entire State, but funds are not available.

Furthermore, we have great need for more physical therapy treatment centers. During the year 1959, we provided treatment for 560 children afflicted with polio and for 425 children afflicted with cerebral palsy; the majority of these cases, as well as the amputees, could benefit from more intensive therapy.

Another urgent unmet need in our State is a program of services for children with speech and hearing defects. It is impossible with funds available to initiate this type of service.

During the past 10 years in West Virginia, there has been an increase of 41 percent in the total number of children provided care on the crippled children's program; during this same period, there has been a 46-percent increase in the average cost per case per year for hospitalization alone with similar increases in other costs of services and materials. Particularly during the past 2 years, there has been a very marked increase in the number of applications for treatment and in the number found financially eligible for care on the State program—a reflection perhaps of the depressed economic conditions in our State.

We will appreciate your interest and your cooperation to the end that sufficient funds may be made available to enable the State to meet these and other unmet needs.

Sincerely yours,

HAROLD H. KUHN, M.D.,
*Chief, Division of Crippled Children's Services, State Department of Public Assistance.*

THOMAS R. EGBERT,
*Director, State Department of Public Assistance.*

---

NORTH CAROLINA STATE BOARD OF HEALTH,
*Raleigh, March 3, 1960.*

Hon. JOHN F. FOGARTY,
*House of Representatives, Congress of the United States,*
*Washington, D.C.*

DEAR CONGRESSMAN FOGARTY: We are hereby respectfully requesting favorable action of your Labor-HEW Subcommittee in the matter of appropriation of the $20 million now authorized by law for the care of crippled and handicapped children of medically indigent families.

Crippled children's services throughout the country are faced with rapidly increasing costs of hospitalization, and other medical services, while the number of children applying for service on every program also increases from year to year.

In North Carolina, we support surgery for congenital heart disease and the demands for our assistance in this expensive program increase from day to day.

This is true of all the entities treated—orthopedic crippling, facial and oral deformities, congenital anomalies of the genito-urinary, gastrointestinal, and cerebral spinal systems, rheumatic fever, and disorders of speech and hearing.

We were able in the fiscal year ending June 30, 1959, to reach the end of the year without a deficit, due to the fact that needed surgery in many cases was deferred until the present fiscal year.

Our service is continually importuned to adopt the support of other handicapping conditions for which help should be available from some source, and we have considered the evaluation and treatment of convulsive seizures but have been unable to undertake such a program on account of lack of funds.

Very sincerely yours,

C. B. KENDALL,
*Chief, Crippled Children's Section.*

---

HARRISBURG, PA.

Hon. JOHN E. FOGARTY,
*Chairman, Subcommittee on Appropriations,*
*House of Representatives, Washington, D.C.:*

The Association of State Maternal and Child Health and Crippled Children's Directors urges appropriations to the full amounts authorized for maternal and child health and crippled children grants to the States.

JACK SABLOFF, M.D.,
*President, Association of State Maternal and Child Health and Crippled Children Directors, Pennsylvania State Department of Health.*

---

AUSTIN, TEX.

JOHN FOGARTY,
*Chairman, Labor-HEW Subcommittee,*
*House Appropriations Committee, Washington, D.C.:*

Urge full amount authorized by law for crippled children's services be appropriated for 1960–61. In Texas, 13.7 percent increase in number of children receiving services. Expenditures up 25.3 percent over previous year.

FRED P. HELM, M.D.,
*Director, Crippled Children's Services.*

---

LOUISVILLE, KY.

CONGRESSMAN JOHN E. FOGARTY,
*House of Representatives,*
*Washington, D.C.:*

I would like to call your attention to an area of great need in public health—the health of children and expectant mothers. It is my opinion that appropriations to the States for maternity and child health and crippled children's services to the full amounts authorized by law would assist immensely in further developing programs to meet the health needs of this group. We sincerely solicit your wholehearted support.

RUSSELL E. TEAGUE, M.D.,
*Kentucky State Health Commissioner.*

## TUBERCULOSIS CONTROL

### WITNESS

### DR. IRVING J. SELIKOFF, MOUNT SINAI HOSPITAL, NEW YORK CITY, AND MEMBER MEDICAL PANEL, AMERICAN COMMITTEE AGAINST TUBERCULOSIS

Mr. FOGARTY. Next, we shall hear from Dr. Irving J. Selikoff. Dr. Selikoff.

Dr. SELIKOFF. My name is Dr. Irving Selikoff. I am attending physician at Seaview Hospital in New York and a member of the American Committee Against Tuberculosis.

Simply by way of identification, I have been working in chemotherapy of tuberculosis for the last 15 years and in 1951 and 1952 participated in the introduction of isoniazid.

My purpose here today is to give my opinion on the current problems of tuberculosis control, and in particular on the problem of the use of vaccines for tuberculosis.

Obviously, I am not against drug therapy for tuberculosis. I am currently engaged in further research in the development of new drugs, and I am very much interested in drug therapy; but I am even more interested in the problem of the control of tuberculosis as a whole. That is where my interest in vaccine in particular comes in.

I would like to start by expressing my concern with regard to our present position in tuberculosis.

Although we have had many successes—and I myself am personally quite proud of the current results with isoniazid—we also have many problems, and, to be frank, many failures. I speak of our failures as a practicing physician.

Our present program of concentrating exclusively on casefinding and drug therapy has recently been analyzed in the February 1960 issue of the bulletin of the National Tuberculosis Association as having the following difficulties:

First of all, former patients who had been treated by old methods—bed rest, and so on—are completely neglected in our current casefinding programs although many still are infectious.

Second, it is currently a very common practices to eliminate former patients and contact cases of active patients from observation after 2 years.

There is a widespread failure—and this is all over the country, unfortunately—to report new cases of tuberculosis, especially since private physicians now are treating many new cases of tuberculosis.

Those patients who are reported and are hospitalized, many of them—because of the rapid effect of the new drugs—leave hospitals—in many instances, as many as 40 percent—prior to such advice.

When they leave the hospital they come back to home care programs which have not been designed for the large caseload which is now present in such home care programs.

I quote from the February 1960 issue of the National Tuberculosis Association Bulletin. I think they summarize it at least as well as I could:

> The 1955 studies of nonhospitalized patients by the Public Health Service—confirmed by later experience—gave striking evidence of the gaps in home treatment. Of people with TB, home health authorities know need supervision, 45 percent were not hospitalized. Of these, 72 percent had active disease, often advanced; a great many had left the hospital against medical advice. One-sixth of the nonhospitalized patients who needed medical supervision were not getting it. Even of those who were, almost half were unknown quantities with regard to their bacteriological status; that is, their present infectiousness. Forty percent had had neither drugs nor rest prescribed for them.

Thus, too many patients are untreated or get inadequate treatment. Too many are unsupervised, and even unreported.

There are too many relapses, and this increases the infectiousness in a community.

As a result, many people are still being infected with tuberculosis.

It is these deficiencies which create a situation where today one-quarter of all tuberculosis deaths never have been reported during life. When found, 75 percent of new cases already have far advanced disease. We have a situation where in 1958 we had 87,000 new active cases of tuberculosis.

With these difficulties it seems to me somewhat Pollyanna-like to talk about the utopia of eradication of tuberculosis using solely the same techniques which have left us with the difficulties I mentioned.

I remember the quotation that "there are many roads to utopia" but unfortunately all of them must traverse the surface of the earth.

Not that eradication cannot be obtained. I think it can. I think we should strive for it. It certainly will call for everything that we can utilize.

In addition to the difficulties, there are even certain dangers beyond difficulties inherent in our present position.

First of all, Mr. Chairman, many young people still are being infected.

At this point in this country there are 2.2 million young people under the age of 25 who have been infected. Eighteen percent of all new active cases of tuberculosis are people under the age of 25.

The National Tuberculosis Association report voices the plaintive admission that, "What's more, we do not know the source of these infections in young people."

Physicians have commonly believed that most infections are in such places as the Bowery and skid rows everywhere, mental institutions, prisons, and so forth, but these youngsters who have been getting tuberculosis have not been in skid row and most of them have not been in prison. Yet 18 percent of all our new cases have been people under the age of 25.

This is true even in children.

The New York tuberculosis and health associations 40th annual review as reported in the Herald-Tribune of December 27, 1959, noted that a number of children with active tuberculosis had remained relatively constant for several years. This was most prominent in the record for children under 5 years of age. For example, in 1958 there were 418 children under 5 with active disease on the tuberculosis register compared to 495 in 1950.

Another disquieting fact is that the rate of decline of active cases of tuberculosis, new active cases, is leveling off, and in some parts of the world it is even beginning to go up again.

Last month there was a report from Brazil where the health authorities in Rio De Janiero, after noting that the rate of new cases had rapidly declined after the utilization of isoniazid, noted that it is now beginning to go up again and they do not know why. We have no guarantee that this will not happen here as well.

Thirdly, a disquieting fact is that with our experience over the last 8 years we find there are inherent limitations to drug therapy. The problem is not that we do not have good drugs; we do. Isoniazid is a remarkable drug. The problem is the application of our good drugs; not merely because of the difficulties I have mentioned above but because even with good therapy only 90 percent are cured.

If we have from 60,000 to 80,000 new cases per year, and if we cure only 90 percent, we doom 7,000 or 8,000 people each year to uncured

tuberculosis, providing a huge reservoir of infection for the future, infection probably with resistant bacteria.

The problem of resistant bacteria is not only here but may approach the United States from other areas such as India, where again large numbers of resistant cases are being produced by incorrect, inadequate therapy, which is difficult to prevent.

Because of these problems and these disquieting thoughts, I thought I would like to call attention to a recent report, particularly from Great Britain, on the problem of prevention of tuberculosis in addition to the currently accepted techniques of treating it.

The second report of the Tuberculosis Vaccines Clinical Trials Committee was published in the British Medical Journal on September 12, 1959.

This was a report to the Medical Research Council of Great Britain.

I would like to submit a copy of this report for the record, sir.

(The report referred to follows:)

[Reprinted from the British Medical Journal, Sept. 12, 1959, vol. II, pp. 379–396]

## B.C.G. and Vole Bacillus Vaccines in the Prevention of Tuberculosis in Adolescents

### Second Report to the Medical Research Council by their Tuberculosis Vaccines Clinical Trials Committee[1]

A clinical trial of B.C.G. and vole bacillus vaccines, directed by the Tuberculosis Vaccines Clinical Trials Committee of the Medical Research Council (M.R.C.), was begun in England in 1950, and is still in progress. The effect of the vaccines is being studied during adolescence and early adult life in groups with no special risk of exposure to tuberculous infection, and initialy free both from active tuberculosis and from known contact with the disease at home. There are more than 50,000 participants of both sexes in the investigation, all aged 14 to 15½ years on entry, and now aged between 21 and 23 years. Those with negative reactions to tuberculin on entry were vaccinated with B.C.G. or vole bacillus vaccine or left unvaccinated, according to a method of random allocation. All the participants, including those with a positive reaction to tuberculin initially, have now (January, 1959) been followed intensively for more than six years.

The first report of this investigation (M.R.C., 1956; see also Hart, Pollock, and Sutherland, 1957) presented complete results after each participant had been in the trial for two and a half years. The present report gives corresponding results for the period of five years since entry to the trial, together with preliminary incomplete information for the period between five and seven and a half years after entry.

The work described was carried out by the Council's Tuberculosis Research Unit, with the assistance of many statutory and voluntary organizations (see Acknowledgments).

#### I. Plan and Conduct of the Trial

A detailed description of the plan and conduct of the trial was given in the first report (M.R.C., 1956). The following are the main features.

*The Intake*

The participants in the trial volunteered with their parents' consent between Setpember, 1950, and December, 1952; they were all aged between 14 and 15½ years, and most (82%) were between 14½ and 15 years. All were in their final year at secondary modern schools in densely populated districts in or near North London, Birmingham, and Manchester (see Acknowledgments). A record

[1] Members of the Committee: Dr. P. D'Arcy Hart (chairman), Dr. C. Metcalfe Brown, Sir John Charles, Professor R. Cruickshank, Dr. Marc Daniels (secretary until his death in 1953), Dr. W. Pointon Dick (resigned in 1951), Dr. J. E. Geddes, Professor A. Bradford Hill, Sir Wilson Jameson, Dr. V. H. Springett, Dr. Ian Sutherland, Dr. A. Q. Wells (died in 1956), Dr. G. S. Wilson, Dr. T. M. Pollock (secretary).

card bearing a printed serial number was prepared for each volunteer, who was then given the following standard examination by one of three special teams of the Tuberculosis Research Unit, each operating in one of the main areas: (*a*) A 35-mm. radiograph of the chest; and, if indicated, a full-plate radiograph. (*b*) An intracutaneous tuberculin (Mantoux) test with 3 T.U. (tuberculin units) of Old Tuberculin (human). (*c*) If there was no palpable infiltration, or if its greatest diameter was less than 5 mm. at the end of 72 hours, the reaction to 3 T.U. was regarded as negative and another test was made with 100 T.U.

Participants with no infiltration, or with a diameter of infiltration of less than 5 mm., in response to the second test, at the end of 72 hours, were regarded as negative reactors to 100 T.U. and were eligible for vaccination.

*Vaccination procedures*

The children eligible for vaccination were allocated, according to the final digit of the serial number on their record card, to the unvaccinated group, or to one of the two vaccinated groups. B.C.G. vaccine was given in all three areas, but vole bacillus vaccine was not given in the London area. On a few occasions in the Birmingham and Manchester areas, when there was a temporary failure in the supply of one of the vaccines, the other was used instead. Because of these local differences the numbers of participants in the unvaccinated groups and in the two vaccinated groups were unequal. Throughout the trial, however, and whatever vaccines were being given, the allocation was always strictly in accordance with the final digit of the serial number, and so was effectively random.

The B.C.G. vaccine used was the fresh liquid preparation from the State Serum Institute, Copenhagen, and was given by intracutaneous injection. In the course of the trial 75 of the Institute's routine batches were used. The viable units/mg. for each batch (Tolderlund, 1952, 1955) ranged from 7.8 to 53.4m., and 74% of the participants given B.C.G. were vaccinated with batches which had counts between 20 and 40m. viable units/mg. The vole bacillus vaccine was a fresh liquid preparation from the Lister Institute, Elstree, Herts, and was given by multiple puncture. The earlier batches of this vaccine were below the strength originally intended. Further details of both vaccines, and of the vaccination procedures, are given in the first report (M.R.C., 1956); the tuberculin conversion rates are given below in Table II.

The appropriate vaccine was given immediately after the reading of the test with 100 T.U.

*Number of participants in the trial*

In this report the numbers of participants in the trial have been estimated from the same representative samples of the record cards as were used in the first report. The cases of tuberculosis and other diseases, however, have, as before, been completely enumerated. (In the final report the analysis will be based on a complete enumeration of the participants also; in the meantime, however, checks have shown that any inaccuracies in the numbers of participants, as estimated from the samples, will not affect the final rates appreciably.)

The following groups of children were excluded from participation: (*a*) Those found or suspected to have any form of tuberculosis (apart from calcification of primary type) at the time of the first examination. (*b*) Those, who, at the time of the first examination, had been in recent contact at home with a case of pulmonary tuberculosis. (*c*) Those who failed to complete the first examination.

In addition, a small number (about 400) have been excluded from the analysis of the results for such reasons as having been given the wrong vaccine, incorrectly left unvaccinated, or given a tuberculosis vaccine prior to entering the trial. After these exclusions there remain 56,700 participants in the analysis.

As a result of the tuberculin tests and vaccinations at the first examination, the children were automatically classified on entry into the following five trial groups, in which they remain for the purpose of the ensuing analysis, whatever the results of subsequent tuberculin tests:

Negative unvaccinated: Negative to 100 T.U. on entry and left unvaccinated: 13,300 participants.

Negative, B.C.G.-vaccinated: Negative to 100 T.U. on entry and then given B.C.G. vaccine: 14,100 participants.

Negative, vole-bacillus-vaccinated: Negative to 100 T.U. on entry and then given vole bacillus vaccine: 6,700 participants.

Positive to 3 T.U.: Positive to 3 T.U. on entry and left unvaccinated: 16,000 participants.

Positive only to 100 T.U.: Negative to 3 T.U. but positive to 100 T.U. on entry, and left unvaccinated: 6,600 participants.

*Second examination of participants*

In 1950 and 1951, the children in the trial had another chest radiograph before leaving school, usually three to five months after the first examination; those with negative reactions to 100 T.U. at the first examination, whether vaccinated or not, were retested as before. At the same time the B.C.G.- and vole-bacillus-vaccination reactions were examined. In 1952, to check the potency of the vaccines, a sample of the children given each batch had tuberculin tests performed, and vaccination reactions examined, three to five months after vaccination.

*Follow-up of participants*

Since leaving school the participants in each of the five trial groups have had the following cycle of inquiry and examination, repeated at intervals of about 14 months; (*a*) An inquiry form by post about four months after leaving school (or after the previous chest radiograph). (*b*) A home visit by a trained nurse about six months after the postal inquiry. (*c*) The three teams have visited each district in turn about four months after the home visit, to take chest radiographs and make tuberculin tests, exactly as at the first examination at school (except that some of the tuberculin tests were read at 48 instead of 72 hours); participants who failed to attend this examination were invited again to a special examination about seven months later. Since June 1954, all the radiographs have been read separately by a physician unconnected with the conduct of the trial as well as by the team physician.

The great majority of the participants have continued to live in their original areas, and only about 6% have moved to a district (either in this country or abroad) not visited by the teams' mobile radiography units. For these participants the home visits and the radiographic examinations were arranged by the local health authority.

Arrangements were made with the medical services of the Royal Navy, the Army, and the Royal Air Force for the close follow-up of participants during their two-year period of military service. This has involved about two-thirds of the young men, mostly between the ages of 18 and 20 years. The Army and the Royal Air Force introduced a special scheme for the prompt notification to the M.R.C. teams of any case of tuberculosis which developed in a trial participant, and arranged, where practicable, for chest radiographs and (in the Royal Air Force) tuberculin tests on demobilization. The Royal Navy made available a nominal roll of those invalided with tuberculosis. During this period of military service the M.R.C. teams also made a single postal inquiry to the participant's home.

In addition, where it was known that a participant had attended one of the mass miniature radiography units of the National Health Service, or had had any other routine chest radiograph (for example, at an antenatal clinic), efforts were made to ascertain the result.

Recent analysis of a sample of the records (for all whose surnames began with A or D, representing 6.5% of the total) has shown that contact was made by one or more of these means with 89% of the participants during the two-year period 1957–8, compared with 94% within the first 18 months after entry to the trial (M.R.C., 1956). Sixty per cent of the participants had at least one chest radiograph taken in 1957–8, compared with at least 74% within the first two years after entry.

Information has also been continually made available to the teams from the tuberculosis notification registers of the medical officers of health and from the records of attendances at the chest clinics and mass radiography units of the National Health Service, in the districts concerned. Cases of tuberculosis have therefore come to the notice of the M.R.C. teams through the usual channels of the National Health Service (56% of the cases within five years of entry) as well as by their own radiographic examinations (44%). Throughout this report, the small number of cases arising among participants during their period of service in the Armed Forces have been included with the National Health Service cases.

*Vaccination of trial participants from outside sources*

No participant was vaccinated or revaccinated by the M.R.C. teams subsequent to the initial examination, and there was little opportunity for participants to

receive B.C.G. vaccine from outside sources during the course of the trial. Those known to be in contact at home with pulmonary tuberculosis at the time of entry were excluded from participation, and the current national scheme for the vaccination of 13-year-old school children (Ministry of Health, 1953) did not begin until all the participants were aged at least 16 years. Some participants, however, have come into contact with tuberculosis at home since entry, and some have had an opportunity for vaccination in their occupation (for example, nursing) or in other ways.

Information on such vaccination has been made available to the teams at frequent intervals from the vaccination records of the chest physicians and medical officers of health in the districts concerned. In addition, any participant in the negative unvaccinated group who has become tuberculin-positive since September, 1955, has been routinely questioned about possible vaccination from outside sources, and the arm has been examined for a vaccination reaction. As a result of these inquiries and other information, it has been found that very few participants have been given B.C.G. vaccine from outside sources. A recent survey of a sample of the records has shown only four instances of non-trial B.C.G. vaccination in a total of about 2,500 participants from all trial groups (1.6 per 1,000). Two were initially in the tuberculin-negative unvaccinated group and one was in each of the two vaccinated groups. It is evident that the present extent of non-trial vaccination of participants can have had only a negligible influence on the results.

*Records of cases*

The physicians in charge of the M.R.C. teams were not responsible for the further investigation or treatment of any participant who had an abnormal radiograph; those found to have an abnormal radiograph at an examination by one of the teams were referred to their local chest clinics. However, almost every case of definite or suspected tuberculosis brought to the notice of the teams was also examined by one of the team physicians, and further details of progress were obtained at regular intervals. To ensure that cases of tuberculosis were not missed, full records were kept, not only for the definite cases, but also for those in which tuberculosis was either suspected or considered to be even a possible diagnosis. Similar records were kept for all non-tuberculous pulmonary lesions which came to the notice of the teams. As a precaution, it was decided in November, 1953 (with restrospective application), that any pulmonary radiographic abnormality, whatever its apparent cause, which persisted for longer than 14 days without complete clearing must be investigated. Details were obtained of all deaths, from whatever cause.

In cases of definite or suspected tuberculosis arising in B.C.G.-vaccinated or vole-bacillus-vaccinated participants, routine examinations of cultures growing acid-fast bacilli were made to investigate whether the organisms were B.C.G. or vole bacilli.

*Assessment of cases*

All definite, suspected, and possible cases of tuberculosis, and all other pulmonary radiographic abnormalities persisting for longer than 14 days, which came to the notice of the teams were reviewed by an independent assessor who was kept unaware of the results of any tuberculin tests and whether any vaccination had been performed. The great majority of the cases were reviewed by one assessor, but a second was used for a small number of cases which happened to be under the routine clinical care of the first; and a few cases of suspected tuberculosis of bones or joints, without bacteriological or histological confirmation, were referred to a third.

The assessor decided, from the periodic radiographs, from the results of the clinical examination by one of the team physicians, from the results of clinical examinations by other physicians, and from the results of any bacteriological or pathological examinations: (*a*) whether the disease was definite (and active) tuberculosis, possible tuberculosis, or not tuberculosis; for a few cases he decided that there was no evidence of any disease, tuberculous or non-tuberculous; (*b*) for cases of definite or possible tuberculosis, the form of the disease and the character, course, initial, and maximal extent of any lesions apparent on the series of radiographs; (*c*) for pulmonary lesions, the date of the first abnormal radiograph, or, for other lesions, the date when the first definite symptoms or signs were observed (irrespective of when the diagnosis of tuberculosis had been made); this date has been regarded as the starting-point of the illness, though it will be appreciated that for some cases the starting-point, thus defined,

may be a considerable time after the true, but unknown, date of onset of the disease.

## II. THE CASES OF TUBERCULOSIS

*Cases of tuberculosis present in entry to the trial*

As described in the first report (M.R.C., 1956), 70 cases of previously unsuspected definite tuberculosis were discovered at the first examination at school, and so were excluded from the trial. In addition (up to the end of January, 1959) 111 cases, discovered after the 56,700 participants had completed the first examination and had entered the trial, were judged by the assessor to have started before entry (all except seven were, unknown to the assessor, tuberculin positive on entry). Of these, 80 were cases of definite but previously unsuspected tuberculosis, 18 were definite cases with a history of tuberculosis prior to entry to the trial (unknown to the teams at the time of the first examination), and 13 were cases of possible tuberculosis. These 111 children should also have been excluded from the trial, and have therefore been excluded from the analysis.

In 86 of the 111 cases the radiograph taken on entry showed, on re-scrutiny, abnormal appearances indicative of tuberculosis; in one case with a normal 35-mm. radiograph on entry there had been a pleural effusion two months earlier, and in 19 cases of non-pulmonary disease symptoms had been present before the participant entered the trial. There remain five cases of definite tuberculosis where the assessor decided that the disease must have been present at the time of entry, although the symptoms or lesions were not apparent until later. In one of the five, symptoms of non-pulmonary disease appeared only three months after the child had entered the trial. In the other four, pulmonary lesions were first seen on radiographs taken at the second examination at school; the 35-mm. radiograph on entry in one case was considered not to be of sufficiently high quality to exclude the presence of the lesion, and in two others the film had been lost; in the fourth case the assessor considered that the lesion was probably present on entry but was obscured by bony shadow. These five children had (unknown to the assessor) all given a positive reaction to tuberculin on entry to the trial.

*Tuberculous lesions attributed to vaccination*

In seven participants, lesions which developed subsequent to B.C.G. or vole bacillus vaccination were brought to the attention of the teams as cases of tuberculosis and submitted to the assessor, but were regarded by him as complications of vaccination. There were three cases of erythema nodosum, all observed one month after entry to the trial. There were also four cases of regional tuberculous adenitis (one cervical, two axillary, and one inguinal) observed three, six, eight, and 22 months respectively after entry to the trial. In the course of his assessment, the assessor suggested that if the participant had been vaccinated the lesions could have been due to the vaccinating organism. For these cases, and for no others, the assessor was then informed that the participant had been vaccinated. As a result, he attributed all seven cases to the vaccinating organism. The three cases of erythema nodosum occurred in B.C.G.-vaccinated participants, and the four cases of tuberculous adenitis in vole-bacillus-vaccinated participants (all of whom were given the vaccine after it had been brought up to standard—see "Vaccination Procedures," p. 379).

In addition, as described in the first report (M.R.C., 1956), examinations of the vole-bacillus-vaccination sites during the follow-up revealed occasional lesions indistinguishable from lupus vulgaris, at or around the site of vaccination. All occurred among the 4,200 participants given the vaccine after it had been brought up to standard. Of these cases, 23 severe enough to require treatment were found up to the end of January, 1959; all had been referred for treatment before July, 1955. A recent inquiry has shown that in 17 of these 23 cases the lesions had healed; three cases had made a satisfactory early response to treatment, but have not been seen recently; and three failed to attend for treatment or subsequent observation. The B.C.G.-vaccination sites were also examined as a routine, but no similar lesions were found.

All these lesions have been regarded as complications of vaccination, and none of the cases has been included in the tables which follow (but see Discussion, p. 391). It should be emphasized that there was no evidence that any of the other cases of tuberculosis in vaccinated participants were due to the vaccinating organism (see "Bacteriological and Pathological Investigations," p. 386).

*Death from tuberculosis in the first five years*

Only one participant is known to have died of tuberculosis within five years of entry to the trial. The participant was in the tuberculin-negative unvaccinated group, and died from acute tuberculous meningitis 39 months after entry.

*Incidence of tuberculosis in the first five years*

By the end of June, 1958, every participant had been in the trial for five years, and some for as long as seven and a half years. The great majority of the cases of tuberculosis starting within five years of entry are therefore presumed to have come by now (January, 1959) to the notice of the tams. A total of 349 cases of definite tuberculosis started within five years of entry (including the above fatal case) and a further 23 were assessed as possible tuberculosis. Of the definite cases, 153 occurred in the negative unvaccinated group, 27 in the B.C.G.-vaccinated group, 11 in the vole-bacillus-vaccinated group, 128 among those initially positive to 3 T.U., and 30 among those initially positive only to 100 T.U.

TABLE I.— *Cases of tuberculosis starting within 5 years of entry to the trial*

| Section [1] | Estimated number of participants | Definite cases of tuberculosis | | Possible cases of tuberculosis starting within 5 years |
|---|---|---|---|---|
| | | Number starting within 5 years | Annual incidence per 1,000 participants | |
| A. Children admitted concurrently with those given B.C.G. vaccine: | | | | |
| Negative unvaccinated | 13,200 | 151 | 2.29 | 9 |
| Negative, B.C.G. vaccinated | 14,100 | 27 | .38 | 3 |
| Positive to 3 T.U | 15,800 | 127 | 1.61 | 6 |
| Positive only to 100 T.U | 6,500 | 30 | .92 | 3 |
| B. Children admitted concurrently with those given vole bacillus vaccine: | | | | |
| Negative unvaccinated | 6,500 | 85 | 2.62 | 7 |
| Negative, vole bacillus vaccinated | 6,700 | 11 | .33 | 2 |
| Positive to 3 T.U | 8,800 | 76 | 1.73 | 3 |
| Positive only to 100 T.U | 3,600 | 17 | .94 | 2 |
| C. Children admitted concurrently with those given B.C.G. and those given vole bacillus vaccine: | | | | |
| Negative, B.G.C. vaccinated | 6,400 | 10 | .31 | 2 |
| Negative, vole bacillus vaccinated | 6,400 | 8 | .25 | 2 |

[1] Many participants and cases of tuberculosis appear in more than one of the three separate sections of this table (see text), and the figures from different sections can therefore not be totalled. The total numbers of participants and cases of tuberculosis in each trial group are shown in table VIII.

TABLE II.—*Conversion rates and incidence of tuberculosis in participants given different batches of the B.C.G. and the vole bacillus vaccines*

| Classification of vaccine batches | Conversion rates (estimated from sample) | | | | Incidence of Tuberculosis | | |
|---|---|---|---|---|---|---|---|
| | Number who completed skin tests 3 to 5 months after vaccination | Percentages with Positive tuberculin reactions | | | Total participants given these batches (estimated from sample) | Definite cases of tuberculosis starting within 5 years | Annual incidence per 1,000 participants |
| | | Positive to 3 T.U. | Positive only to 100 T.U. | Total positive | | | |
| B.C.G. vaccine: | | | | | | | |
| Viable units (million) per milligram: | | | | | | | |
| Under 20 | 1,200 | 76 | 24 | 100 | 1,900 | 4 | 0.42 |
| 20 | 2,200 | 82 | 17 | 99 | 4,300 | 12 | .56 |
| 30 | 3,000 | 89 | 11 | 100 | 6,200 | 7 | .23 |
| 40 or more | 800 | 97 | 3 | 100 | 1,500 | 4 | .53 |
| All batches [1] | 7,200 | 86 | 14 | 100 | 13,900 | 27 | .39 |
| Vole bacillus vaccine: | | | | | | | |
| Concentration of bacilli and strain: | | | | | | | |
| Substandard [2] (January 1951 to July 1951) | 1,800 | 31 | 56 | 87 | 2,500 | 5 | .40 |
| Standard (September 1951 to December 1952) | 2,000 | 88 | 12 | 100 | 4,200 | 6 | .29 |
| All batches | 3,800 | 61 | 33 | 94 | 6,700 | 11 | .33 |

[1] Excluding 1 batch of B.C.G. vaccine, given to about 200 participants, for which no viable count was available.

[2] That is, below the standard originally intended.

A valid assessment of the value of B.C.G. vaccination must be based upon those children who were admitted *concurrently* to the negative unvaccinated, the B.C.G.-vaccinated, and the two tuberculin-positive groups. The data are presented in this way in Section A of Table I. (The comparison includes all the children admitted to the trial in these four groups, except for the small number who entered when vole bacillus vaccine only was available.) In this comparison there were 151 cases of tuberculosis in the tuberculin-negative unvaccinated group, giving an annual incidence of 2.29 cases per 1,000 participants. With its 27 cases, the annual incidence in the B.C.G.-vaccinated group was much lower, being 0.38 per 1,000, or approximately one-sixth of the rate in the negative unvaccinated group. The possibility of this difference having occurred by chance is remote (less than one in a million). Among those initially positive to 3 T.U. the annual incidence was 1.61 per 1,000, rather less than that in the negative unvaccinated group, while in the group positive only to 100 T.U. it was much less, namely 0.92 per 1,000; the latter rate was, however, higher than the rate in the B.C.G.-vaccinated group. These four rates all differ significantly from each other at the 1% level. The variations in incidence *within* the group initially positive to 3 T.U., noted in the first report (M.R.C., 1956), are considered in detail below (see "Incidence of Tuberculosis in Different Periods," p. 387).

Similarly, a valid assessment of the value of vole bacillus vaccination must be based upon those children admitted *concurrently* to the negative unvaccinated, the vole-bacillus-vaccinated, and the two tuberculin-positive groups, as shown in Section B of Table I. (This comparison therefore includes some but not all of the children considered in Section A above, together with the small number who entered the trial at a time when vole bacillus vaccine only was available.) In this comparison there were 85 cases of tuberculosis in the negative unvaccinated group, giving an annual incidence of 2.62 per 1,000; in the vole-bacillus-vaccinated group there were 11 cases, giving a rate of 0.33 per 1,000, or approximately one-eighth of the rate in the negative unvaccinated group. The possibility of this difference having occurred by chance is remote (less than one in a million). Among those initially positive to 3 T.U. the annual

incidence was 1.73 per 1,000, rather less than that in the negative unvaccinated group, while in the group positive only to 100 T.U. it was much less, namely 0.94 per 1,000; the latter rate was, however, higher than that in the vole-bacillus-vaccinated group. These four rates all differ significantly from each other at the 1% level (apart from the rates in the two initially positive groups, which differ from each other at the 5% level).

Finally, a valid comparison between the value of B.C.G. and vole bacillus vaccination must also be based on concurrent admissions to these two groups; the data for this comparison are shown in Section C of Table I. (These participants are all included either in Section A or in Section B.) The difference between the annual rates for the B.C.G.-vaccinated group (0.31 per 1,000) and for the concurrent group of vole-bacillus-vacinated children (0.25 per 1,000) does not attain statistical significance.

The 23 cases judged by the assessor to be possibly but not definitely due to tuberculosis are also shown in Table I; their distribution among the five trial groups is similar to that of the definite cases. The above comparisons would not have been appreciably affected if these possible cases had been included with the definite cases.

Although it is essential for valid comparisons between the trial groups to base them upon concurrent admissions, it is also evident from Table I that the incidence of tuberculosis in each trial group is closely similar in the different sections of the table. In fact, when allowance is made for the overlap between the sections, none of these differences in incidence attains statistical significance. Because of this homogeneity of the findings, it is unnecessary to set out all the results on a strictly concurrent basis. For most of this report, therefore, the findings are presented for the *whole* of each trial group.

*Incidence of tuberculosis in participants given different batches of B.C.G. vaccine*

Counts of viable bacilli were made as a routine on each weekly batch of B.C.G. vaccine at the State Serum Institute, Copenhagen, prior to dispatch to Britain. These counts were available for all except one of the 75 batches used in the trial (Tolderlund, 1952, 1953). It was thus possible to investigate whether the tuberculin conversion rate, or the incidence of tuberculosis, following vaccination, was associated with routine fluctuation in the strength of the vaccine. The batches were divided into four groups, according to viable count (Table II).

The total proportion converted (based on representative samples) was practically 100% for each group of batches: but there was a definite trend in the proportion converted to 3 T.U. with increasing viable count, from 76% for the batches with a count of less than 20m. viable units/mg. to 97% for those with a count of 40m. or more.

Despite the trend in percentage converted to 3 T.U., there was no obvious trend in the incidence of tuberculosis following vaccination with the different groups of batches. In particular, it is of value to note that the weakest batches in the range used conferred substantial protection against the disease. Of the 12 batches with counts of less than 20m. viable units/mg., 11 had counts between 19.2 and 11.4m., and one had a count of 7.8m. Four cases of tuberculosis started within five years of entry among the 1,900 participants vaccinated with these 12 batches, giving an annual incidence of 0.42 per 1,000. This was considerably less than the annual rate of 2.00 per 1,000 for the 18 cases occurring in the 1,800 concurrent admissions to the negative unvaccinated group (not shown in Table II); the difference is significant at the 1% level.

*Incidence of tuberculosis in participants given certain batches of vole bacillus vaccine*

As described in the first report, the early batches of vole bacillus vaccine, used from January to July, 1951, were weaker than the standard originally intended, and the strength of the subsequent batches was adjusted to the intended standard. The findings on tuberculin conversion and subsequent incidence of tuberculosis in participants given these two groups of batches are shown in the lower part of Table II.

For the early batches the proportion converted to 3 T.U. was 31%, and the total proportion converted was 87%: for the latter batches the corresponding proportions were 88% and 100%.

Despite this considerable difference in the degree of sensitivity produced by the two groups of batches, the incidence of tuberculosis in the participants given

the early vaccine was not substantially different from that in the participants given the late vaccine. These early batches, despite the low conversion rate, thus afforded considerable protection against the disease. Five cases of tuberculosis started within five years of entry among the 2,500 participants vaccinated with the early batches, giving an annual incidence of 0.40 per 1,000, compared with 35 cases among the 2,300 concurrent admissions to the negative unvaccinated groups, an annual incidence of 3.04 per 1,000 (not shown in Table II). The difference between the rates is significant at the 0.1% level.

*Evidence of vaccination in cases of tuberculosis occurring in vaccinated participants*

Evidence that the vaccination was technically satisfactory for the 38 definite cases of tuberculosis in the two vaccinated groups is summarized in Table III.

TABLE III.—*Evidence of technically satisfactory vaccination in the 38 vaccinated participants who developed definite tuberculosis within 5 years of entry to the trial*

| Results of first skin test after vaccination and before starting point of disease | Vaccination reaction | | | |
|---|---|---|---|---|
| | Total | Present | Absent | Not examined |
| Tests within 6 months of vaccination: | | | | |
| Positive to 3 T.U | 18 | 14 | 2 | 2 |
| Positive only to 100 T.U | 3 | 2 | 1 | 0 |
| Negative to 100 T.U | 0 | 0 | 0 | 0 |
| Tests 6 months or more after vaccination: [1] | | | | |
| Positive to 3 T.U | 4 | 4 | 0 | 0 |
| Positive only to 100 T.U | 1 | 0 | 1 | 0 |
| Negative to 100 T.U | 0 | 0 | 0 | 0 |
| No test | 12 | 10 | 1 | 1 |
| All cases | 38 | 30 | 5 | 3 |

[1] Of the total of 26 vaccinated participants known to have become tuberculin positive, 24 had a normal chest radiograph at the same time or subsequently; 2 had no chest radiographs taken after vaccination and before the starting point of the disease.

Within six months of vaccination 21 were found to be tuberculin positive (18 to 3 T.U.), and 19 of these (not shown separately in the table) had a normal radiograph either then or subsequently (two had no radiograph before the disease started). A further five cases were tuberculin positive (four to 3 T.U.) when first tested more than six months after vaccination, and all five had a normal chest radiograph at the same time or subsequently. Of these 26 cases, 20 were found to have in addition a healed vaccination reaction, in two the vaccination site was not examined, and in four (all vole-bacillus-vaccinated) the vaccination reaction was looked for but not found (four, six, six, and 12 months after vaccination respectively).

In 12 cases there were no tuberculin tests after entry and before the disease developed, and therefore no information on whether vaccination produced tuberculin conversion, but 10 had a healed vaccination reaction. In one of the remaining two cases it has not been possible to examine the B.C.G.-vaccination site, and, in the other, the vole-bacillus-vaccination site was examined only 24 months after entry to the trial, when no reaction was observed; a reaction may nevertheless have occurred and subsequently disappeared (M.R.C., 1956).

In summary, these last two cases of the 38 may not have been satisfactorily vaccinated, as judged by the usual criteria. It should be added that one B.C.G.-vaccinated case had a starting-point three months after vaccination; for this, the only case in a vaccinated participant within 12 months of vaccination, the disease could well have arisen before any protection had been conferred.

*The forms of tuberculosis*

The forms of tuberculosis which occurred in the various trial groups are shown in Table IV. If two or more were present, the case was assigned to the major form—for example, tuberculous meningitis took precedence over any other form, and pulmonary tuberculosis took precedence over a pleural effusion.

Seventy per cent, of the cases (245 of 349) were of pulmonary tuberculosis. There is no evidence of any important differences between the five trial groups in this percentage.

Tuberculous pleural effusion, without pulmonary tuberculosis, was the next most numerous form, with 59 cases (17%). In addition, a pleural effusion preceded, or was discovered at the same time as, the pulmonary lesions in 13 more cases (not identified separately in the table). The ratio of pleural effusions to total cases was greatest in the negative unvaccinated group (44 of 153, or 29%) and least among those initially positive to 3 T.U. (12 of 128, or 9%), this difference being significant at the 0.1% level. There were eight pleural effusions among the 38 cases in the vaccinated groups combined, and eight among the 30 cases initially positive only to 100 T.U. There was no significant difference in the ratio of plueral effusions to total cases between the vaccniated and the negative unvaccinated groups.

There were two cases of hilar gland enlargement, with no other lesion, both in the negative unvaccinated group. Hilar gland enlargement was also found, however, in association with other lesions (mainly pulmonary lesions, pleural effusions, or both) in 34 more cases (not identified separately in the table). In all, hilar gland enlargement was noted most frequently among the cases in the negative unvaccinated group (27 of 153, or 18%) and least frequently among those initially positive to 3 T.U. (two of 128, or 2%), this difference being significant at the 0.1% level. Hilar gland enlargement was noted in three of the 38 cases in the vaccinated groups combined and in four of the 30 cases initially positive only to 100 T.U. There was no significant difference in the ratio of hilar gland enlargements to total cases between the vaccinated and the negative unvaccinated groups.

Twelve cases of tuberculous cervical adenitis (one associated with tuberculous tonsils) occurred in the group initially positive to 3 T.U., and three in the negative unvaccinated group; none occurred in any of the other groups.

There were five cases of tuberculous meningitis—four in the negative unvaccinated group and one (41 months after entry) in the group initially positive to 3 T.U. In addition, five of the pulmonary lesions were of military type; four of these were in the negative unvaccinated group and one (with a starting-point 57 months after entry) in the group initially positive to 3 T.U. Thus, tuberculous meningitis or military tuberculosis occurred in eight of the 153 cases in the negative unvaccinated group and in two of the 128 cases in the group initially positive to 3 T.U. None occurred in the vaccinated groups, or in the group initially positive to 100 T.U.

*Nature, initial and maximal extent of the pulmonary lesions*

The assessor classified the pulmonary lesions according to both their initial and their maximal extent. The *initial* extent was that seen on the first abnormal chest radiograph, a substantial proportion of these being 35-mm. radiograph. If a full-size chest radiograph had been taken within six weeks after the abnormal 35-mm. radiograph, the assessments of cavitation and extent were made instead from the full-size radiograph, because of the difficulty of making an accurate classification from a miniature film. (In a few instances a "5- by 4-in." (12.5- by 10-cm.) film was used similarly for the assessments, if no suitable full-size radiograph was available.) In all 54 (22%) of the assessments of initial extent were made only from a 35-mm. radiograph; these included 12 cases which subsequently developed cavitation, no cavitation having been seen on the abnormal 35-mm. radiograph.

The nature and *initial* radiograph extent of the pulmonary leisons are shown in Table V. Of the total of 245 pulmonary cases, 5, but referred to, were of military type, and 51 (21%) showed cavitation on the first abnormal radiograph. Lesions with cavitation were observed in 25% of the 100 cases in the negative unvaccinated group; in 22% of the 27 cases in the vaccinated groups combined; and in 17% of the 117 cases in the groups initially positive to 3 T.U. or 100 T.U. There is thus no evidence of important differences in the presence of cavitation between cases in the different groups.

Leisons involving more than two rib interspaces (with or without cavitation, and including the military cases) were observed on the first abnormal film in 26 (26%) of the 100 cases in the negative unvaccinated group, compared with 3 (11%) of the 27 cases in the vaccinated groups combined; at the other extreme, lesions up to 6 sq. cm. in extent (on a full-size chest radiograph) were observed in 32 (32%) of the cases in the negative unvaccinated group, compared with 13 (48%) of those in the vaccinated groups combined. There is thus a suggestion (which does not attain statistical significance) that in the vaccinated cases the lesions, when first detected, were on average not as extensive as those in the negative unvaccinated group.

The nature and the *maximal* radiographic extent of the pulmonary leisons are shown in Table VI. Comparison with Table V shows that cases with cavitation (on one or more postero-anterior radiographs) had increased from 51 to 79 since the first abnormal radiograph. (Tomograms were not taken as a routine; to avoid bias in comparing the severity of the lesions in the different groups, evidence of cavitation obtained only from tomograms has therefore been disregarded.) Many of the lesions had also increased in extent since the first abnormal radiograph; lesions which involved more than two rib interpsaces (with or without cavitation) had increased from 43 to 64, and lesions with an extent of 6 sq. cm. or less had decreased from 85 to 55.

TABLE IV.—*Definite cases of tuberculosis starting within 5 years of entry to the trial, according to form of disease*

| Trial group | Total cases | Form of tuberculosis: Pulmonary tuberculosis | | Tuberculous pleural effusion [1] | Hilar gland enlargement [2] | Tuberculous meningitis | Bone or joint tuberculosis | Tuberculous cervical adenitis | Tuberculous peritonitis | Erythema nodosum | Other forms |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Number | Percent | | | | | | | | |
| Negative unvaccinated | 153 | 100 | 65 | [3] 36 | 2 | 4 | [4] 2 | 3 | [5] 2 | 3 | [6] 1 |
| Negative, B.C.G. vaccinated | 27 | 20 | 74 | 5 | 0 | 0 | 0 | 0 | 1 | 1 | 0 |
| Negative, vole bacillus vaccinated | 11 | 7 | 64 | 3 | 0 | 0 | 1 | 0 | 0 | 0 | 0 |
| Positive to 3 T.U | 128 | 97 | 76 | 9 | 0 | 1 | 3 | 11 | 1 | 0 | [7] 6 |
| Positive only to 100 T.U | 30 | 21 | 70 | 6 | 0 | 0 | 2 | 0 | 0 | 0 | [8] 1 |
| All groups | 349 | 245 | 70 | 59 | 2 | 5 | 8 | 14 | 4 | 4 | 8 |

[1] Without evidence of pulmonary tuberculosis.
[2] Without other evidence of tuberculosis.
[3] 3 with erythema nodosum.
[4] 1 with erythema nodosum.
[5] 1 with small associated pulmonary lesion.
[6] Tuberculous bronchiectasis.
[7] 1 tuberculous endobronchitis; 1 tuberculous tonsils and cervical glands; 1 lupus vulgaris; 3 genitourinary tuberculosis.
[8] Tuberculous axillary adenitis.

TABLE V.—*Definite cases of pulmonary tuberculosis starting within 5 years of entry to the trial, according to the nature and extent of the pulmonary lesions seen on the 1st abnormal chest radiograph*

| Trial group | Total pulmonary cases | Miliary type of lesions | Lesions with cavitation: Lesions involving more than 2 rib interspaces | Lesions with cavitation: Lesions more than 6 square centimeters in extent, involving up to 2 rib interspaces | Lesions with cavitation: Lesions up to 6 square centimeters in extent | Lesions without cavitation: Involving more than 2 rib interspaces | Lesions without cavitation: More than 6 square centimeters in extent, involving up to 2 rib interspaces | Lesions without cavitation: Up to 6 square centimeters in extent |
|---|---|---|---|---|---|---|---|---|
| Negative unvaccinated | 100 | 4 | 18 | 6 | 1 | 4 | 36 | 31 |
| Negative, B.C.G. vaccinated | 20 | 0 | 2 | 2 | 1 | 0 | 6 | 9 |
| Negative, vole bacillus vacinated | 7 | 0 | 1 | 0 | 0 | 0 | 3 | 3 |
| Positive to 3 T.U | [1] 96 | 1 | 8 | 7 | 1 | 8 | 37 | 34 |
| Positive only to 100 T.U | 21 | 0 | 1 | 3 | 0 | 1 | 11 | 5 |
| All groups | [1] 244 | 5 | 30 | 18 | 3 | 13 | 93 | 82 |

[1] Excluding one patient for whom the extent of the lesions was not classified because the first abnormal radiograph, taken before a thoracoplasty was performed, could not be found; the diagnosis was confirmed bacteriologically.

TABLE VI.—*Definite case of pulmonary tuberculosis starting within 5 years of entry to the trial, according to the nature and maximal extent of the pulmonary lesions*

| Trial group | Total pulmonary cases | Miliary type of lesions | Lesions with cavitation | | | Lesions without cavitation | | |
|---|---|---|---|---|---|---|---|---|
| | | | Lesions involving more than 2 rib interspaces | Lesions more than 6 square centimeters in extent involving up to 2 rib interspaces | Lesions up to 6 square centimeters in extent | Involving more than 2 rib interspaces | More than 6 square centimeters in extent, involving up to 2 rib interspaces | Up to 6 square centimeters in extent |
| Negative unvaccinated | 100 | 4 | 22 | 10 | 1 | 10 | 31 | 22 |
| Negative, B.C.G. vaccinated | 29 | 0 | 5 | 0 | 1 | 0 | 6 | 8 |
| Negative, vole bacillus vaccinated | 7 | 0 | 1 | 2 | 0 | 0 | 2 | 2 |
| Positive to 3 T.U | [1] 96 | 1 | 19 | 12 | 0 | 4 | 44 | 16 |
| Positive only to 100 T.U | 21 | 0 | 1 | 5 | 0 | 2 | 8 | 5 |
| All groups | [1] 244 | 5 | 48 | 29 | 2 | 16 | 91 | 53 |

[1] Excluding one patient for whom the extent of the lesions was not classified because the first abnormal radiograph, taken before a thoracoplasty was performed, could not be found: the diagnosis was confirmed bacteriologically.

Lesions with cavitation were now observed in 33% of the 100 cases in the negative unvaccinated group, in 33% of the 27 cases in the vaccinated groups combined, and in 32% of the 117 cases in the tuberculin-positive groups combined. There is again no evidence of important difference in the presence of cavitation between cases in the different groups.

On the other hand, lesions involving more than two rib interspaces (with or without cavitation, and including the military cases) were now observed in 36 (36%) of the cases in the negative unvaccinated group, in six (22%) of the cases in the vaccinated groups combined, and in 27 (23%) of the cases in the tuberculin-positive groups combined; at the other extreme, lesions up to 6 sq. cm. in extent were observed in 23 (23%) of the cases in the negative unvaccinated group, in 11 (41%) of those in the vaccinated groups, and in 21 (18%) of those in the tuberculin-positive groups. There is again a suggestion (which does not attain statistical significance that pulmonary tuberculosis was on average rather less extensive in the vaccinated than in the unvaccinated cases. In other words, the degree of protection from vaccination for the extensive lesions was at least as great as, and may have been greater than, that for the less extensive lesions.

*Action taken by the national health service physician assuming charge of the patient*

Further evidence of the serious nature of many of the cases of tuberculosis which occurred is provided by Table VII. Of the 349 patients, 243 (70%) were taken off work for at least three months by the physician assuming charge of the patient. Of these 243 patients, 222 received chemotherapy, collapse therapy, or surgical treatment, in addition to rest in bed: 14 of the remaining 21 were cases of pleural effusion. At the other extreme, 84 patients (24%) remained at work and were kept under observation; 18 of these patients also received some chemotherapy.

Of the 153 patients in the negative unvaccinated group, 73% were taken off work for three months or more, compared with 58% of the 38 patients in the vaccinated groups combined, and 69% of the 158 in the tuberculin-positive groups combined. There is thus again a suggestion (not statistically significant) that the cases were less severe in the vaccinated than in the unvaccinated. In other words, the degree of protection from vaccination for the severe lesions was at least as great as, and may have been greater than, that for the less severe leisons.

*Bacteriological and pathological investigations*

Of the 245 cases of pulmonary tuberculosis, 18 had no bacteriological examination at any time. Positive bacteriological results were obtained in 92 of the re-

maining 227 cases—in 67 on culture and in 25 only on direct microscopic examination. In 10 of the 135 with negative results the examinations were made only after the start of chemotherapy, but all the other 125 had negative results (76 from culture or laryngeal swab or gastric lavage, 18 on direct examination, and 21 on culture of sputum) at a time when no chemotherapy had been given. Since the investigation and treatment of all cases were carried out at local chest clinics and were not the responsibility of the M.R.C. team physicians, there was no opportunity for the latter to initiate intensive bacteriological examinations, and in many instances no special emphasis was laid upon these tests in the routine management of the cases. As a consequence, the proportion of cases confirmed bacteriologically is low.

TABLE VII.—*Definite cases of tuberculosis starting within 5 years of entry to the trial, according to action taken by the clinician*

| Trial group | Total cases | Taken off work | | Remaining at work under observation |
|---|---|---|---|---|
| | | For 3 months or more | For less than 3 months | |
| Negative unvaccinated | 153 | 112 | 7 | [1] 34 |
| Negative, B.C.G. vaccinated | 27 | 15 | 1 | [1] 11 |
| Negative, vole bacillus vaccinated | 11 | 7 | 0 | 4 |
| Positive to 3 T.U | 128 | 86 | 12 | [1] 30 |
| Positive only to 100 T.U | 30 | 23 | 2 | 5 |
| All groups | 349 | 243 | 22 | 84 |

[1] Including 1 patient who failed to attend the clinic for complete investigation.

In all, tubercle bacilli were isolated from 39 of the 100 cases of pulmonary tuberculosis in the tuberculin-negative unvaccinated group, from nine of the 20 cases in the B.C.G.-vaccinated group, from three of the seven in the vole-bacillus-vaccinated group, from 31 of the 97 in those positive to 3 T.U., and from 10 of the 21 in those positive only to 100 T.U. The organisms isolated from the nine cases in the B.C.G.-vaccinated group and from the three in the vole-bacillus-vaccinated group were found to be virulent and of human type.

A specimen of the fluid was examined in only 36 of the 59 cases of pleural effusion classified as tuberculous; in 32 the fluid was sterile, and in 23 of these a high proportion of lymphocytes was recorded; in the other four cases (none vaccinated) tubercle bacilli were cultured from the fluid. In six of the eight cases of tuberculosis of bones or joints, and in 10 of the 14 cases of cervical adenitis, the diagnosis was established by histological examination; in one of the remaining four cases of cervical adenitis the diagnosis was confirmed bacteriologically. Of the five cases of tuberculous meningitis, four were confirmed by bacteriological examination of the cerebrospinal fluid, and one at the post-mortem examination (see "Death from Tuberculosis," p. 382).

*Reliability of the independent assessments*

It is conceivable that the withholding of the information on the results of skin tests, essential though it is for an unbiased comparison between the various groups, might have resulted in some cases being incorrectly diagnosed by the assessor. As in the previous report, therefore, his diagnosis is compared with that of the chest clinic or other physician taking charge of the case. For 332 (95%) of the 349 definite cases of tuberculosis arising after entry and accepted for this report, there was agreement on diagnosis between assessor and physician in charge. In addition to the 349 cases, however, a further 13 were regarded by the physician in charge, but not by the assessor, as definite tuberculosis.

*Incidence of tuberculosis in different periods since entry to the trial*

As already described, the assessor decided, retrospectively, from the detailed records of each case of tuberculosis, the date of the earliest radiographic or clinical manifestation of the disease. This has been regarded as the starting-point of the illness. Because the starting-point does not necessarily represent the true (and unknown) date of onset of the disease, the number of cases with starting-points in a given period will depend partly upon the intensity of radiographic examination of participants during that period. Since this intensity has not differed from group to group, the incidence rates in different trial groups *in a particular period of time* may validly be compared. However, the

intensity of radiographic examination has shown some decline in the course of the trial, and caution must therefore be exercised when comparing the incidence rates in a particular trial group *from one period to another.*

Table VIII gives the numbers of definite cases of tuberculosis with starting-points in the first and second periods of two and a half years since entry to the trial, with corresponding incidence rates (also illustrated in Figs. 1 and 2). The table and the figures also contain some preliminary information for a third period, from five to seven and a half years after entry. Although the information is incomplete for this period, the annual incidence rates have been calculated by taking into account the varying periods of observation for participants beyond the first five years.

TABLE VIII.—*Definite cases of tuberculosis, according to the interval between entry and the earliest radiographic or clinical manifestation (the starting-point) of the illness*

| Trial group | Estimated number of participants | Total cases | | | Annual incidence per 1,000 participants | | |
|---|---|---|---|---|---|---|---|
| | | Starting within 2½ years of entry [1] | Starting between 2½ and 5 years after entry | Starting between 5 and 7½ years after entry (incomplete) | 0–2½ years | 2½–5 years | 5–7½ years |
| Negative unvaccinated | 13,300 | 66 | 87 | 30 | 1.98 | 2.62 | 1.38 |
| Negative, B.C.G. vaccinated | 14,100 | 15 | 12 | 8 | 0.43 | 0.34 | 0.34 |
| Negative, vole bacillus vaccinated | 6,700 | 7 | 4 | 3 | 0.42 | 0.24 | 0.29 |
| Positive to 3 T.U.: | | | | | | | |
| Induration 15 mm. or more in diameter | 7,200 | 63 | 30 | 10 | 3.50 | 1.67 | 0.88 |
| Induration 5–14 mm. in diameter | 8,800 | 17 | 18 | 6 | 0.77 | 0.82 | 0.44 |
| Positive only to 100 T.U | 6,600 | 12 | 18 | 8 | 0.73 | 1.09 | 0.76 |
| All groups | 56,700 | 180 | 169 | 65 | | | |

[1] These figures are slightly greater than those for the first two and a half years given in the first report (M.R.C., 1956) as a result of more recent information.

During the first two and a half years the annual incidence in the negative unvaccinated group was 1.98 per 1,000, in the B.C.G.-vaccinated group 0.43 per 1,000, and in the vole-bacillus-vaccinated group 0.42 per 1,000 (Fig. 1). The incidence in the two vaccinated groups combined was 21% of that in the negative unvac-

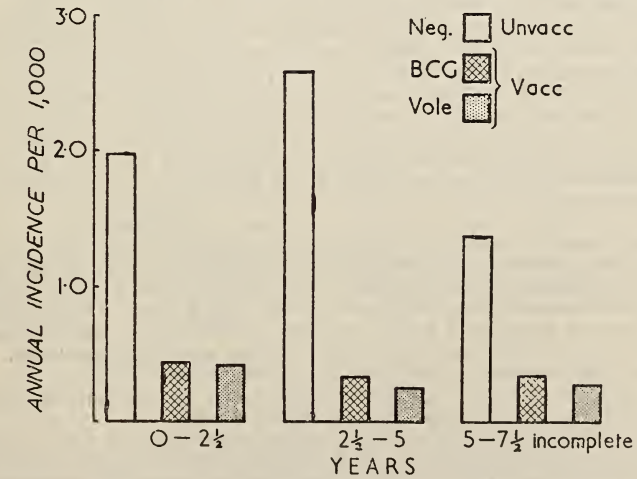



FIG. 1.—Annual incidence of tuberculosis in the negative unvaccinated and the two vaccinated groups.

cinated group. During the second two and a half years the corresponding rates were 2.62, 0.34, and 0.24 per 1,000; the incidence in the two vaccinated groups combined was 12% of that in the negative unvaccinated group. There is clearly no evidence of any waning in the protection afforded by either of the vaccines up to five years after vaccination. The incomplete figures for the period between five and seven and a half years also show no evidence of any serious decline in protection, the incidence in the two vaccinated groups combined being 24% of that in the negative unvaccinated group. The average duration of observation of the participants so far is six and a half years. Protection from both vaccines has therefore remained at a high level for at least this length of time.

Turning to the groups with positive reactions to tuberculin initially, those with the largest reactions (15 mm. induration or more to 3 T.U.) have been separated in Table VIII and Fig. 2 from those with smaller reactions to 3 T.U., because

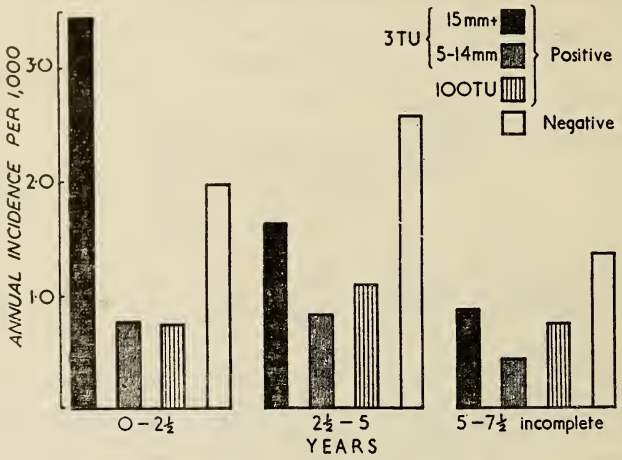



Fig. 2.—Annual incidence of tuberculosis in initially positive and negative unvaccinated groups.

they were found in the first report (M.R.C., 1956) to have a particularly high incidence of tuberculosis in the first two and a half years. During this period the annual incidence in this subgroup was 3.50 per 1,000, substantially greater than that in the negative unvaccinated group (1.98 per 1,000). It was very much greater than the rates among those with smaller reactions to 3 T.U. (0.77 per 1.000), as well as among those positive only to 100 T.U. (0.73 per 1,000). During the second two and a half years the incidence in the group with the larger initial reactions to 3 T.U. (1.67 per 1,000) was now substantially *less* than that in the negative unvaccinated group (2.62 per 1,000) ; the rate still was greater than the rates of 0.82 and 1.09 per 1,000 among the two groups with weaker positive reactions. On the basis of the incomplete information for the period between five and seven and a half years, the incidence in the group with the larger initial reactions to 3 T.U. was still rather greater than the rates in the two groups with weaker positive reactions; as in the preceding period, it was less than that in the negative unvaccinated group. It will be noted that in each of the three periods the lowest rates were those among the vaccinated participants.

In interpreting the trends in incidence from period to period, a number of points must be considered. First, there is the steep increase in the total incidence of tuberculosis between the ages of 15 and 20 years, and one might therefore expect an increase in at least some of the trial groups. On the other hand, there has been in England a fall in the risk of exposure to tuberculosis in this age groups (as indicated by notification data) from about 1952 onwards. Finally, the general slight decline in the intensity of follow-up during the course of the trial (see "Follow-up of Participants," p. 380) may have enhanced any decline, and detracted from any increase, in the incidence rates.

Considering first the group with the larger reactions to 3 T.U. initially, and taking these points into account, there seems no doubt of the steep decline in incidence from the high initial rate. (The different forms of tuberculosis appear

to have declined to a similar extent in this group; between the first and second periods of two and a half years, the number of cases of pulmonary tuberculosis decreased from 47 to 23, the cases of pleural effusion from three to two, and the other cases from 13 to five.) In contrast, the rates in the two groups with weaker positive reactions initially have remained at much the same level during the whole period of seven and a half years, with the result that the rates in all three initially tuberculin-positive groups are now not markedly different.

In the negative unvaccinated group, an increase between the first and second periods of two and a half years, and a larger decrease between the second and the third period, have been apparent. Parallel with this there has been little change in the rates in the two vaccinated groups. It is difficult to decide the relative contributions of the factors referred to above in explaining these trends.

### III. MORTALITY AND MORBIDITY FROM CAUSES OTHER THAN TUBERCULOSIS

*Deaths from causes other than tuberculosis*

The number of particpants known to have died within five years of entry to the trial is 126: one from tuberculosis (see p. 382), 70 from other diseases, and 55 from accidental causes or on active military service. Of the 70 deaths from non-tuberculosis diseases, 22 were due to malignant disease; no other individually classified cause was responsible for as many as 10 deaths.

Table IX shows that the mortality from non-tuberculosis diseases was less in each of the vaccinated groups than in the corresponding negative unvaccinated group, but the numbers are small and the differences are not statistically significant. The mortality among those who were tuberculin positive (to either 3 or 100 T.U.) was rather greater than among those who were tuberculin negative on entry (whether vaccinated or not); for Section A of the table the difference is significant at the 5% level.

Table IX also shows that the mortality from accidental causes (including deaths on active military service) was similar in each of the vaccinated groups and in the corresponding unvaccinated group. There was no great difference in the mortality between those who were tuberculin positive (to either 3 or 100 T.U.) and those who were tuberculin negative on entry (whether vaccinated or not).

*Cases of non-tuberculous diseases*

A total of 152 cases, when submitted to the assessor, were classified by him as not due to tuberculosis. These consisted mainly of chest diseases such as pneumonia, bronchiectasis, and pleurisy, submitted because the radiographic abnormality persisted for more than 14 days (see "Records of Cases," p. 381), but they included also a few non-pulmonary lesions where tuberculosis, although a possible diagnosis, was not accepted by the assessor.

Table IX shows that there are no more than chance differences between the rates in the various trial groups, and indicates that there is no protective effect of B.C.G. or vole bacillus vaccine against these non-tuberculous diseases, when taken as a group. The principal categories were pneumonitis and other non-specified pulmonary lesions (62 cases), pneumothorax (22 cases), non-tuberculous pleural effusions (as judged by duration, resolution with non-tuberculous chemotherapy, etc.—18 cases), bronchiectasis and allied lesions (16 cases), and definite or possible sarcoidosis (seven cases). Analysis of the figures for each of these categories separately suggests that vaccination does not influence the incidence of disease in any of them. For example, three of the pleural effusions were in the negative unvaccinated group and five in the two vaccinated groups combined; nine occurred among those initially positive to 3 T.U., and one among those positive only to 100 T.U.

The final column of Table IX shows the distribution of the 34 cases, submitted to the assessor as suspected or possible cases of tuberculosis, for which he decided that there was no evidence of any disease, tuberculous or non-tuberculous: the number in each trial group is roughly proportionate to the number of participants in that group.

### IV. CRITICAL APPRAISAL OF THE DESIGN OF THE TRIAL

The present investigation was designed to give reliable estimates of the degree of protection afforded by B.C.G. and vole bacillus vaccination, and embodied three main safeguards against bias. These were, first, the random allocation of the tuberculin-negative participants to the unvaccinated and vaccinated groups on entry to the trial; second, the comprehensive scheme for

the follow-up of the participants and the detection of cases of tuberculosis and other chest diseases among them, these methods being designed to be equally intensive and comprehensive in all the trial groups; and, third, the system for the independent assessment of all the cases discovered, without any knowledge of skin-test results or of vaccination. It is desirable to examine critically the possibility of any deficiencies in the practical working-out of these safeguards before reliance is placed on the degree of protection revealed.

Before doing so, a general point concerning the background of the investigation will be considered. The trial took place among volunteers, initially not in known contact with tuberculosis at home, approximatley 60% of those approached agreeing to participate. It is possible that the effect of vaccination in this selected community may differ from its effect in the whole adolescent and young adult population of Britain. This point cannot be tested directly; but there is indirect evidence that the trial population is not grossly unrepresentative—namely, that when allowance is made for the effects of vaccination, the total of 349 cases of tuberculosis within five years of entry to the trial is of the order of magnitude that would have been expected from the national notification figures (Sutherland, 1959).

TABLE IX.—*Deaths from causes other than tuberculosis and cases assessed as diseases other than tuberculosis within 5 years of entry to the trial; also cases assessed as having no evidence of any disease*

| Section [1] | Estimated number of participants | Deaths from diseases other than tuberculosis [2] | | Deaths from accidental causes | | Cases assessed as diseases other than tuberculosis | | Cases assessed as no disease |
|---|---|---|---|---|---|---|---|---|
| | | Number occurring within 5 years | Annual mortality per 1,000 participants | Number occurring within 5 years | Annual mortality per 1,000 participants | Number starting within 5 years | Annual incidence per 1,000 participants | |
| A. Children admitted concurrently with those given B.C.G. vaccine: | | | | | | | | |
| Negative unvaccinated | 13,200 | 16 | 0.24 | 12 | 0.18 | 35 | 0.53 | 9 |
| Negative, B.C.G. vaccinated | 14,100 | 8 | .11 | 16 | .23 | 42 | .60 | 7 |
| Positive to 3 T.U | 15,800 | 25 | .32 | 15 | .19 | 49 | .62 | 12 |
| Positive only to 100 T.U | 6,500 | 12 | .37 | 10 | .31 | 17 | .52 | 3 |
| B. Children admitted concurrently with those given vole bacillus vaccine: | | | | | | | | |
| Negative unvaccinated | 6,500 | 10 | .31 | 4 | .12 | 18 | .55 | 2 |
| Negative, vole baccillus vaccinated | 6,700 | 7 | .21 | 3 | .09 | 9 | .27 | 3 |
| Positive to 3 T.U | 8,800 | 19 | .43 | 9 | .20 | 19 | .43 | 7 |
| Positive only to 100 T.U | 3,600 | 5 | .28 | 4 | .22 | 7 | .39 | 1 |

[1] Many participants, deaths, cases of diseases other than tuberculosis, and cases with no evidence of disease appear in both sections of this table (see text), and the figures from the 2 sections can therefore not be totaled.

[2] There was 1 death from tuberculosis within 5 years of entry (see text).

*Allocation to the tuberculin-negative unvaccinated and vaccinated groups on entry to the trial*

The reason for allocating the tuberculin-negative participants to the unvaccinated or to one of the vaccinated groups, according to the final digit of the serial number on the record card, was to ensure that the allocations were not determined either by any of the team members personally or by the participants themselves, but by an independent process. Care was taken to exclude from the analysis all of the few participants who were allocated to the incorrect group, in case any personal choice might have entered into these allocations. This effectively random allocation process should therefore have resulted in the concurrent admission of similar groups of participants to the negative unvaccinated and the two vaccinated groups, with no more than chance differences between them. Direct checks made on representative samples of the records show that the unvaccinated and vaccinated groups were closely similar on entry in their distributions by age, sex, and number of brothers and sisters.

*Intensity of follow-up and case-finding procedures*

It was shown in the first report (M.R.C., 1956, Table II) that the success of the follow-up during the first 18 to 24 months after entry was similar in those concurrently admitted to the negative unvaccinated and the two vaccinated groups. Recent analysis of a further random sample of the records has also shown no appreciable differences between the negative unvaccinated and the two vaccinated groups in the proportions of the participants brought in contact with the teams, or given chest radiographs, in the period 1957–8. It may be concluded that the co-operation of the participants has been similar in these groups throughout the trial; there is thus no reason to believe that the numbers of cases reported have been affected by any differences in the intensity of the case-finding procedures from group to group.

*Knowledge by the participant of the skin-test and vaccination state*

As described in the first report (M.R.C., 1956), leaflets explaining the scheme were distributed to the children before it started. In addition, those vaccinated were given other leaflets describing the normal course of the vaccination reaction, and the vaccination sites were later examined. It is conceivable that this knowledge could have influenced the comparisons between the groups. For example, believing themselves to be protected, those vaccinated might have taken less care to avoid exposure to infection; this would tend to reduce the apparent degree of protection. In the same belief, they might alternatively have been less ready to attend for radiographic examination, or to report any symptoms; this would tend to exaggerate the degree of protection.

The data provide some evidence on the latter possibility. First, as stated above the amount of co-operation, and in particular the proportions who had routine chest radiographs taken by the M.R.C. teams, were similar in the vaccinated and the unvaccinated groups. Secondly, the first section of Table X shows the total of 191 cases of definite tuberculosis starting within five years of entry in the negative unvaccinated and the two vaccinated groups, subdivided into the cases which were discovered because the participants sought medical attention from the National Health Service for symptoms—that is, where the participants knew they were ill—and into those which were discovered only as a result of a routine chest radiograph (whether taken by the M.R.C. teams or elsewhere)—that is, where the participants were unaware that they were ill. The final line of Table X shows the percentage reduction in the incidence of tuberculosis, attributable to vaccination, for each method of discovery. The degree of protection for participants who were aware of their illness was closely similar to that for partcipants who were unaware of it; this does not suggest that the vaccinated participants ignored their illnesses.

TABLE X.—*Definite cases of tuberculosis in the negative unvaccinated and the 2 vaccinated groups within 5 years of entry, subdivided (a) according to the method of discovery of the disease, (b) according to the physician first diagnosing the case, and (c) according to the trial area*

| Trial group | Total cases of definite tuberculosis | Method of discovery of disease | | Physician first diagnosing case | | Area | | |
|---|---|---|---|---|---|---|---|---|
| | | Medical attention sought for symptoms | Routine chest radiograph | National Health Service | Medical Research Council | London | Birmingham | Manchester |
| Negative unvaccinated | 153 | 71 | 82 | 103 | 50 | 37 | 67 | 49 |
| Negative, B.C.G. vaccinated | 27 | 11 | 16 | 14 | 13 | 7 | 7 | 13 |
| Negative, vole bacillus vaccinated | 11 | 4 | 7 | 7 | 4 | ---- | 4 | 7 |
| Total | 191 | 86 | 105 | 124 | 67 | 44 | 78 | 69 |
| Percentage reduction in incidence of tuberculosis attributable to vaccination | 84 | 86 | 82 | 87 | 78 | 81 | 91 | 78 |

Further, if there was any suppression of illnesses by vaccinated participants, this would presumably occur mainly with the less extensive and less severe lesions; the degree of protection would thus appear to be greater for these than for the other lesions. It has already been found, on the contrary, that the degree of protection is *not* greater for the less extensive and severe lesions, as judged by their radiographic extent and the action taken by the physician in charge (see "Extent of the Pulmonary Lesions," p. 385, and "Action Taken by the Physician," p. 386).

*Knowledge by the physician of the skin-test and vaccination state of the participant*

*Physicians in the National Health Service.*—For those cases which were first discovered by the usual methods of the National Health Service, it is possible that the physician might have been influenced in making the diagnosis by knowledge of the patient's participation in the trial, and of the skin-test and vaccination state. However, the follow-up scheme through the chest clinics ensured that both tuberculous and non-tuberculous diagnoses would have come to the notice of the M.R.C. teams for review of the case by the assessor. The diagnoses of the National Health Service physician can therefore validly be compared with those of the independent assessor. Of the total of 124 National Health Service cases accepted as definite tuberculosis by the assessor, two were regarded by the National Health Service physician as only possibly due, and three as not due, to tuberculosis, and in a further case no diagnosis was made; three of these six disagreements occurred among the 21 cases in the two vaccinated groups combined. On the other hand, three cases (not included in the 124) were regarded by the National Health Service physician as definite tuberculosis; the assessor regarded two of these as possibly due to tuberculosis, and one as inactive tuberculosis, present on entry, with no evidence of subsequent activity; two of these three disagreements occurred in vaccinated participants. Thus any knowledge of skin-test results or of vaccination on the part of the National Health Service physicians has not influenced the results appreciably.

*M.R.C. Team Physicians.*—It has been suggested (Palmer, Shaw, and Comstock, 1958) that knowledge of the skin-test and vaccination state by the M.R.C. team physicians may have led them to select which cases were to be submitted to the independent assessor, and thereby to introduce a bias between the tuberculin-negative unvaccinated and the vaccinated groups.

Knowledge of the skin-test and vaccination state of the participants was indeed readily available to the teams. If this had influenced the diagnoses of the team physicians—and had thereby affected which of their cases were submitted to the assessor—a different degree of protection might be expected for cases first discovered by the team physicians and for those first dicovered by the National Health Service. The relevant subdivision of the total cases of definite tuberculosis is made in the second section of Table X. The final line shows a similar degree of protection for the cases discovered in the two ways.

Supplementary evidence on this point is provided by the third section of Table X, in which the cases of definite tuberculosis are subdivided according to the three main areas of the study; the degree of protection afforded by vaccination is of the same high order in all three. The conduct of the trial in each area was the responsibility of a different M.R.C. team physician, and the findings thus do not indicate that there was any differential bias between these physicians.

Finally, as has been emphasized (see "Records of Cases," p. 381), *all* cases with a pulmonary radiographic abnormality persisting for more than 14 days were submitted to the assessor. Moreover, all 35-mm. as well as full-size chest radiographs of the participants have been read separately by a physician unconnected with the trial and unaware of the skin-test or vaccination state of any participant, as well as by the team physician (see "Follow-up of Participants," p. 380). A persistent abnormality found by either reader qualified the case for submission to the assessor. With this comprehensive system, any unconscious suppression of cases of tuberculosis by the team physician is highly improbable.

*The independent assessor*

There remains the possibility that the independent assessment was itself in some way biased. However, the assessor was rigorously kept unaware of the reults of any tuberculin tests and of whether any vaccination had been performed. Moreover, as already stated, these "blind" assessments showed a very substantial difference in the incidence of definite tuberculosis between the negative unvac-

cinated and the vaccinated groups (Table I), but no important differences in the incidence of cases and deaths from non-tuberculous causes (Table IX).

### V. ESTIMATED BENEFITS OF VACCINATION

From the foregoing critical appraisal it appears justifiable to conclude that no serious bias has entered into the comparison between the unvaccinated and vaccinated groups, and that their difference in incidence of tuberculosis may be confidently attributed to the vaccination.

On the basis of this conclusion it is permissible to assign limits of chance fluctuation to the observed degree of protection afforded by each of the two vaccines. The percentage reduction in the incidence of tuberculosis in the B.C.G.-vaccinated group, compared with the incidence in those concurrently admitted to the negative unvaccinated group, was 83% for the five-year period following vaccination. Making allowance for chance fluctuations in the numbers of cases observed, it is possible to say with a high degree of confidence (99%) that the protection afforded by B.C.G. vaccination in the tuberculin-negative section of the population studied lay between 71% and 90%.

The corresponding estimate for the degree of protection afforded by vole vacillus vaccination was 87%. Allowing for chance fluctuations, it is very likely (99%) that the protection lay between 73% and 96%.

In any mass-vaccination scheme this protection would apply only to the tuberculin-negative section of the population. There would be no direct effect on the number of cases among those who were already tuberculin positive at the pre-vaccination test (and therefore ineligible for vaccination) : in assessing the total contribution of vaccination to the reduction in incidence of tuberculosis these cases must be taken into account. In the present trial 158 cases of tuberculosis were found in such tuberculin-positive participants within five years of entry; this represents 29% of the total of 550 cases expected in the trial population if no vaccination had been given (see next paragraph).

According to the present results, if *none* of the tuberculin-negative entrants had been vaccinated, 392 cases would have been expected among them within five years. If *all* of them had received B.C.G. vaccine, 65 cases would have been expected among them, or, if all had received vole bacillus vaccine, 56 cases. Including the 158 cases observed among the tuberculin-positive entrants within five years of entry with each of these estimates, the reduction in the total number of cases within five years of entry would have been from 550 (392 plus 158) to 223 (65 plus 158) with B.C.G. vaccination, or to 214 (56 plus 158) with vole bacillus vaccination. This represents a reduction of 59% with B.C.G. vaccine, or of 61% with vole bacillus vaccine, in the incidence of tuberculosis in the entire trial population—that is, in the tuberculin-negative and tuberculin-positive groups combined—for the five-year period. The figure of 59% corresponds to that of 55% for B.C.G. vaccine for the first two and a half years, given in the first report (M.R.C., 1956).

The above estimate has been calculated after the exclusion of 150 previously unsuspected cases of definite tuberculosis which were present on entry to the trial, this being discovered in the great majority because there was an initial radiographic examination (70 excluded at the time of entry plus 80 excluded subsequently by the assessor—see "Cases of Tuberculosis Present on Entry," p. 381). If the preliminary radiograph had not been taken, many of these cases would apparently have arisen after entry, and would have increased the total cases among those tuberculin positive from 158 to a figure of the order of 300. The apparent reduction in the incidence of tuberculosis, as a result of vaccinating all those who were initially tuberculin negative, would in these circumstances have been of the order of 50% with each vaccine, instead of the 60% estimated above.

### VI. DISCUSSION

In this second report of the Medical Research Council's Tuberculosis Vaccines Clinical Trials Committee, the period of observation of the participants is extended from two and a half years (M.R.C., 1956) to five years after entry to the trial. The results show that the two vaccines conferred substantial protection against tuberculosis for this period in a large group of adolescents living under the ordinary urban and suburban conditions prevailing in industrial communities in Britain; the reduction in incidence in the vaccinated group, compared with the tuberculin-negative unvaccinated group, was 83% for B.C.G. vaccine and 87% for vole bacillus vaccine. Preliminary incomplete information

beyond five years has shown that the protective efficacy of the vaccines has been maintained at a similar high level for at least six and a half years.

Most of the 349 definite cases of tuberculosis known to have started within five years of entry were clinically important, as judged by the form of the disease, its extent, and the treatment given; and the pulmonary lesions in the negative unvaccinated group were clinically as important as those in the initially tuberculin-positive groups. Moreover, the degree of protection from vaccination for the clinically important lesions was certainly as great as (and may even have been greater than) that for the less important lesions. These findings should be set against the doubts expressed by Myers (1957) and again by Anderson *et al.* (1959) that in this trial the protection might apply only to "primary pulmonary infiltrates" and not to clinical tuberculosis.

Seven cases (three of erythema nodosum closely following B.C.G. vaccination, and four of regional adenitis following vole bacillus vaccination) were regarded as complications of vaccination and were not included in the total of 349 cases. It is possible that some or all of these may nevertheless have resulted from infection with virulent tubercle bacilli. If, as an extreme, all seven cases had been regarded instead as cases of tuberculosis in vaccinated participants, the apparent protection against tuberculosis within five years of entry would only have been reduced from 83% to 82% for B.C.G. vaccine and from 87% to 81% for vole bacillus vaccine.

The incidence of non-tuberculous deaths and diseases in the different trial groups has been compared in this report as for tuberculosis. Taken as a whole, such deaths and diseases were found to have a similar incidence in the vaccinated and the tuberculin-negative unvaccinated groups; the mortality was, however, slightly greater in the two tuberculin-positive groups. When the more frequent diagnoses were considered separately, no evidence of protection by B.C.G. or vole bacillus vaccination was revealed against any specific cause of death, nor against any chest disease other than tuberculosis.

The batches of B.C.G. vaccine maintained a satisfactory protective potency, despite routine fluctuations in viable count and corresponding slight variations in the degree of post-vaccination tuberculin sensitivity. The data provide no information on the level of viable count at which protective efficacy would show a decline. It is of particular interets that the early batches of vole bacillus vaccine, which were unintentionally weaker than the later batches, also conferred a high degree of protection against tuberculosis. Thus these "substandard" batches, or possibly even weaker batches still, could have been used throughout the trial, and would have provided substantial protection, despite the low level of tuberculin sensitivity which they produced. This finding has important practical implications for the assessment of vole bacillus vaccine. The routine use of this vaccine seemed to be contraindicated (M.R.C., 1956) because of the occurrence of lupus vulgaris at the site of vaccination in a number of cases. Such complications, however, occurred only among the participants receiving the later, stronger vaccine, none being observed among those receiving the earlier, weaker vaccine. This weaker vole bacillus vaccine has therefore proved both safe and effective, in agreement with the experience of Sula (1958), using an attenuated strain of the vole bacillus.

From the data just discussed it also appears that the protective efficacy of vole bacillus vaccine cannot necessarily be gauged by the degree of post-vaccination tuberculin sensitivity, at least to human tuberculin. The same conclusion is not justified for B.C.G. vaccine, since even the weakest batches produced an acceptably high degree of post-vaccination sensitivity (76% to 3 T.U. and 100% to 100 T.U.); a high conversion rate should therefore remain the aim of any B.C.G. vaccination scheme.

Although the vaccinated and the tuberculin-negative unvaccinated groups were alike, except for the fact of vaccination, the groups tuberculin positive on entry differed not only by virtue of their sensitivity but also by the (unknown) previous circumstances which produced that sensitivity. A notable feature of the first report was the high incidence of tuberculosis occurring during the first two and a half years among those participants who entered the trial with high degrees of tuberculin sensitivity (induration of 15 mm. or more to 3 T.U.), which was much greater than among those with weaker positive reactions (5–14 mm. induration to 3 T.U., or positive reactions only to 100 T.U.). A similar contrast was previously noted among African mining recruits (Report of the Tuberculosis Research Committee, 1932), and among young nurses in England (Daniels, Ridehalgh, and Springett, 1948), and has since been reported for other population

groups (Frimodt-Moller, 1957; Palmer, 1957; Palmer, Jablon, and Edwards, 1957; Groth-Petersen, 1959). It has now been found that this high incidence of tuberculosis among the highly tuberculin-sensitive entrants has after a few years become markedly reduced, although it is still rather higher than the rates in the groups with lesser sensitivity. This suggests that in any programme for the periodic radiography of adolescents found to be highly sensitive to tuberculin in connexion with the national vaccination scheme for 13-year-old schoolchildren, the highest yield of cases of tuberculosis is likely to be in the first few years of observation.

The initial high incidence of tuberculosis among the participants with high tuberculin sensitivity may well reflect active infections acquired before entry, but not visible on the initial radiograph, a proportion of these giving radiographic manifestations of disease soon after entry. It seems unlikely that many of the active cases in these participants have arisen from a fresh infection sustained after entry, since there is evidence from other studies that the tuberculosis incidence in groups with high levels of initial tuberculin positivity is largely independent of subsequent exposure to tuberculosis. Thus, a substantial incidence has been found in environments where the rate among initially tuberculin-negative persons observed in parallel was relatively low (Frimodt-Moller, 1957; Palmer, 1957; Palmer *et al.*, 1957), as well as in environments where it was relatively high (Daniels *et al.*, 1948). It should be noted that the decline in incidence in the highly tuberculin-sensitive group in the present trial was associated not only with a lengthening interval from the time of the original infection but also with an increase in age from 15–17 years to 20–22 years, and so perhaps with a change in susceptibility.

The comparatively stable low incidence of tuberculosis among those with initial low-grade sensitivity (weak positive reactions to 3 T.U. or positive reactions only to 100 T.U.) may reflect, in the main, old or subsiding infections, or more recent infections of a minor character. However, whether these or some other explanations apply, it should be noted that these tuberculosis rates were considerably lower throughout the whole period of observation than those in the tuberculin-negative unvaccinated group. This finding suggests that low-grade sensitivity is associated with a naturally acquired specific immunity against fresh exogenous tuberculous infections, of a degree not possessed by those who were tuberculin negative on entry.

It has been suggested (World Health Organization Tuberculosis Research Office, 1955; Palmer, 1957; Edwards and Palmer, 1958) that low-grade tuberculin sensitivity in man is mainly due to previous infection with organisms other than mammalian tubercle bacilli, but closely related antigenically. Latterly it has been further suggested that these "non-specific" infections may confer some degree of antituberculous immunity (Palmer, 1957). This is not the place to enter deeply into this matter, but it should be stated that none of the conclusions from the present trial is inconsistent *either* with the hypothesis that all grades of tuberculin sensitivity concerned are caused by the tubercle bacillus, *or* with the extreme hypothesis that positive reactions of 15 mm. or more to 3 T.U. are tuberculous in origin, while positive reactions of 5–14 mm. to 3 T.U., as well as positive reactions to 100 T.U. but not to 3 T.U., are caused by other organisms (provided that these organisms also confer protection against tuberculosis).

The benefit to be expected from mass-vaccination of a given population—that is, the reduction in the total incidence of tuberculosis—will depend in general upon four main factors, which may vary with circumstances: (1) the basic degree of protection afforded by vaccination to those who are tuberculin negative; (2) the risks run by the latter (if not vaccinated) of acquiring natural tuberculous infection and disease during the ensuing years; (3) the incidence of disease during the ensuing years in those already tuberculin positive at the age at which vaccination is offered; and (4) the relative proportions of individuals tuberculin positive and negative at this age. These factors are to some extent interrelated.

In the present trial, the benfit that would have accrued to the entire population, tuberculin positive and negative combined, during the first five years, had *all* the tuberculin-negative entrants been vaccinated, was estimated as 59% for B.C.G. vaccine and 61% for vole bacillus vaccine. This assessment relates to a large section of the urban population of Britain, whose observation began in 1950–2. Since then there has been a decrease in the exposure to tuberculous infection in the young adult age group, which, by decreasing the cases to be expected in the tuberculin-negative group, and leaving those in the positive

groups largely unaffected, would tend to decrease the benefit. But there has also been a notable decline in the prevalence of tuberculin sensitivity to 3 T.U. in those aged 13–15 years (compare M.R.C., 1958, with M.R.C., 1956), which, by increasing the proportion of the population group eligible for vaccination, would tend to increase the benefit. Because of these opposing tendencies, the percentage reduction in total incidence of tuberculosis, as a result of vaccination of a similar group of schoolchildren at the present time, is unlikely to differ substantially from the above figure of about 60% (Sutherland, 1959). As a corollary, however, vaccination at a rather earlier age than 14 years, when a smaller proportion would have been infected naturally, would tend to increase the benefit of vaccination.

Since the publication of our first report, other controlled trials of B.C.G. vaccination have progressed further. That in North American Indians by the late J. D. Aronson and his wife concerned about 1,500 tuberculin-negative subjects from infancy to 20 years old who were given B.C.G. vaccine; a similar number were left unvaccinated. The tuberculosis morbidity, judged by annual radiography, was studied for 11 years and the mortality for 20 years (Aronson, Aronson, and Taylor, 1958). The protection against pulmonary tuberculosis was 75% and against death from tuberculosis 82%; since very few deaths had occurred in the latter part of the 20-year observation period, it was difficult to be sure that the protection was maintained beyond the first 10 years. The incidence of non-tuberculous pulmonary lesions was somewhat greater in the control group than among the vaccinated; the non-tuberculous death rate was similar in the two groups.

The follow-up of Muslim children in Algiers, after oral vaccination of half of them at birth and again at the ages of 1 and 3 years, has continued to show an advantage to the vaccinated in mortality from all causes up to the age of 7 years (Sergent, Catanei, and Ducros-Rougebief, 1956). Rosenthal (1955, 1956) has followed 5,737 vaccinated and 4,378 unvaccinated newborn infants in Chicago (of whom 311 and 250 respectively were born into tuberclous households) for periods of up to 18 years; he found a 77% reduction in morbidity and an 81% reduction in mortality in the vaccinated as compared with the control group. To these planned trials, all with results of a similar order to those in the Medical Research Council trial, must be added the unique study by Hyge (1947) of an epidemic in a school which had been partly subjected to prior B.C.G. vaccination; the follow-up has now been extended to 12 years (Hyge, 1956) and is of particular interest in providing some evidence of protection against "post-primary" tuberculosis appearing after a considerable interval.

The preliminary stages of two large trials under the U.S. Public Health Service—in Puerto Rico and in Georgia and Alabama—were mentioned in the first report (M.R.C., 1956). A progress report, summarizing the results during a follow-up period of six to seven years, has now been published (Palmer, Shaw, and Comstock, 1958). In Puerto Rico nearly 200,000 volunteers aged 1–18 years were included; in Georgia and Alabama the 64,000 volunteers were aged 5 and upwards. The results differ from those of the present trial in two principal respects over a similar observation period. First, the proportion of the total cases which arose among the initially tuberculin-positive participants was much greater in the American trials; second, B.C.G. vaccination was found to have a much lower protective efficacy—namely, 31% in Puerto Rico and 36% in Georgia and Alabama, compared with 83% on Britain.

There are many obvious differences between the U.S. Public Health Service trials and the British trial, in the populations studied, the criteria for vaccination, the vaccines used, and the methods of follow-up. Because of these numerous differences in approach, it is difficult to discuss profitably the reasons for the differences in the results until further information on all three trials has been published. In this connexion, however, an important epidemiological point deserves mention. This is the inclusion, both in the vaccinated and in the control groups in the American trials, of some persons who, while negative to the tuberculin tests used as criteria for vaccination, still had some low-grade tuberculin sensitivity (to 100 T.U.), and possibly a certain degree of specific antituberculous immunity. According to Palmer (1957) the prevalence of such low-grade sensitivity is much greater in the areas covered by the two American trials than in the British investigation. If this factor has contributed to the differing results it follows that in the areas of the U.S.A. where, like Northern Europe, low-grade sensitivity is relatively uncommon (World Health Organization Tuberculosis Research Office, 1955), a similar efficacy to that found in the British trial might

have been discovered, had the American investigations taken place there instead of in the southern States and in Puerto Rico.

The main objective of the present trial is to define the extent and duration of the protective efficacy of B.C.G. and vole bacillus vaccination among those who were tuberculin negative on entry. The official national mass-vaccination scheme (Ministry of Health, 1953) for tuberculin-negative schoolchildren aged 13, which in 1958 was responsible for the B.C.G. vaccination of 241,434 children in England and Wales (Ministry of Health, 1959) out of a total of 658,000 of this age, is designed to cover the susceptible years of adolescence: and the duration of protection is thus crucial if revaccination is to be avoided. Duration of protection is also important in relation to the suggestion (Barns, 1955; Griffiths and Gaisford, 1956; Pollock, 1957) that the age for vaccination should be earlier in childhood, in order to anticipate some of the naturally acquired infections already present at age 13. It is therefore our intention to continue this trial in its present form until 1960, in order to provide information on the duration of protection up to eight to 10 years after vaccination.

Tuberculosis is still a major problem in young adults in England and Wales. In 1958, 2,501 new cases were notified among those aged 15–19 years, and 3,414 at ages 20–24 years. These figures underline the scope which still exists for the vaccination of adolescents in Britain.

## VII. SUMMARY

A controlled clinical trial of B.C.G. and vole bacillus vaccines in the prevention of tuberculosis in England started in 1950 and is still in progress. The 56,700 participants were initially free both from active tuberculosis and from known contact with the disease at home. On entry they were children, all aged 14 to 15½ years, and about to leave school; they are now (1959) young men and women aged between 21 and 23 years. The great majority have continued to live in their original urban areas, in or near North London, Birmingham, and Manchester, apart from the two-year period of military service, which has involved about two-thirds of the young men. This second report presents results after each participant had been in the trial for five years, with preliminary incomplete information up to seven and a half years.

As a result of an initial examination at school by M.R.C. teams, the participants were automatically classified into five trial groups: tuberculin negative (to 100 tuberculin units—T.U.) and left unvaccinated (13,300 participants); tuberculin negative, B.C.G. vaccinated (14,100); tuberculin negative, vole bacillus vaccinated (6,700); tuberculin positive to 3 T.U. (16,000); and tuberculin positive to 100 T.U. but not to 3 T.U. (6,600). Those tuberculin negative, and thus eligible for vaccination, were allocated to the unvaccinated or to one of the two vaccinated groups by a random process.

The participants in all five trial groups have been followed intensively by means of routine periodic radiographic examinations and tuberculin tests by the M.R.C. teams, individual contact also being maintained by postal inquiries and visits to the home. Cases of tuberculosis and other chest diseases have also been discovered by chest clinic and other National Health Service physicians and by the medical services of the Armed Forces, and have been brought to the notice of the teams by routine inquiries.

All definite and suspected cases of tuberculosis, and all cases of pulmonary radiographic abnormality persisting for more than 14 days, were submitted to an independent assessor for a final diagnosis; to avoid bias, he was kept unaware of the results of all tuberculin tests, and of whether any vaccination had been performed. As an integral part of the present report, a detailed appraisal was made of these and other essential safeguards against bias incorporated into the trial; this showed that no serious bias had entered into the comparisons between the unvaccinated and vaccinated groups, and that their difference in incidence of tuberculosis could be confidently attributed to the vaccination.

A total of 349 definite cases of tuberclosis started within five years of entry to the trial: of these, 70% were of pulmonary tuberculosis and 17% of tuberculous pleural effusion without evidence of pulmonary tuberculosis; 70% of the total cases (73% in the negative unvaccinated group) were severe enough to be taken off work for at least three months: 32% of the pulmonary cases (33% in the negative unvaccinated group) showed cavitation radiographically, and 28% (36% in the negative unvaccinated group) involved more than two rib interspaces. There was one death from tuberculosis in the five-year period.

During the five-year period the annual incidence of tuberculosis in the B.C.G.-vaccinated group was 0.38 per 1,000, compared with 2.29 per 1,000 among those in the tuberculin-negative unvaccinated group who were admitted concurrently; this represents a reduction, attributable to vaccination, of 83%. Over the same period, the annual incidence of tuberculosis in the vole-bacillus-vaccinated group was 0.33 per 1,000, compared with 2.62 per 1,000 among those admitted concurrently to the tuberculin-negative unvaccinated group; this represents a protection of 87%. (The difference in incidence between the two vaccinated groups, when based also on concurrent admissions, could well have arisen by chance.) The protective efficacy of each vaccine was thus substantial and was closely similar to that found for the first two and a half years in the earlier report (M.R.C., 1956). Moreover, the incomplete information beyond five years shows that similar high levels of protection have continued up to at least six and a half years after entry.

The degree of protection was similar for pulmonary tuberculosis, for tuberculous pleural effusion, and for hilar gland enlargement (in association with other lesions). On the other hand, since four cases of tuberculous meningitis and four of military tuberculosis were found among the negative unvaccinated participants, but none among those who were vaccinated, the degree of protection may have been greater for these forms. There is now a suggestion also that the lesions in the vaccinated cases were less extensive (both on the first abnormal radiograph and at their maximal extent) and less severe (as judged by the action taken by the clinician) than those in the negative unvaccinated cases. In other words, the degree of protection for the more extensive and severe lesions was certainly as great as, and may even have been greater than, that for the less extensive and severe lesions.

The proportion of participants reacting to 3 T.U. after B.C.G. vaccination varied slightly with the routine fluctuations in the viable count of the batches used, though virtually all participants converted to 100 T.U. Even the batches with the lowest counts gave substantial protection.

The strength of the early batches of vole bacillus vaccine was below the standard intended, and the conversion rates, both to 3 T.U. and to 100 T.U., were considerably less for these batches than for the later batches. The early batches, nevertheless, conferred substantial protection against tuberculosis, and lupus vulgaris at the site of vaccination (noted in the first report) did not occur with these batches.

Among those with strong positive reactions to 3 T.U. on entry (15 mm. induration or more) the annual incidence of tuberculosis was 3.50 per 1,000 in the first two and a half years, 1.67 in the second two and a half years, and 0.88 in the (incomplete) five to seven-and-a-half year period. In contrast, the annual incidences among those with weaker positive reactions to 3 T.U., and among those positive only to 100 T.U., were respectively 0.77 and 0.73 per 1,000 in the first two and a half years, and remained at much the same level thereafter. Thus, in this age group, those highly sensitive to tuberculin had a special risk of developing tuberculosis during the following few years. Those with lesser sensitivity to tuberculin on entry had consistently lower rates than those in the negative unvaccinated group, suggesting that they had some degree of protection against fresh infection, though not as great as that in the vaccinated groups.

In assessing the benefit that would have accrued to the entire trial population from the use of vaccine for *all* those tuberculin negative on entry, the contribution to the total tuberculosis morbidity made by those initially tuberculin positive (and therefore ineligible for vaccination) had to be included. This benefit—that is, the percentage reduction in incidence of tuberculosis during the five-year period—was 59% for B.C.G. vaccine and 61% for vole bacillus vaccine.

In all, 125 participants died from causes other than tuberculosis within five years of entry to the trial. In addition 151 cases, when submitted to the assessor, were classified by him as not due to tuberculosis, these consisting mainly of other chest diseases submitted because the radiographic abnormality persisted for more than 14 days. The incidence of these non-tuberculous deaths and diseases in the five trial groups reveals no significant evidence of protection by B.C.G. or vole bacillus vaccination against any specific cause of death, nor against any chest disease other than tuberculosis.

The trial is still in progress, and later reports will contain more detailed analyses over longer periods of time.

ACKNOWLEDGEMENTS

The work described was carried out by the Council's Tuberculosis Research Unit, with the assistance of many statutory and voluntary organizations. The team operating in the London area was directed first by Dr. W. Pointon Dick and later by Dr. T. M. Pollock, that in the Birmingham area by Dr. J. P. W. Hughes and later by Dr. D. N. Mitchell, and that in the Manchester area by Dr. G. G. Lindsay; then by Dr. S. Keidan, and then by Dr. C. S. Hunter. The trial was coordinated by the late Dr. Marc Daniels and then by Dr. Pollock. Throughout its planning and execution there has been close co-operation with the Council's Statistical Research Unit, and Dr. Ian Sutherland of that unit has taken a major part in it, assisted latterly by Miss B. J. Kinsley. Dr. Pollock, Dr. Sutherland, and Miss Kinsley have analysed the results and prepared the present report. Independent assessments of the cases of tuberculosis were made by Dr. V. H. Springett; a small number of cases which happened to be under Dr. Springett's routine clinical care were assessed by Dr. J. G. Scadding, and a few supplementary assessments of non-pulmonary disease were made by Mr. J. A. Cholmeley.

Examinations of cultures from cases of tuberculosis in B.C.G.-vaccinated children were undertaken by Colonel H. J. Benstead, Dr. H. D. Holt, and Dr. K. A. Machacek, and in the vole-bacillus-vaccinated children by the late Dr. A. Q. Wells and then by Dr. R. L. Vollum. Histological specimens were assessed by Dr. R. J. W. Rees. Part-time assistance to the physicians directing the teams was given by Dr. Christine Miller, and also by Drs. M. C. Davitt, E. C. Fear, W. L. Gordon, Nancy C. Janes, Phyllis A. Lavelle, Mary Pollock, and F. E. Sparshott. Advice on radiological procedures was given by A. J. Eley. Dr. Eley, Dr. L. A. McDowell, and Dr. J. Rimington made independent additional readings of the routine chest radiographs taken by the teams. The follow-up in the Armed Forces was arranged by the Director-General of the Medical Services of the Royal Navy, of the Army, and of the Royal Air Force, and their staffs.

The public health and education authorities in the following areas are co-operating in the investigation:

*Buckinghamshire:* Slough, M.B.; *Cheshire:* Stockport C.B.; *Essex:* Barking M.B., Chigwell U.D., Chingford M.B., Dagenham M.B., East Ham C.B., Ilford M.B., Leyton M.B., Romford M.B., Walthamstow M.B., Wanstead and Woodford M.B., West Ham C.B.; *Hertfordshire:* Barnet U.D., St. Albans M.B., Watford U.D.; *Lancashire:* Bolton C.B., Manchester C.B., Oldham C.B. Rochdale C.B., Salford C.B.; *Middlesex:* Acton M.B., Brentford and Chiswick M.B., Ealing M.B., Hendon M.B., Heston and Isleworth M.B., Southgate M.B., Tottenham M.B., Wembley M.B., Wood Green M.B.; *Staffordshire:* Smethwick C.B., Walsall C.B., West Bromwich C.B., Wolverhampton C.B.; *Warwickshire:* Birmingham C.B., Coventry C.B.; *Yorkshire:* Bradford C.B., Leeds C.B.

The following medical officers of health, deputy medical officers of health, school medical officers, and chest physicians are taking, or have taken, part in these areas.

*Medical Officers of Health and School Medical Officers.*—Drs. A. Fairgrieve Adamson, W. Alcock, A. Anderson, K. M. Bodkin, W. G. Booth, D. B. Bradshaw, Arnold Brown, C. Metcalfe Brown, F. G. Brown, H. O. M. Bryant, J. L. Burn, Matthew Burn, M. A. Charrett, T. M. Clayton, H. M. Cohen, J. S. Coleman, Kenneth Cowan, D. E. Cullington, I. G. Davies, F. R. Dennison, R. J. Dodds, J. Douglas, J. L. Dunlop, R. W. Elliott, G. M. Fleming, A. Forrest, J. F. Galloway, S. C. Gawne, M. Gilchrist, J. Adrian Gillet, I. Gordon, F. Groarke, E. Grundy, W. Clunie Harvey, C. E. Herington, G. Hamilton Hogben, Alexander Hutchinson, John Innes, E. M. Jenkins, J. T. Chalmers Keddie, V. McDonagh, M. Manson, E. L. M. Millar, A. Moir, J. L. Patton, Hugh Paul, G. E. Payne, R. C. Pearson, A. C. T. Perkins, A. T. Powell, G. Ramage, A. I. Ross, T. Ross, J. B. Samson, S. W. Savage, J. F. Skone, J. C. Sleigh, G. G. Stewart, G. W. H. Townsend, A. A. Turner, M. Watkins, C. L. Williams, (the late) J. Wood-Wilson, J. Yule.

*Chest Physicians.*—Drs. J. Aspin, H. S. Bagshaw, P. E. Baldry, G. P. Bardsley, A. O. Bech, B. Butterworth, H. Climie, C. W. D. Cole, J. G. Currid, L. F. Dale, J. D. P. David, T. B. D'Costa, G. F. Edwards, T. A. Watkin Edwards, P. Ellman, A. Gordon Evans, Duncan Forbes, L. S. Fry, P. A. Galpin, J. E. Geddes, M. J. Greenberg, R. Grenville-Mathers, R. Heller, A. G. Hounslow, J. T. Hutchison, J. H. Pratt Johnson, D. J. Lawless, D. J. Leahy, W. Lee, G. R. W. N. Luntz, V. U. Lutwyche, J. N. Macartney, L. G. MacLachlan, T. A. McQuiston, W. R. May, J. Mitchell, D. Murphy, (the late) A. Ogg, T. L. Ormerod, H. Duff Palmer, J. T.

Paterson, H. Ramsay, E. Ratner, F. Ridehalgh, W. Robinson, P. W. Roe, H. J. T. Ross, A. Wilson Russell, E. Shieff, E. R. Smith, J. Morrison Smith, V. H. Springett, D. K. Stevenson, J. Sumner, J. A. F. Swoboda, H. E. Thomas, B. C. Thompson, S. Thompson, C. H. C. Toussaint, H. J. Trenchard, F. W. A. Turnbull, H. Vallow, D. C. Waddy, T. M. Wilson, W. E. Zundel.

In addition to those named, many other medical officers of health and chest physicians in all parts of the United Kingdom arranged visits and examinations for participants who moved into their areas. National and local health authorities in the following countries have given similar assistance: Aden, Australia, Bahama, Bahrain, Belgium, Bermuda, Burma, Canada, Cyprus, Denmark, Eire, Falkland Islands, France, Germany, Ghana, Gibralter, Holland, Hong Kong, India, Israel, Italy, Kenya, Luxembourg, Malaya, Malta, New Zealand, Nigeria, Norway, Nyasaland, Portugal, the Rhodesias, Sierra Leone, Singapore, Spain, Sweden, Switzerland, Tanganyika, Tangier, Trinidad, Turkey, Union of South Africa, and forty of the United States of America.

The Committee regrets that it is impossible to name individually the large number of health visitors and school nurses who are making a vital contribution to the trial by repeated visiting of the participants, as an addition to their normal duties; without their devoted work this investigation could not have continued.

The mobile vans for miniature radiography were lent by the Ministry of Health and maintained by the Ministry of Works, the van in the London area being provided by the North-west Metropolitan Regional Hospital Board. Mass radiography units in many of the areas, and the Slough Industrial Health Service co-operated by arranging for extra radiographic examinations of participants. The Chest and Heart Association helped in providing publicity material.

The following also assisted locally in various ways in maintaining contact with the participants: Women's Voluntary services; the Order of Red Cross and St. John; industrial medical officers; youth employment officers; chambers of commerce; a large number of employers; the public relations officer of Middlesex County Council; cinema circuits; leaders of youth clubs.

The Committee wishes to thank all these, and the many other individuals and organizations which are assisting in the investigation.

Finally, the Committee thanks the secretarial and technical staff of the Tuberculosis Research Unit for the their unstinting efforts and the contributions they have made to the smooth running of the trial.

REFERENCES

Anderson, A. S., Dickey, L. B., Durfee, M. L., Farber, S. M., Jordan, L. S., Jordan, K. B., Kupka, E., Lees, H. D., Levine, E. R., McKinlay, C. A., Marshall, M. S., Meyerding, E. A., Myers, J. A., Ornstein, G. G., Slater, S. A., Stoesser, A. V., and Sweany, H. C. (1959). *Brit. med. J.*, 1, 1423.

Aronson, J. D., Aronson, C. F., and Taylor, H. C. (1958). *A.M.A. Arch. intern. Med.*, 101, 881.

Barns, T. (1955). *J. Obstet. Gynaec. Brit. Emp.*, 62, 162.

Daniels, M., Ridehalgh, F., and Springett, V. H. (1948). *Tuberculosis in Young Adults.* Lewis, London.

Edwards, L. B., and Palmer, C. E. (1958). *Amer. J. Hyg.*, 68, 213.

Frimodt-Moller, J. (1957). *Bull. int. Un. Tuberc.*, 27, 111.

Griffiths, M. I., and Gaisford, W. (1956). *Brit. med. J.*, 2, 565.

Groth-Petersen, E. (1959). *Acta tuberc. scand.*, Suppl. 47, p. 132.

Hart, P. D'Arcy, Pollock, T. M., and Sutherland, I. (1957). *Advanc. Tuberc. Res.*, 8, 171.

Hyge, T. V. (1947). *Acta tuberc. scand.*, 21, 1.

——— (1956), Ibid., 32, 89.

Medical Research Council (1956). *Brit. med. J.*, 1, 413.

——— (1958). Ibid., 1, 79.

Ministry of Health (1953). Circular 22/53.

——— (1959). Personal communication.

Myers, J. A. (1957). *Advanc. Tuberc. Res.*, 8, 272.

Palmer, C. E. (1957. *Bull. int. Un. Tuberc.*, 27, 106.

——— Jablon, S., and Edwards, P. Q. (1957). *Amer. Rev. Tuberc.*, 76, 517.

——— Shaw, L. W., and Comstock, G. W. (1958). Ibid., 77, 877.

Pollock, T. M. (1957). *Brit. med. J.*, 2, 20.

Report of the Tuberculosis Research Committee (1932). *Publ. S. Afr. Inst. med. Res.*, 5, No. 30.

Rosenthal, S. R. (1955). *J. Amer. med. Ass.*, 157, 801.
——— (1956). *Amer. Rev. Tuberc.*, 74, No. 2, Part 2 (Suppl.), p. 313.
Sergent, E., Catanei, A., and Ducros-Rougebief, H. (1956). *Bull. Acad. nat. Méd. (Paris.)*, 140, 562.
Sula, L. (1958). *Tubercle (Lond.)*, 39, 10.
Sutherland, I. (1959). To be published.
Tolderlund, K. (1952). *Acta path. microbiol. scand.*, Suppl. 93, p. 299.
——— (1955). Personal communication.
World Health Organization Tuberculosis Research Office (1955). *Bull. Wld Hlth Org.*, 12, 63.

Dr. Selikoff. This study of the journal is perhaps one of the most remarkable biological studies in the history of medicine. It is the largest, longest, best-organized, most carefully planned, most carefully executed such study in the history of medicine. It can be termed a "classical study." It was conducted by a very distinguished group of tuberculosis experts, by a medical research council team with the assistance of the National Health Service, a nationwide system of chest clinics, and the medical services of the Armed Forces in Great Britain.

It was a controlled clinical trial of BCG and the prevention of TB in England. It started in 1950 and it is still in progress.

They studied 56,700 youngsters from the age of 14 to 15½. These youngsters now are 21 to 25.

Each participant has been studied for at least 5 years, some as long as 7½ years. They have been very carefully observed with periodic X-rays, routine home visits, analysis of their condition while in Army service, et cetera.

There are many interesting data derived from this study, but for our purposes today the following verbatim conclusion is important:

> During the 5-year period the annual incidence of tuberculosis in BCG vaccinated group was 0.38 per thousand, compared with 2.29 per thousand among those in the tuberculosis negative unvaccinated group who were admitted concurrently. This represents a reduction attributable to vaccination of 83 percent. Moreover, the incomplete information beyond 5 years shows that similar high levels of production have continued up to at least 6½ years after entry.

It would be of interest to consider how this utilization of BCG, which provides approximately 85 percent protection—and, by the way, it is of interest to note that this figure of 80 to 85 percent has been duplicated in other studies as well—it is interesting these studies were conducted in Algeria, among our Indian population out West, Great Britain, Denmark—so apparently human beings respond the same pretty much all over the world.

I would like to apply this information to our problem.

In the next 5 years, 1960 to 1964, we expect to have roughly 208,000 new active cases of tuberculosis in this country. Those are the Public Health Service's conservative estimates. I think we will have more because they are anticipating a continued decline in the new case rate. I hope they are right.

If they are right we will have roughly 208,000 new active cases.

Of these 52,000 will appear among people who are presently tubercular negative, who never have been infected and who are therefore suitable for BCG vaccination.

If these people were to get BCG vaccination, and if the figure found throughout the rest of the world of 80 to 85 percent protection were

to hold, we could prevent from 1960 to 1964, 42,000 new active cases of tuberculosis.

I think that the British data, which, incidentally, is unchallenged in it accuracy, objectiveness, and completeness, indicates that there is no longer any significant objection to the use of BCG vaccination.

Any objections with regard to safety are unsupported by the huge practical experience with BCG. In almost every country in the world apart from the United States, including very extensive studies in the Soviet Union, there is now no longer any question with regard to efficacy.

At one time doubts with regard to efficacy were perhaps justified. I confess I myself held them until several years ago. This has a historical derivation.

BCG was discovered in France and the early clinical trials were conducted on a very haphazard basis. This is not to indicate any criticism of the French medical profesison but it is simply that 25 or 30 years ago, when these trials were undertaken, all clinical trials were on a pretty haphazard basis.

The data derived from these trials were not fully acceptable to us, and I myself doubted the efficacy of BCG as unproven, but with the current British results, as well as those of Rosenthal, and Aronson in this country, and the results in Denmark, Sweden, Algeria, and so on, there is no longer any question with regard to efficacy.

Further, the few minor objections to BCG, such as its interference with the tuberculin tests, can hardly be considered as very serious objections to an efficacious vaccine. I hardly consider the loss of the specificity of the Schick test as an objection to the use of the vaccination.

Moreover the tuberculin test has very limited use. As a clinician, frequently faced with severe problems of tuberculosis, I know, and every experienced clinician knows, that a negative tuberculin test has no significance in a seriously ill person. They could just as well have tuberculosis as not.

Moreover, in the countries in which large-scale BCG programs have been undertaken, such as Great Britain, the Soviet Union, and Denmark, the medical profession has made no complaint with regard to the minor inconvenience of the loss of the tuberculin test. It may make some difficulty in epidemiological studies and they will have to have another table in the statistics. There will be the TB negative and the TB positive, BCG. With this study, therefore, I consider that the utilization of BCG is most important in this country and that the recommendations of the Surgeon General's ad hoc committee of 1957, should be put into effect; namely, it should be used in high incidence areas and in high incidence groups, in fact, high incidence cities, and the Public Health Service should be encouraged to increase grants-in-aid to States where such high incidence areas are present. They should encourage areas under their influence to know the value and the efficacy of BCG, and this should be done as rapidly as possible.

Mr. Fogarty. I have just received an interesting letter and attachments on this same subject from Dr. Davison, of Duke University, which we will place in the record.

(The letter referred to follows:)

DUKE UNIVERSITY MEDICAL CENTER,
OFFICE OF THE DEAN, SCHOOL OF MEDICINE,
*Durham, N.C., March 1, 1960.*

Hon. JOHN E. FOGARTY,
*House of Representatives, Washington, D.C.*

DEAR MR. FOGARTY: I recently learned that you are holding hearings on March 3 on fiscal year health appropriations and I hope very much that the BCG vaccine program can be included and that the enclosed reprint can be made a part of the record of the hearings.

I am the dean of the Duke University School of Medicine and professor of pediatrics, and have been interested for many years in the prevention of tuberculosis by the use of BCG vaccine.

Thanking you for your cooperation, I am,

Yours sincerely.

W. C. DAVISON.

[Reprinted from Quarterly Review of Pediatrics, August 1958]

THE ADVANTAGES OF BCG VACCINATION IN PREVENTING TUBERCULOSIS

(W. C. Davison, professor of pediatrics and dean, School of Medicine, Duke University)

Tuberculin tests, chest roentgenograms, early recognition, and sanatorium care have reduced the incidence of and death rate from tuberculosis, but the rates would be even further decreased if the American medical profession would use BCG (bacille Calmette Guérin) as some British and Scandinavian physicians do, especially for newborn infants, hospital personnel, and students of medicine and nursing.

The new freeze-dried BCG vaccine [1] is safe and stable. More than 100 million children and adults have been safely vaccinated with BCG, including 20 million in Japan and 14 million by the World Health Organization in 23 countries.

Tuberculosis in students of medicine and nursing has been reduced by BCG. Furthermore, tuberculous meningitis, which is at present the greatest tuberculosis problem, has been reported in only two BCG-vaccinated infants. Almost all cases of tuberculous meningitis occur at less than 3 years of age, emphasizing the need for BCG in newborn infants.

It is amazing that many pediatricians and family doctors are not even doing routine tuberculin tests, on the ground that a positive reaction alarms the mother. It should be quite the reverse. A negative test calls for the protection of BCG.

Failure to adopt routine BCG is largely due to the belief that tuberculosis can be eradicated solely by routine chest roentgenograms, early recognition, sanatorium care, and the treatment of patients after they have acquired tuberculosis. These methods, of course, deserve most of the credit for the present marked reduction of the disease, but something more is needed to make the results comparable to those for diphtheria, smallpox, and typhoid. The present low incidence of tuberculosis and the scarcity of positive tuberculin reactions in Sweden and Minnesota, though splendid for those who remain there, is correspondingly dangerous for those who go unprotected into other areas with a high incidence of tuberculosis, and is no argument for not using BCG. The present low diphtheria, smallpox, and typhoid rates certainly have not made toxoid and vaccines unnecessary. The early isoniazid therapy of recently acquired tuberculosis will actually cause some positive tuberculin reactions to become negative, and thereby require the protection of BCG vaccine; it would have been preferable to have given BCG vaccine in the first place during the newborn period. Furthermore, tuberculous meningitis may occur during isoniazid therapy.

Typhoid fever is rare and is curable by antibiotics, and tetanus also is rare and cures are as frequent as in tuberculous meningiits, but no one questions the advisability of using typhoid vaccine and tetanus toxoid for children and the Armed Forces.

[1] Obtainable from the Research Foundation, 70 West Hubbard Street, Chicago 10, Ill.

The following statement is given to patients at the Duke Pediatric Outpatient Clinic:

"STATEMENT FOR PARENTS

"BCG (bacillus of Calmette and Guérin) vaccine is composed of nonvirulent tubercle bacilli. Vaccination with this organism produces an immunity against tuberculosis in over 90 percent of those vaccinated.

"The safety of BCG vaccine has been tested by millions of vaccinations in many countries, and the introduction of the Rosenthal multiple-puncture method of administering it has practically eliminated all complications after vaccination.

"In many countries, such as France, Norway, Denmark, Japan, and Brazil, BCG vaccination has become mandatory by law.

"One if the best-planned and best-controlled studies on the efficacy of BCG vaccination was recently carried out by the Medical Research Council of Great Britain. The results revealed a marked reduction in the incidence of tuberculosis in vaccinated persons as compared with nonvaccinated controls.

"The American Trudeau Society has recommended BCG vaccination for those individuals who will be exposed to tuberculosis, for groups considered to have inferior resistance, and for those who live in communities in which the tuberculosis mortality is unusually high.

"The vaccine is given only to individuals who have had no known recent contact with tuberculosis, and who have had a negative tuberculin test (at 1:100, not the usual 1:1000 because some individuals with healed tuberculosis may only be sensitive to 1:100 and giving them BCG may activate the process). These recommendations have been accepted by the U.S. Public Health Service and recognized by the Council on Drugs of the A.M.A.

"BCG is available at the Duke University Medical Center. Arrangements can be made by contacting the resident in the pediatric clinic."

Mr. Fogarty. You know that there is a difference of opinion between you and many others in this area.

Dr. Selikoff. There certainly is.

Mr. Fogarty. It is still going on, according to our Public Health Service.

Dr. Selikoff. Yes. This same difference of opinion existed in Great Britain simultaneously with the United States and it was their own experience with the tremendous efficacy and value of BCG that has led the entire British profession to change its mind about the use of BCG, so it is now recommended for use throughout Great Britain by the Ministry of Health.

Mr. Fogarty. Dr. Blomquist testified that they are spending about $120,000 this year on continued investigation of the BCG vaccine and he said in his testimony before our committee:

One of the problems in a disease like tuberculosis, being a chronic disease, is that we must know the long-term effects. It is not just what happens this year. We want to know if the initial results hold over a long period of time. Consequently, we continue to follow up the individuals who are enrolled in the BCG studies in the areas you mentioned to see if the results earlier in the course of the research hold in future years.

That was their followup in Puerto Rico and Georgia and Alabama, I think. He further said:

Those are the activities we are currently involved in, followed up by GBC studies. What was found in the preliminary results continues to be true.

We feel that there is a very limited usefulness of BCG in this country primarily for the reason I mentioned a minute ago, that so many of the individuals, 75 percent at least and probably a higher proportion of the newly reported cases are not individuals who would benefit from a vaccine like BCG. BCG can only be used in the uninfected, the tuberculin negatives.

I would say it this way: BCG is effective only in the tuberculin negative individual, the person who does not react to the tuberculin test, the person who has not come in contact with an active case close enough or long enough to have a seeding of the infection lying dormant in his body.

Then Dr. Burney interjected to supplement Dr. Bromquist's comment by saying:

May I supplement Dr. Blomquist's comment relative to your question about why we should continue the BCG research? If we had not believed it desirable to use it nationwide in this country, our stand on that, I believe, has been that with the low incidence of new cases of tuberculosis in the United States in most areas; it is not an effective agent and does not mask somewhat our ability to find the other cases because it makes them tuberculin positive.

On the other hand, we have not discouraged its use in segments of the population in which there is a high risk. We have recommended, and our expert committee recommended, that it be used with nurses and attendants and physicians who are working in or around a hospital group.

Is that something new, that recommendation?

Dr. SELIKOFF. No. I think that was probably recommended in 1946. This was repeated in the ad hoc committee's report in 1957, which reviewed the problem.

Mr. FOGARTY. He said:

But in addition, it is my understanding, Dr. Blomquist, that there is not complete satisfaction with the BCG vaccine itself, that the ability to standardize the vaccine so that all lots have equal ability to produce antibodies—it is not in the same category as smallpox vaccine or whooping cough vaccine; it cannot at the present time be standardized so that each lot is the same.

In addition to our special uses in the United States—in the special risk groups and perhaps some Indian groups and perhaps in some groups in large metropolitan areas—I think there is an additional area in which we can be of some benefit worldwide through the development of a better BCG vaccine; if this does prove to be a valuable device in addition to working on a vaccine, in addition to BCG, which would be used worldwide in India, Asia, Africa, where tuberculosis is still a tremendous problem, and we would be contributing not only to the small and circumscribed uses we might make of it, but we would be contributing, I think, greatly, to the armamentarium to reduce tuberculosis in other parts of the world.

What do you say about that?

Dr. SELIKOFF. I wish that Dr. Burney, rather than using the phrase "we have not discouraged this," would have used the phrase, "we would encourage this," where it is applicable.

First of all, Dr. Blomquist remarked that we are interested in the long-term results. I would certainly second that interest. I, too, am interested in the long-term results; and I am, therefore, particularly gratified to read of the Medical Research Council's 5 to 7½ years followup to date of this very carefully studied 56,700 children group. I do not know what will happen after 13 years, but I do know that as of 5 to 7½ years, the efficacy of the vaccine has held up exactly as in the first year.

Now, I assume any difference of opinion would depend upon analysis of what we mean by "long term," and I will not be able to give Dr. Blomquist any long-term 30-year results for another 25 years. We have every reason to expect, on the basis of current data, that the 30 years' results will be just as good—85 percent effective—as the 5-year results.

Secondly, with regard to the Public Health Service's followup of their own study, as you probably know, the Public Health Service study is the only study which has given only 35 percent protection rather than 85 percent. As a practicing physician, I would not sneeze at the 35 percent protection, by the way, but the discrepancy between the Public Health Service's results and those obtained over the rest of the world have been analyzed, obviously by all people who have

been interested in this problem. It is pointed out there have been differences in the populations studied, in the vaccine used, in the criterion for vaccination, and a most important difference, in the methods of study.

For example, in the British study every single child that was vaccinated was followed up. This, unfortunately, was not true in the Public Health Service's study where only notification rates were depended upon for analysis. This is not an invalid method of studying, but it is hardly comparative to all cases vaccinated. In fact, the British Medical Research Council has stated that perhaps if the U.S. Public Health Service had done its study in comparable areas to theirs, they would probably have gotten the same results. But be that as it may, the results all over the world have been exceedingly good.

The second point I would like to comment on with regard to Dr. Blomquist's statement is that the vaccine is not available for 75 percent of our potential new cases. I agree with him. It is not available for those who have already been infected. I am sorry that 75 percent, by the way, had not been vaccinated before they became infected; we cannot help that, but I am concerned with the 25 percent, or 52,000 new potential cases by 1964 who are currently uninfected and who can be protected by BCG.

We can rescue 42,000 new active cases by giving these people good, adequate vaccine. I am sorry that I cannot help the other 75 percent, the 152,000 new active cases that we anticipate by 1964.

I agree with Dr. Burney that the use of BCG vaccine "overall the country is not logical." I would certainly not recommend it in the rural counties in Minnesota where the possible incidence of new active cases is very small. But I would urge it for Harlem. I would urge it for cities like Philadelphia, Newark, N.J., where the new case incidence is 90 per 100,000, and I would recommend that BCG be concentrated precisely in those areas in which we expect our 200,000 new cases in the next 4 years.

With regard to the question that the present vaccine is not fully satisfactory—well, we are never fully satisfied with anything and I hope we will get a better vaccine. The British Medical Research Council has found in their studies that despite the variations in the batches of vaccine, and even the types of vaccine that were used in their studies, it made no difference whatsoever clinically in the protection that was given. For example, they have the same protection using vole bacillus vaccine os BCG. They have the same protection whether the vaccine was made in Britain or by the Danish State Vaccine Institute. So the variations in potency which do exist have not prevented the efficacy, and indeed all the active vaccines that we use in these trials all give protection. Apparently it does not mean much.

Moreover, with regard to standardization, I think that the British are just as much aware of this problem as we, and indeed they have gone to some length to standardize their vaccine, and perhaps we might read about their standardization.

They are contained, if Dr. Blomquist wants the references, in the Therapeutic Substances Regulations, 1952, and in Her Majesty's Stationery Office Publication, 1937. Just a year and a half ago, in the British Pharmacea, page 68.

I hope that our skilled people here will be able to improve on the British standardization, but the standardizations are available.

I think that I have discussed the question of the interference with the tuberculin tests. I don't think that is worth repeating. These problems which have been mentioned before, almost every year, and will be mentioned again, I am sure, next year, hardly have relevance now to the facts of life. The facts of life are that careful, adequate, skilled extensive studies are now being done under actual conditions of life in Birmingham, Manchester, and London and the vaccine is found to protect 85 percent of those to whom it was given.

I propose that we give it here as well to those who need it; namely, those who are tuberculin negative and who live in areas, or parts of areas of new incidence.

Mr. Fogarty. We had before us Dr. Andrews regarding infectious diseases, and I note in his justifications under the heading of "Tuberculosis" he says:

> If tubercule bacilli can float through the air and cause disease in people who inhale them, some scientists have reasoned, Why not atenuated (weakened) bacilli be transmitted the same way to achieve mass vaccination? Following this possibility, highly successful immunization of guinea pigs has been achieved by exposing them in test chambers to BCG, a strain of weakened microbes used in vaccination against tuberculosis. Initial trials of this method which humans appear to have been successful.
>
> If it is apparent the effectiveness is confirmed, airborne vaccination will have a cost advantage over multiple inoculations with BCG. With these and other possibilities for development of improved vaccine close at hand, it would appear desirable to press forward with a vigorous program of research in this area.

Dr. Selikoff. My comment on that is this: Dr. Andrews' detail of the present studies which have been done by Dr. Gardner Middleblock, of Denver, on the administration of BCG vaccine by inhalation indicates that new techniques can be sought, and indeed should be sought and perhaps will be even better than what we now have. I would hope that such new techniques would raise our efforts and our efficacy rate from 85 percent protection to 95 percent protection perhaps. Indeed, other techniques have been utilized elsewhere in the world.

The Soviet Union oral administration of other strains of BCG vaccine have been used on a very large scale. In the Soviet Union the TB authorities feel they will be able to really eradicate TB within the next 15 years, utilizing our techniques of case finding, drug treatment, and BCG prevention.

Mr. Fogarty. Are they making their own vaccines?

Dr. Selikoff. Yes. They have several large institutes in the Soviet Union and very advanced institutes in Czechoslovakia and Poland. By the way, the impetus to these institutes and to their program was given by the United Nations World Health Organization. They have taken advantage of the great help which was given to them by the United Nations and they have gone on from there.

I hope, if I may be facetious, we do not have to watch their public health rockets go past our nice little TB programs. They expect to have TB eradicated in 15 years, utilizing case-finding, drug treatment, and prevention of new cases by adequate vaccination.

Mr. Fogarty. Thank you very much, Doctor.

(The following was subsequently received from Dr. Selikoff:)

THE PATERSON CLINIC,
*Paterson, N.J., March 5, 1960.*

HON. JOHN E. FOGARTY,
*Chairman, Subcommittee on Labor, Health, Education and Welfare Appropriations, Appropriations Committee, House of Representatives, Washington, D.C.*

DEAR MR. FOGARTY: I appreciate deeply the opportunity you gave me, on March 3, to appear before your subcommittee to discuss vaccination against tuberculosis and the importance of its inclusion in our tuberculosis public health program. This opportunity further allowed m to place on the record the brilliant studies of the Medical Research Council of Great Britain (1950–59), demonstrating conclusively the high efficiency of BCG in the prevention of tuberculosis.

I am grateful, too, for your probing questions which led to clarification of a few stated disadvantages of such vaccination, indicating that such disadvantages are at most very minor and insignificant when weighed against the protection against tuberculosis afforded by vaccination.

I would appreciate the additional privilege of including the enclosed supplementary statement of recommendations, as a conclusion of my remarks, into the record of the hearing.

With sincere thanks,
Cordially,

IRVING J. SELIKOFF, M.D.

SUPPLEMENTARY STATEMENT OF RECOMMENDATIONS

The testimony presented emphasizes that BCG can play an important part in the tuberculosis public health program. If we envisage—and we must—the elimination rather than mere control of tuberculosis, then vaccination programs in high incidence areas must be added to our present program of case finding and chemotherapy.

I therefore recommend that the Public Health Service designate funds for:

(1) The institution of BCG vaccination programs in current high incidence areas, such as the 24 cities where the new case rate per 100,000 exceeds the national average;

(2) The initiation and support of State BCG programs for vaccination in special high incidence groups, such as inmates of prisons, institutions, etc.;

(3) Expansion and support of existing programs which have recently been developed in New York City and elsewhere for vaccination of contact cases; and

(4) Initiation and support, through State and city facilities, of pilot projects for the vaccination of newborn infants in high incidence areas.

It is my opinion that the current budget request of the Public Health Service is inadequate in that it carries no request for funds for the above-outlined specific purposes.

IRVING J. SELIKOFF, M.D.

## CONTROL OF TUBERCULOSIS

Mr. FOGARTY. We have received literally hundreds of letters protesting the administration's action in reducing the funds for control of tuberculosis. I think our hearings record should indicate the interest without the expense of printing them all, so perhaps the best way to do this would be to just place in the record the letters I have received from Members of Congress.

(The congressional letters referred to follow:)

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D. C., February 15, 1960.*

Hon. JOHN E. FOGARTY,
*Committee on Appropriations,*
*House of Representatives.*

DEAR MR. CHAIRMAN: I have been requested to transmit for consideration by the Appropriations Subcommittee on the Department of Health, Education, and Welfare the attached letter of protest addressed to me by the president of the Jefferson County Tuberculosis Association, Pine Bluff, Ark., who is also a member of the board of directors of the National Tuberculosis Association.

The protest is in opposition to the reduction of $1 million in the budget request for fiscal year 1961 for grants to States in the tuberculosis program of the Public Health Service. I have inquired of the subcommittee clerk and am advised that the reduction proposed is correctly stated.

The official to whom I have referred, Mrs. Ingram, points out in her letter that there is urgent need in the State of Arkansas for continuation of adequate Federal grants under this program, and gives certain statistics to support this statement. The matter is one of real concern to me, of course, and I shall appreciate the subcommittee's action in seeing to it that sufficient funds are recommended for grants to Arkansas and any other of the several States which may be in similar need of Federal aid for this health program.

Sincerely yours,

W. F. NORRELL., *Member of Congress.*

JEFFERSON COUNTY TUBERCULOSIS ASSOCIATION, INC.,
*Pine Bluff, Ark., February 10, 1960.*

Hon. W. F. NORRELL,
*Senate Office Building,*
*Washington, D.C.*

DEAR SIR: I have been notified by the National Tuberculosis Association that the proposed budget for the tuberculosis program of Public Health Service, for the fiscal year 1960–61, includes a cut of $1 million in that portion allocated to grants to States.

As a member of the NTA board of directors, and as a president of a local association, I want to voice a strong protest to the proposed budget.

It is true that in some States there has been a decline in the tuberculosis death rate, but this is decidedly not the case in the Southern States. With 205 TB deaths in Arkansas in 1958 and 1,045 new cases discovered in 1958, certainly a curtailment of the program in Arkansas and other Southern States would be most unwise.

I am very interested in getting this protest to the House Appropriations Subcommittee and ask that you forward my views to them.

Yours very truly,

MRS. FRED J. INGRAM, *President.*

---

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C., February 17, 1960.*

Hon. JOHN FOGARTY,
*Chairman, Subcommittee on Health, Education, and Welfare,*
*House Committee on Appropriations,*
*Washington, D.C.*

DEAR MR. CHAIRMAN: I enclose copy of a telegram from the New Mexico Tuberculosis Association and copy of a letter from Mrs. Stanley J. Leland of Santa Fe, who is the wife of the Director of Public Health Service in New Mexico, both in connection with forthcoming hearings which will include the tuberculosis control programs. I will greatly appreciate the consideration of the committee to the enclosures.

Thanking you and with my kindest personal regards, I remain,

Sincerely yours,

JOSEPH M. MONTOYA.

SANTA FE, N. MEX., *February 11, 1960.*

Representative JOSEPH M. MONTOYA,
*House Office Building, Washington, D.C.:*

We have learned that there is some sort of decreasing the budget request of the U.S. Public Health Service for grants-in-aid to States for tuberculosis control programs. Any cut in the $4 million request for the TB grant-in-aid programs to States would seriously jeopardize New Mexico's TB control program which is now just getting into high gear. We urge you to give support to the House Subcommittee on Appropriations to pass on the requested $4 million allocation for the above-stated purpose.

ROBERT J. UTZINGER,
*Executive Director, New Mexico Tuberculosis Association.*

---

SANTA FE, N. MEX., *February 10, 1960.*

Hon. JOSEPH MONTOYA,
*House Office Building,*
*Washington, D.C.*

DEAR MR. MONTOYA: I understand that there is some sentiment toward decreasing the appropriation for the budget of the U.S. Public Health Service which would result in a sharp cut in the funds available for Federal assistance in the tuberculosis program.

As a member of the board of directors of the New Mexico Tuberculosis Association, let me urge that you do what you can to see that the House Appropriations Subcommittee approves a total of no less than $4 million for the current fiscal year.

As you know, New Mexico is one of the few States in which tuberculosis continues to be a real problem. As not everybody does know, great strides are being made, especially in setting up outpatient chest clinics all around the State, operated jointly by the State health department and the New Mexico Tuberculosis Association. It would be most unfortunate if this program should have to be curtailed at all.

If you will be so kind as to make known these facts to Mr. John E. Fogarty, of Rhode Island, Mr. Wilfred Denton, of Indiana, Mr. Fred Marshall, of Minnesota, Mr. Melvin R. Laird, of Wisconsin, and Mr. Elford Cederberg, of Michigan, the members of the House Appropriations Subcommittee, I would appreciate it very much.

Very truly yours,

MRS. STANLEY J. LELAND.

---

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C., February 8, 1960.*

Hon. JOHN E. FOGARTY,
*House of Representatives,*
*Washington, D.C.*

DEAR COLLEAGUE: I understand that the President has requested $3 million in his recent budget message for the tuberculosis program of the Public Health Service, and I wish to call to your attention the need for additional funds. I am convinced that if tuberculosis-control activities in a State and local health department are not to suffer, a minmum of $4 million is needed in Federal grants to States for tuberculosis control. Medical authorities are at a point where, by continued concentrated effort, it is hoped to eradicate tuberculosis as a public health problem. This is not the time that efforts should be lessened but rather that they should be intensified, and I would very much appreciate it if you could give consideration to additional funds for this program. From the information I have from those working on this program, I understand that great strides are being made toward the complete eradication of this dreadful disease, and adequate money is one of the factors which has helped to make such progress possible.

I would be grateful for your help and for your support of additional funds for this program.

Kind regards.

Cordially yours,

FRANK THOMPSON, Jr.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C., February 27, 1960.*

HON. JOHN FOGARTY,
*Chairman, Subcommittee on Labor-HEW,*
*Committee on Appropriations, House of Representatives.*

DEAR MR. CHAIRMAN: Enclosed, for your attention, is a copy of a letter which I recently received from Mr. Glen McPherren, president of Hood River County, Oreg., Tuberculosis & Health Association.

Mr. Pherren points out that a decrease in funds to support the tuberculosis program in 1961, as reflected in the budget presented on January 18, would cut the Oregon allocation by $6,900. He further states that Oregon needs to extend its control program to reach more of those needing care and treatment.

It would appear to me that a cut in funds at this time would be very short-sighted indeed.

Sincerely,

EDITH GREEN.

HOOD RIVER COUNTY,
TUBERCULOSIS & HEALTH ASSOCIATION,
*Hood River, Oreg., February 19, 1960.*

HON. EDITH GREEN,
*Washington, D.C.*

DEAR MRS. GREEN: We are writing you in regard to the Federal appropriations for the tuberculosis program, 1961, 86th Congress, 2d session.

In looking over the figures, we find that the budget as presented to Congress on January 18 included a request for $5,430,000 for the support of the TB program in 1961. This figure represents a decrease of over a million dollars from the amount appropriated last year. The major portion of this decrease is accounted for by the much smaller amount requested for grants to States.

This decrease in allocation for Oregon would amount to $6,900 for this purpose. Our State board of health officer and the director of the TB control section of the Oregon State Board of Health indicate that this cut would have a very detrimental effect on the TB control program in our State. We have a serious TB problem in Oregon, and it is very important that we have enough funds with which to extend our control program. Many nonhospitalized patients are not receiving care or treatment, and this situation contributes to the further spread of this disease.

Accordingly, we recommend that the "grants to States" appropriation stay at the figure of $4 million, which it was the past year.

As our Representative, we ask that you support the request of the National Tuberculosis Association for $4 million for grants to States to remain as in 1960, and also that you convey your approval to the members of the House Appropriations Subcommittee.

Thanking you for your cooperation, we are,

Cordially yours,

GLEN MCPHERREN, *President.*

---

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C., February 19, 1960.*

HON. JOHN E. FOGARTY,
*Chairman, Subcommittee on Appropriations,*
*House of Representatives, Washington, D.C.*

MY DEAR COLLEAGUE: I am enclosing a letter from Mrs. L. U. West, executive director of the Augusta Area Tuberculosis Association, Inc., 712 Telfair Street, Augusta, Ga., urging an appropriation of at least $4 million for the tuberculosis program of the Public Health Service for fiscal year 1961.

I hope the committee will see fit to include this amount in the bill.

Sincerely yours,

PAUL BROWN.

P.S.—I am also enclosing a letter from Geo. H. Sumerau, Georgia representative of the National Tuberculosis Association, Post Office Box 1185, Augusta, Ga., concerning this matter.

AUGUSTA AREA TUBERCULOSIS ASSOCIATION, INC.,
*Augusta, Ga., February 16, 1960.*

Hon. PAUL BROWN,
*House of Representatives,*
*Washington, D.C.*

DEAR MR. BROWN: At a meeting of the board of directors of the Augusta Area Tuberculosis Association on February 15, 1960, I, as executive director, was instructed to write to you in connection with the proposed appropriation by the Federal Government to the tuberculosis program of the Public Health Service.

The entire membership of our board concurred that the appropriation for TB control should be at least $4 million. If the figure of $3 million for grants to States in connection with tuberculosis control is appropriated for the fiscal year July 1, 1960, to June 30, 1961, the State of Georgia would lose about $21,000 for tuberculosis control in this 1 year.

We understand that this matter is now before the House of Representatives Appropriations Subcommittee and we would very much appreciate your expressing the views of our board of directors to the five Congressmen on this subcommittee.

Very truly yours,

ELIZABETH M. WEST
Mrs. L. U. West,
*Executive Director.*

---

AUGUSTA EXECUTIVES CLUB,
*Augusta, Ga., February 12, 1960.*

Hon. PAUL BROWN,
*Old House Office Building,*
*Washington, D.C.*

DEAR SIR: I have the honor of being the representative director of the National Tuberculosis Association and with my good friend, Julian Sipple of Savannah, represent our State in the NTA.

Mr. Sipple is chairman of the NTA Committee on Cooperation with Federal Agencies. He has communicated with me relative to the budget presented by President Eisenhower to Congress on January 18 for the support of the tuberculosis program for the fiscal year July 1, 1960, to June 30, 1961. The amount suggested for grants to States is $3 million, which is a $1 million cut from last year's appropriation.

We voluntary workers in the TB Association are also taxpayers and of course are interested in economizing whenever possible. But seeing the situation from all angles as we must we believe it will be false economy to make a 25 percent cut in this valuable service for the year 1960–61.

If we can keep up the fight we are now waging, there is the high hope that in a very few years there will be a radical change and a good chance for the eradication of tuberculosis in the United States.

No doubt Mr. Sipple has communicated with you regarding this matter and I would like to add my plea to his that you help us have the $1 million added to $3 million before the bill is approved by Congress.

I understand that the House Appropriations Subcommittee is made up of the following members of Congress—John E. Fogarty, Rhode Island; Winfield Denton, Indiana; Fred Marshall, Minnesota; Melvin R. Laird, Wisconsin; Elford Cederberg, Michigan.

Any assistance you can give us by speaking to members of the above committee will be appreciated by the thousands of voluntary workers with the Tuberculosis Associations in the country.

Sincerely yours,

G. H. SUMERAU,
*NTA Representative Director from Georgia.*

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C., March 2, 1960.*

HON. JOHN E. FOGARTY,
*Chairman, Subcommittee on Labor, Health, Welfare, and Education,*
*House Appropriations Committee, Washington, D.C.*

DEAR MR. CHAIRMAN: I hand you herewith copies of two letters which are, I believe, self-explanatory and are forwarded for your information.

Sincerely yours,

WALTER ROGERS,
*Member of Congress.*

POTTER COUNTY TUBERCULOSIS ASSOCIATION, INC.,
*Amarillo, Tex., February 23, 1960.*

WALTER ROGERS,
*New House Office Building,*
*Washington, D.C.*

DEAR MR. ROGERS: As a board member of the Potter-Randall Counties Tuberculosis Association and a citizen of Amarillo, I am asking that you use your influence against the 1961 decrease in Federal grants to the States for tuberculosis control and the amount remain $4 million which is a minimum to meet this need. I ask that you forward my views to the House Appropriations Subcommittee.

Tuberculosis is an infectious disease and must not be allowed to disrupt the homes and lives of our Nation. Hoping you will give this your serious consideration.

Very sincerely,

MRS. W. F. MONNING.

---

POTTER-RANDALL COUNTY TUBERCULOSIS ASSOCIATION, INC.,
*Amarillo, Tex., February 23, 1960.*

WALTER ROGERS,
*New House Office Building,*
*Washington, D.C.*

DEAR MR. ROGERS: As executive director of the Potter-Randall Counties Tuberculosis Association and a citizen of Amarillo, I am asking that you use your influence against the 1961 decrease in Federal grants to the States for tuberculosis control and the amount remain $4 million which is a minimum to meet this need. I ask that you forward my views to the House Appropriations Subcommittee.

I am in a position to know and see the effects of this dread disease and how hard it is to get funds sufficient to prevent and control it. We must not do anything to retard or delay the battle against tuberculosis.

I trust you will give this your serious consideration.

Very sincerely,

MRS. J. L. SCOTT,
*Executive Director.*

---

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C., February 24, 1960.*

HON. CLARENCE CANNON,
*Committee on Appropriations,*
*The Capitol, Washington, D.C.*

DEAR MR. CHAIRMAN: There is enclosed a copy of a letter received from Mr. W. W. Wilmore, executive secretary of the Kansas Tuberculosis and Health Association, regarding the decrease in the President's budget for TB control.

Although amazing results have been accomplished in the reduction of TB cases, many of us feel that before the budget amount is reduced we should be certain that effective control could be continued.

Thank you for your cooperation.

Yours sincerely,

NEWELL A. GEORGE.

THE KANSAS TUBERCULOSIS AND HEALTH ASSOCIATION,
*Topeka, Kans., February 9, 1960.*

Representative NEWELL A. GEORGE,
*House of Representatives, Congress of the United States,*
*Washington, D.C.*

DEAR REPRESENTATIVE GEORGE: We learn that the President's budget calls for a decrease of over a million dollars for tuberculosis control. Federal funds have been lessening and State funds for this purpose are not making up the deficit. Meanwhile, TB, our leading communicable disease killer, goes too "merrily" on.

After talking with our president, Dr. Ralph I. Canuteson, this morning we decided to send you some information regarding the TB problem in Kansas. If it weren't for the interest of folks like you, the results would not be as favorable as they are. And Kansas does have a comparatively good standing.

As we look ahead into the space age, we see not just the world, but the universe getting smaller. Our "spacemen" cannot fare too well with pulmonary difficulties. Whether it's here or on the moon, contagious TB can cause only continued waste of life and resources.

We believe it is sound procedure for the Federal Government—with very few dissenting voices—to make an intensified drive to rid our Nation of this continuing serious public health problem.

Sincerely yours,

W. W. WILMORE, *Executive Secretary.*

---

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C., February 26, 1960.*

Hon. JOHN E. FOGARTY,
*Chairman, Subcommittee on Appropriations for Labor, Health, Education, and Welfare, Appropriations Committee, House of Representatives, Washington, D.C.*

DEAR MR. CHAIRMAN: While the problem of tuberculosis is not so much in the public eye these days as some other diseases, we cannot lose track of the fact that it is still numbered among our most serious health problems nationally. Tuberculosis is still killing, crippling, and costing a tremendous number of people millions of dollars annually.

Great strides have been taken in the treatment and cure of this dread disease. There are, however, gaps in the tuberculosis control programs in many States. No one suffering from the disease today should be without adequate treatment, and it is within our power to completely eliminate tuberculosis within this century as a major public health problem.

In view of these facts, I am seriously disturbed, as are a great many of my constituents, over what appears to be a premature slackening of efforts and appropriations in this category. With the battle not yet won, I feel that our efforts should be speeded up rather than relaxed.

For the foregoing reasons I would like to go on record as feeling strongly that the tuberculosis control program should be continued at its present level.

Sincerely yours,

LEONARD G. WOLF,
*Representative in Congress.*

---

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C., February 24, 1960.*

Hon. JOHN E. FOGARTY,
*Chairman, House Appropriations Subcommittee on Labor and Health, Education, and Welfare.*

DEAR JOHN: Since I understand hearings are still in process on the tuberculosis program of the Public Health Service I should like to express my strong support for the full amount requested by the National Tuberculosis Association Committee on Cooperation With Federal Agencies.

No money can be saved in this field by failure to do an adequate job of detection and treatment, but will merely pile up larger expenses in the years ahead. The NTA committee suggests the following:

| | |
|---|---|
| Federal grants to States, minimum | $4,000,000 |
| Direct operations | 2,430,000 |
| Total | 6,430,000 |

May I request your serious consideration of their recommendation, and emphasize again the need for retaining the $4 million figure for 1961 in grants to States.

Sincerely yours,

BYRON L. JOHNSON, *Member of Congress.*

---

U.S. SENATE,
COMMITTEE ON FOREIGN RELATIONS,
*February 23, 1960.*

HON. JOHN E. FOGARTY,
*Chairman, Subcommittee on Health, Education, and Welfare, House Appropriations Committee, House of Representatives, Washington, D.C.*

DEAR MR. CHAIRMAN: I enclose several letters which I have received from my constituents concerning the President's budget request for the tuberculosis program of the Public Health Service.

The control of tuberculosis in Arkansas is far from a solution, and the proposed cut in the budget for the program will adversely affect the progress which is being made in the State to eradicate this disease. I hope that the subcommittee will give careful consideration to the information contained in these letters concerning the importance of this program to Arkansas, and to the Nation.

With best wishes, I am

Sincerely yours,

J.W. FULBRIGHT.

ARKANSAS COUNTY TUBERCULOSIS ASSOCIATION,
*Stuttgart, Ark., February 19, 1960.*

Re Federal appropriations, 1961.

Senator J. WILLIAM FULBRIGHT,
*Senate Office Building, Washington, D.C.*

DEAR SENATOR FULBRIGHT: We are very much concerned about Federal support of the tuberculosis program for the fiscal year 1960–61.

We note that the President's recommendation and request for the new fiscal year is over $1 million less than the amount appropriated for the current fiscal year. Also note that most of this decrease appears in the form of a much smaller amount requested for grants to States.

It seems that no reasonable basis exists for such decrease. The State programs are just as vital as they have ever been, and are certainly just as expensive. Therefore, it seems that the only possible result would be that the State programs for tuberculosis control must suffer a major setback if this decrease is allowed to stand.

We respectfully request that you use all means available to help keep the amount appropriated for State tuberculosis control programs at its current level of $4 million.

We also request that you make our views known to the members of the House Appropriations Subcommittee.

Respectfully,

MRS. BYRON M. MORRIS, *President.*

---

ARKANSAS TUBERCULOSIS ASSOCIATION,
*Little Rock, Ark., February 12, 1960.*

HON. J. WILLIAM FULBRIGHT,
*Senate Office Building, Washington, D.C.*

DEAR SENATOR FULBRIGHT: As president of the Arkansas Tuberculosis Association, I am writing to express the great concern of our association over the

proposed sharp cut in funds for the next fiscal year in the budget of the tuberculosis program of the Public Health Service. You undoubtedly have noted the proposed cut from $6,452,000 for 1960 to $5,430,000 for 1961 means a loss of over $1 million. We have noted that $1 million of this cut is to come from the grants to States. This cut would affect the program of the division of tuberculosis control in Arkansas at a time when we are needing increased revenue rather than a decreased amount. Information which we have shows that in 1959 the allocation to Arkansas for tuberculosis control was $66,500, in 1960 $62,800, and the estimate for 1961 is $46,200, which is a decrease of $16,600 under the current fiscal year.

We recently sent you a 1958–59 report from the Arkansas Tuberculosis Association. Just in case this was misplaced or was not called to your attention, I am enclosing another, so that you may see the true circumstances in your State. May I urge you to carefully consider the facts that are included in the report.

We believe you will agree with us that Arkansas can ill afford to lose the assistance from the Federal Government in its tuberculosis control program. On behalf of the State association and its county affiliate associations, may I urge you to forward your views to the members of the House Appropriations Subcommittee. I also want to take this opportunity to thank you for your splendid cooperation and prompt response to our past requests.

Sincerely,

BEN N. SALTZMAN, M.D., *President.*

---

JEFFERSON COUNTY TUBERCULOSIS ASSOCIATION, INC.,
*Pine Bluff, Ark., February 10, 1960.*

Hon. J. W. FULBRIGHT,
*Senate Office Building, Washington, D.C.*

DEAR SIR: I have been notified by the National Tuberculosis Association that the proposed budget for the tuberculosis program of Public Health Service, for the fiscal year 1960–61, includes a cut of $1 million in that portion allocated to grants to States.

As a member of the NTA board of directors and as a president of a local association, I want to voice a strong protest to the proposed budget.

It is true that in some States there has been a decline in the tuberculosis death rate, but this is decidedly not the case in the Southern States. With 205 TB deaths in Arkansas in 1958 and 1,045 new cases discovered in 1958, certainly a curtailment of the program in Arkansas and other Southern States would be most unwise.

I am very interested in getting this protest to the House Appropriations Subcommittee and ask that you forward my views to them.

Very truly yours,

Mrs. FRED J. INGRAM, *President.*

---

DANVILLE, ARK., *February 16, 1960.*

Hon. J. WILLIAM FULBRIGHT,
*U.S. Senate, Washington, D.C.*

DEAR SIR: I am sure that you are as much aware of the tuberculosis situation in our State as I am, and are equally as distressed over the proposed reduction in Federal aid and what it would mean to us.

The Arkansas Tuberculosis and its county affiliates are very optimistic concerning the immediate launching of a skin-testing program for all preschool children with followups on each of their contacts. We feel that this may be the beginning of the end for tuberculosis; however, the association is not strong enough financially to carry this program alone and a decrease in Federal aid at this time would be almost catastrophic.

Since we rate third in the Nation in TB deaths, our State would perhaps be one of the hardest hit by such a reduction.

Will you please use your influence with the House Appropriations Committee to see that they know our plight and to convince them that this just must not happen if we hope ever to conquer this plague.

Respectfully,

Mrs. M. R. COGER,
*Executive Secretary, Yell County TB Association.*

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C., February 23, 1960.*

Hon. JOHN E. FOGARTY,
*Chairman, Subcommittee on Labor, Health, Education, and Welfare, House Committee on Appropriations, Washington, D.C.*

DEAR COLLEAGUE: The attached letters from the Polk County and Nassau County, Fla., Tuberculosis and Health Association, are respectfully forwarded for consideration by your distinguished committee.

With kindest regards, I am,

Sincerely,

D. R. (BILLY) MATTHEWS,
*Member of Congress.*

---

NASSAU COUNTY TUBERCULOSIS & HEALTH ASSOCIATION,
*Fernandina Beach, Fla., February 15, 1960.*

Hon. D. R. MATTHEWS,
*House Office Building,*
*Washington, D.C.*

HON. CONGRESSMAN MATTHEWS: We respectfully urge you to support the 1961 appropriation for tuberculosis grants to States be not less than $4 million for the current fiscal year to further our program.

Please use your influence on the Appropriation Committee.

Thanking you in advance for your support.

NASSAU COUNTY TB & HEALTH ASSOCIATION,
KATHERINE HIRTH, *Secretary.*

---

TUBERCULOSIS AND HEALTH ASSOCIATION OF POLK COUNTY, INC.,
*Barlow, Fla., February 22, 1960.*

Re proposed budget decrease, 1961 tuberculosis control funds, U.S. Public Health Service.

Hon. D. R. MATTHEWS,
*House of Representatives,*
*House Office Building,*
*Washington, D.C.*

MY DEAR MR. MATTHEWS: We have been advised that the budget presented to Congress by President Eisenhower on January 18 includes a request for $5,430,000 for the support of the tuberculosis control program for the fiscal year July 1, 1960, to June 30, 1961. This is a decrease of $1 million to be realized by requesting a smaller amount ($1 million) for grants to States. The appropriation for grants to States in 1960 was $4 million, the amount proposed for 1961 is $3 million.

The National Tuberculosis Association's Committee on Cooperation With Federal Agencies has conferred and concluded that $4 million, if TB control activities in State and local health departments are not to suffer, is needed for grants to States in the 1961 budget.

The board of directors of the Tuberculosis and Health Association of Polk County urgently requests that you get in contact with the House Appropriations Subcommittee and forward to them our convictions that the amount which should be allocated for tuberculosis control should be $6,430,000 (of which $4 million should be available to States) based on the study and recommendations of our national committee. Mr. Julian Sipple, chairman of the committee, has initiated correspondence with the House Appropriations Subcommittee. It is our hope that you will urge this committee to carefully consider the NTA's views on this matter and that the final appropriation for tuberculosis control be $6,430,000.

Thank you very much for your attention to this matter and my personal best wishes to you.

Sincerely,

C. V. O. HUGHES, *President.*

52692—60——34

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C., February 26, 1960.*

Hon. JOHN E. FOGARTY,
*Chairman, Subcommittee on Health, Education, and Welfare,*
*House Appropriations Committee, Washington, D.C.*

DEAR MR. CHAIRMAN: I attach hereto a letter I received from the Dade County Tuberculosis Association requesting an increase in the President's budget for tuberculosis grants to the States.

I join with this association in asking for your committee's careful consideration of the need for these funds, and requests that this letter be made part of the record of the hearings on this bill.

Sincerely,

DANTE B. FASCELL,
*Member of Congress.*

DADE COUNTY TUBERCULOSIS ASSOCIATION,
*Miami, Fla., February 22, 1960.*

Hon. DANTE B. FASCELL,
*House Office Building,*
*Washington, D.C.*

YOUR HONOR: The members of the board of directors of the Dade County Tuberculosis Association wish to make known to you their interest in the 1961 appropriations for tuberculosis grants to the States.

We have been informed by the National Tuberculosis Association that the budget presented to Congress by President Eisenhower on January 18, includes a request for $5,430,000 for the support of the tuberculosis program in the fiscal year July 1, 1960, to June 30, 1961. This represents a decrease of over a million dollars from the amount appropriated in the current fiscal year.

The major portion of this decrease is accounted for by the much smaller amount requested for grants to States, a reduction from the current year of 25 percent.

The board members of the Dade County Tuberculosis Association have concluded that if tuberculosis control activities in State and local health departments are not to suffer, a minimum of $4 million is needed for grants to States. If the amount for grants is not sustained at its present level, the anticipated decrease in allocation for Florida in 1961 would be $20,500.

The Dade County Tuberculosis Association board members urge you to forward their views to members of the House Appropriations Subcommittee, that the appropriations for the 1961 tuberculosis program be in the amount of $6,452,000, of which $4 million will be available for Federal grants to States, for tuberculosis control.

We will appreciate your attention and consideration of this request.

Sincerely yours,

SARA MACNAMARA, *Executive Director*
(For the Board of Directors).

---

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C., February 23, 1960.*

Hon. JOHN E. FOGARTY,
*Chairman, Subcommittee on Departments Labor, and Health, Education, and Welfare, and Related Agencies, House of Representatives, Washington, D.C.*

DEAR MR. CHAIRMAN: I would like to voice my opposition to the sharp cut in funds proposed for the budget of the tuberculosis program, particularly the decrease in grant-in-aid funds for New Jersey.

In my district in Hudson County, there is a very serious tuberculosis problem. Although the rate of decline in tuberculosis deaths has been greater in the past decade than in earlier years, newly reported active cases have not declined as rapidly as deaths. As a matter of fact, Jersey City, which is in my district, ranks third in New Jersey for new active cases with rates well above the national average.

Because of the imperative need to bring tuberculosis under control, I again respectfully urge your favorable consideration of restoring this appropriation to the budget without any decrease in grant-in-aid funds.

I have received many letters from my constituents on this matter, among them a letter from Mr. Henry Abramson, chairman of the Hudson County Tuberculosis & Health League, in which he points out the significant need for this program to be continued.

I would very much appreciate if Mr. Abramson's letter would be made part of the record of these hearings, and I am enclosing it herewith.

With my thanks and best wishes.

Sincerely,

CORNELIUS E. GALLAGHER,
*Member of Congress.*

BAYONNE, N.J., *February 15, 1960.*

Hon. CORNELIUS E. GALLAGHER,
*House of Representatives, Washington, D.C.*

DEAR NEIL: I am greatly concerned about the sharp cut in funds proposed for the next fiscal year in the budget of the tuberculosis program of the Public Health Service, particularly the decrease in grant-in-aid funds for New Jersey.

New Jersey and Hudson County have a real tuberculosis problem. In Hudson County, Hoboken and Jersey City rank second and third respectively in New Jersey for new active cases reported last year with rates well above the national average. In a metropolitan area such as ours, we have a changing, unpredictable population which makes our TB problem greater. I do not believe this is the time to curtail our tuberculosis programs, since we are not showing any marked decrease in newly reported active cases of tuberculosis.

The Tuberculosis League and the local health departments, in cooperation with the State health department are carrying out plans to discover unknown cases. A special meeting of all health officers and other persons interested in tuberculosis control in Hudson County will be held on February 17 to discuss the problem of 152 active tuberculosis cases not in the hospital. A cut in the grant-in-aid funds would seriously hamper our tuberculosis control programs.

I urge you to express my thinking to the members of the House Appropriations Subcommittee. If you wish any further information, I should be very glad to send it to you.

Sincerely yours,

HENRY ABRAMSON,
*Chairman, Hudson County Tuberculosis and Health League Christmas Seals, 1959.*

---

HOUSE OF REPRESENTATIVES,
*Washington, D.C., February 19, 1960.*

Hon. JOHN E. FOGARTY,
*Chairman, Subcommittee on Departments of Labor, and Health, Education, and Welfare Appropriations, House Appropriations Committee.*

DEAR MR. FOGARTY: I am pleased to submit to you the enclosed letter from the Lynn Tuberculosis League, Lynn, Mass., in support of the full appropriation for the Federal tuberculosis program for 1961 of the amount of $4 million.

I will appreciate it if you will incorporate the letter as part of the record when the matter is considered.

With kind regards, I remain,

Sincerely yours,

THOMAS J. LANE.

LYNN TUBERCULOSIS LEAGUE, INC.,
*Lynn, Mass., February 17, 1960.*

Hon. THOMAS J. LANE,
*House Office Building, Washington, D.C.*

DEAR CONGRESSMAN LANE: We note with concern the request by our Federal administration for a considerable decrease in the appropriation for tuberculosis control for the fiscal year 1961.

According to our information the administration request compared to the 1960 fiscal year is as follows:

| | *Appropriation, 1960* | *Requested, 1961* |
|---|---|---|
| Grants to States | $4,000,000 | $3,000,000 |
| Direct operations | 2,452,000 | 2,430,000 |
| Total | 6,452,000 | 5,430,000 |

The major decrease noted above is in grants to States. If the grants are not restored this year Massachusetts will lose about $26,700 in a possible reduction from $98,000 to $71,900. Grant funds, as you know, are used principally to strengthen case-finding programs. If this reduction in appropriations is allowed to stand it is not expected that the State and local health departments would take over the reduction.

We appreciate the fact that the number of new, active cases of tuberculosis found each year shows some decrease. Unfortunately, however, it is well to consider that approximately two-thirds of the new cases found are in the advanced stages of TB—indicative that our case-finding programs need to be maintained in full strength if we are to detect TB early to break the chain of infection. The full control of TB will not come with decreased appropriations. The control of TB is not specifically or generally a local problem. Leadership and support must come from our Federal administration.

We sincerely hope that the appropriation request for 1961 will not be reduced so that an all-out effort against TB can continue to wipe out this disease.

We hope that your views and ours will be presented to the proper Federal appropriations subcommittee to see that a full appropriation for the Federal tuberculosis program for 1961 is restored.

May we count on your help?

Yours sincerely,

ROBERT E. WEBBER, *President.*

---

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C., February 24, 1960.*

COMMITTEE ON APPROPRIATIONS,
*House of Representatives, Washington, D.C.*

GENTLEMEN: Enclosed is a copy of a letter from Mr. C. V. O. Hughes and a copy of my reply to him.

I am forwarding this to you so that you might consider the situation as explained in Mr. Hughes' letter. Your attention to the views in this letter will be appreciated.

With kindest regards, I am,

Sincerely,

CHARLES E. BENNETT,
*Member of Congress.*

TUBERCULOSIS & HEALTH ASSOCIATION OF POLK COUNTY, INC.,
*Bartow, Fla., February 22, 1960.*

Re proposed budget decrease 1961, tuberculosis control funds, U.S. Public Health Service.

Hon. CHARLES E. BENNETT,
*House of Representatives,*
*House Office Building, Washington, D.C.*

MY DEAR MR. BENNETT: We have been advised that the budgt presented to Congress by President Eisenhower on January 18 includes a request for $5,430,000 for the support of the tuberculosis control program for the fiscal year July 1, 1960, to June 30, 1961. This is a decrease of $1 million to be realized by requesting a smaller amount ($1 million) for grants to States. The appropriation for grants to States in 1960 was $4 million; the amount proposed for 1961 is $3 million.

The National Tuberculosis Association's Committee on Cooperation with Federal Agencies has conferred and concluded that $4 million, if TB control activities in State and local health departments are not to suffer, is needed for grants to States in the 1961 budget.

The board of directors of the Tuberculosis & Health Association of Polk County urgently requests that you get in contact with the House Appropriations Subcommittee and forward to them our conviction that the amount which should be allocated for tuberculosis control should be $6,430,000 (of which $4 million should be available to States) based on the study and recommendations of our national committee. Mr. Julian Sipple, chairman of the committee, has initiated correspondence with the House Appropriations Subcommittee. It is our hope that you will urge this committee to carefully consider the NTA's views on this matter and that the final appropriation for tuberculosis control be $6,430,000.

Thank you very much for your attention to this matter and my personal best wishes to you.

Sincerely,

C. V. O. HUGHES, *President.*

---

U.S. SENATE,
*Washington, D.C., February 17, 1960.*

HON. JOHN E. FOGARTY,
*Chairman, Subcommittee on Labor and HEW, House Appropriations Committee, House Office Building, Washington, D.C.*

DEAR MR. CHAIRMAN: I am enclosing a letter from a constituent, Mr. John R. Papp, Jr., president of the Middlesex County Tuberculosis & Health League, at his request. It has already been acknowledged.

Sincerely,

CLIFFORD P. CASE, *U.S. Senator.*

MIDDLESEX COUNTY TURERCULOSIS & HEALTH LEAGUE,
*New Brunswick, N.J., February 8, 1960.*

HON. CLIFFORD P. CASE,
*U.S. Senate, Washington, D.C.*

DEAR SENATOR CASE: I am writing this letter in behalf of the Middlesex County Tuberculosis & Health League which is an affiliate of the National Tuberculosis Association.

We are deeply concerned that the appropriation for the tuberculosis program of the Public Health Service has been reduced for 1961, and we hope you will do everything possible to try to get the $4 million which is the minimum needed in Federal grants to States for tuberculosis control. Any attempt to reduce the amount at this time would be exceedingly grave now that we are concentrating our efforts in a final onslaught to eradicate tuberculosis as a public health problem.

We would be very grateful to you if you would convey our thinking to the members of the HouseAppropriation Subcommittee.

Very sincerely yours,

JOHN PAPP, Jr., *President.*

---

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C., February 18, 1960.*

CONGRESSMAN JOHN E. FOGARTY,
*House Committee on Appropriations,*
*House Office Building, Washington, D.C.*

DEAR COLLEAGUE: I have received a letter from Dr. Bruce W. Johnson, president, Adams County Tuberculosis Association, located in Quincy, Ill., in the 20th District which I represent, explaining the necessity of a State tuberculosis grant of not less than $4 million to be appropriated for the current fiscal year. Dr. Johnson states that an appropriation less than this amount will handicap the progress in tuberculosis control.

Thanking you for your consideration of this matter, I am,

Sincerely yours,

MRS. SID SIMPSON, *Member of Congress.*

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C., February 17, 1960.*

HOUSE APPROPRIATIONS COMMITTEE,
*Subcommittee on Department of Labor, Health, Education and Welfare and Related Agencies, the Capitol, Washington, D.C.*

GENTLEMEN: Enclosed is letter to me from Mr. Ben Duke, president of Colquitt County Tuberculosis Association, in behalf of $4 million for distribution to the States for the tuberculosis program of the Public Health Service.

You will note their view that $3 million for this program is inadequate.

With best wishes, I am,

Sincerely yours,

J. L. PILCHER, *Member of Congress.*

COLQUITT COUNTY TUBERCULOSIS ASSOCIATION,
*Moultrie, Ga., February 15, 1960.*

Hon. J. L. PILCHER,
*House of Representatives,*
*Washington, D.C.*

DEAR SIR: Relative to Federal appropriations for tuberculosis control in President Eisenhower's budget presented to Congress on January 8 of this year, we want to ask that you express our view to the five Congressmen who comprise the House of Representatives Appropriations Subcommittee.

It is the belief of those familiar with the tuberculosis program of the Public Health Service that $3 million for distribution to the States is inadequate and that this should be at least $4 million.

As you know, tuberculosis is still very much with us and there is a great need for this money in our State to promote education, patient service, and the other things needed to control tuberculosis.

Sincerely yours,

BEN DUKE, *President.*

---

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C., February 17, 1960.*

Hon. JOHN E. FOGARTY,
*Chairman, Labor-HEW Subcommittee,*
*House Appropriations Committee,*
*Washington, D.C.*

DEAR MR. CHAIRMAN: At the request of the Grant County Tuberculous & Health Association of my district, I am forwarding herewith a statement which they ask to have included in the record of the hearings of your subcommittee considering the budget of the Public Health Service.

Sincerely yours,

AL ULLMAN, *Member of Congress.*

GRANT COUNTY TUBERCULOUS & HEALTH ASSOCIATION,
*Canyon City, Oreg., February 11, 1960.*

Mr. AL ULLMAN,
*U.S. Representative, House of Representatives,*
*Washington, D.C.*

DEAR MR. ULLMAN: Affiliated asosciations of the Oregon Tuberculosis & Health Association are being asked to urge that there be no cut in funds for the fiscal year July 1, 1960, to June 30, 1961. The decrease in allocation for Oregon would be $6,900 if the amount for grants is not sustained at its present level. Dr. R. R. Wilcox, State health officer, and Dr. Ambrose S. Churchill, director of the tuberculosis control section of the Oregon State Board of Health, indicate that this reduction would have a detrimental effect on the tuberculosis control program in this State. Here in Grant County we had an increase of 2 tubercular cases during the last year, and about 27 contacts of those cases. TB is not as yet whipped, as many seem to think.

We urge you to present this letter to the members of the House Appropriations Subcommittee if you will be so kind.

Thank you very much.

Very sincerely,

MRS. E. P. TRUESDELL, *President.*

THURSDAY, MARCH 4, 1960.

ALLERGIES AND INFECTIOUS DISEASE ACTIVITIES

WITNESS

DR. WILLIAM B. SHERMAN, ASSOCIATE CLINICAL PROFESSOR, COLUMBIA UNIVERSITY

Mr. FOGARTY. And now we have before us Dr. William B. Sherman of Columbia University.

Dr. Sherman, this is your first appearance before the committee. You may identify yourself.

Dr. SHERMAN. I am Dr. William B. Sherman. I am a practicing physician in New York City, particularly interested in allergic diseases. I do some teaching. I am an associate clinical professor of medicine at Columbia University and do some research in the field of allergic diseases.

I am a member of the National Advisory Allergy and Infectious Diseases Council.

Mr. FOGARTY. Do you think that that institute is doing a pretty good job?

Dr. SHERMAN. I think that they are doing an excellent job. We are quite proud of them.

Mr. Chairman, in any examination of research and training needs in the fields of allergy and the infectious diseases, one must keep in mind two cardinal points. First, we are dealing with the basic disciplines which supply investigators, not merely for research on allergic and microbial disease, but for studies in all branches of medical research. Second, we are dealing with a group of diseases representing by far the most prevalent illnesses of man.

As an allergist practicing in a field of medicine which suffers acutely from a shortage of trained investigators, I am continually reminded of the above observations. I know only too well how meager is our basic understanding of allergy and how often we fail in bringing substantial relief to the many millions of our people who suffer from allergies in one form or another. We fail because there are too few of us to treat the many who require our attention.

To overcome this deficit, we need greatly increased numbers of allergists, of course. We also need better teaching of allergy to all medical students so that practicing physicians in general will be more aware of allergy as a major medical problem. But most of all, we urgently need a continuing supply of highly trained young investigators to take advantage of opportunities for critical study—opportunities which have been opened up by the development of new tools and techniques in recent years.

To find these investigators and to provide the climate necessary for fruitful study, we must greatly improve the quality of training in our teaching institutions. An encouraging start has been made in this direction. If continued and augmented, this effort will do much to erase the accumulated deficits of the past decade—years in which the training of microbiologists was allowed to languish.

This seems ironic when we stop to consider that many of the most promising areas of medical research today are precisely those in which

research can be successfully prosecuted only with the skills of microbiology. Cancer research is a conspicuous example. Without carefully trained immunologists and virologists, the most exciting leads in the cancer-virus area could not be properly exploited.

The same is true of the broad range of diseases encompassed by allergy. We look to the immunologist and the immunochemist to penetrate the mysteries which surround the mechanisms of the individual cell and how they are altered when an allergic response occurs in the body's tissues and organs.

As an allergist and member of the National Advisory Allergy and Infectious Diseases Council, I am greatly heartened by the progress made in the last 2 or 3 years in encouraging talented young investigators to seek careers in the fields of allergy and basic immunology. As an investigator myself, I am also keenly aware of the strategic importance of a related action recently taken by the Advisory Council. I am referring to the creation of a full-time committee on standardization of allergens.

The immediate objective of this committee is to clear the way for extended studies to devise a practical method for ragweed pollen purification. For years, clinical allergists have been hampered by the fact that allergenic extracts available to them are such crude preparations that it is impossible to substitute one make of ragweed extract for another. Standardization must depend on the content of the active agents, and we frankly do not now know what these are or even how many there are in ragweed pollen. It is our hope that by employing the newer purification techniques, it will be possible to provide investigators with allergenic products which meet rigid norms of potency, purity, and specificity. This would open the way for a new era in immunological research, where so much remains to be learned before we can devise rational methods for treating allergic disorders.

In my opinion, the 1961 budget presented to Congress covering the activities of the National Institute of Allergy and Infectious Diseases is inadequate to maintain the momentum of the program. This is particularly true of the training grants program, which is of critical importance to medical research in general as well as to future progress against infectious and allergic disease.

The citizens committee believes that a total budget for this Institute amounting to $42,187,000 would represent a sound and prudent investment, one which would eventually pay dividends in the form of better health for all our people.

The increase which we are proposing would enable the Institute to provide $27 million for the support of research grant projects in nongovernmental institutions. While this is about $7 million above current expenditures, it would actually make available about $5 million for program increases. The remaining amount would be required to finance increases for the Gorgas Memorial Laboratory in Panama, to launch the proposed clinical research centers, and to provide for an increase in overhead allowances.

I am happy to note that the National Institutes of Health is again recommending payment of full indirect overhead costs to grantee institutions. I am advised by the dean of my university that this figure for Columbia University is 25 percent rather than the presently allowed 15 percent.

We believe the Institute's training grants program should be increased to a total of $5 million. This would enable the Institute to fund its present backlog of applications for training grants, leaving between $600,000 and $700,000 to apply to new grants in the coming year.

A total expenditure of $1,250,000 is proposed by the citizens committee for the support of research fellowships. This would represent a modest increase of $200,000 over current spending levels. We believe this is a reasonable program increase which will insure continued high quality of research fellows.

For the Institute's direct operations, we should like to recommend funds totaling $8,687,000, an increase of $500,000 over the budget presented to Congress. This would enable the Institute to carry out recommendations made by its Board of Scientific Counselors and by the evaluation team which recently assessed the research program of the Middle America Research Unit. Of this increase, $250,000 would be used to establish a clinical research program in tropical medicine at the Middle America Research Unit in the Canal Zone. In conjunction with this program it will be necessary to provide housing for professional personnel. The sum of $250,000 is recommended for this purpose.

In summary, I would urge the committee to recommend that the Congress safeguard the Nation's investment in medical research by increasing substantially the budget of the National Institute of Allergy and Infectious Diseases.

Mr. FOGARTY. Thank you very much, Doctor. That was a fine statement. Sometimes we have difficulty in getting Members of Congress interested in the program for allergy. It is not like cancer or heart trouble.

Dr. SHERMAN. Oftentimes it is hard to get deans of medical schools interested in allergy as a branch of medical activities.

Mr. FOGARTY. I have often thought that it would do much better if it had a different name.

Dr. SHERMAN. I suppose possibly it would.

Mr. FOGARTY. I think that some of your requests are very modest, but one especially so, and that is in the area of research fellowships. You are only asking for $200,000 in addition to what the President has in his budget. The President's budget this year is the same as last year's, and they told us that the number of applicants have been more than twice the number of available fellowships. I wonder why you are so modest.

Dr. SHERMAN. We have not had so much of a problem there as in the training grants. That is where we would like to see a rather generous increase.

Mr. FOGARTY. There are no new training grants allowed under the present President's budget. That is the area that you would like to see expanded?

Dr. SHERMAN. I think that is the field that is very important right now.

Mr. FOGARTY. Thank you very much.

## Medical Research Programs

### STATEMENT OF NATIONAL HEALTH FEDERATION

Mr. Fogarty. We will place in the record at this point the statement we have received from the National Health Federation.

(The statement referred to follows:)

STATEMENT BY HAROLD EDWARDS, VICE PRESIDENT, NATIONAL HEALTH FEDERATION, WASHINGTON, D.C., RE MEDICAL RESEARCH APPROPRIATIONS, 1960

*To Subcommittee on Health, Education, and Welfare Appropriations, U.S. House of Representatives:*

Thoughtful, informed Americans give only highest acclaim and recognition to the devoted efforts of the committee in behalf of the Nation's health. We wish to thank you for this opportunity of expressing the views of the federation on this important matter.

Events of the past year have shown that the question of American health is a critical one, so it is evident that all the arts and resources of healing must be activated, financed, and expertly directed. Your committee has shown a most commendable willingness to lead the way in the development of the essentials that will lead to the enhancement of our Nation's life and full physical vigor.

The tragic death of Secretary Dulles in May emphasized anew the dire need of new methods, new tools, new thinking applied to the problem of cancer. The exceedingly bountiful increase of $105 million added to the 1960 budget for cancer research indicated the concern of the Congress with that growing problem.

In the same spirit, every member of the society earnestly desires that this great Nation's fading health be given the benefit of the wisest and best brains available in its solution. We are convinced that no nation can long endure, let alone fulfill the obligation to lead, under the threat of physical and mental deterioration with which we seem to be faced. The succeeding intervals of crises with which we have been confronted call for enlightened minds which cannot adequately function in less than bountifully healthy bodies.

In these times of increasing gravity surely no one wants to be guilty of obstructionism if the means to an end of crippling disease is in sight. It is our belief that every deeply loyal and patriotic American desires an end to the serious threat of disabling, disaster bearing illness—both for family and for country. Public response in repeated national health solicitations amply provides that testimony.

However, millions of those cooperative Americans are beginning to ask when the hundreds of millions of dollars expended in medical research will begin to cut back the fearful toll and burdensome expense of medical bills. A look at the record shows the adult population of this country to be in more imminent danger from serious degenerative disease today than at any time in the past. It indicates that only the infant population has benefited in the mortality column. But the mortality column does not begin to show the true condition of American health. The threat to our continued existence and our place in the family of nations lies more realistically in the mushrooming areas of degenerative disease.

Recently a most impressive and obviously expensive survey was mailed to every Member of Congress. It has probably the most comprehensive statistical study of the disease question ever compiled. It demonstrates what unlimited technical skill and funds can be made available by private interests with a stake in increased medical research. Since official governmental and professional sources of information were used in the compiling there is no question of reliability in the data produced.

It is our belief a most salutary contribution to public health consciousness could be made were those facts and figures to be made available to the American public in a condensed, easily understood form. Because of this conviction we

are going to draw upon those data and combine them with health statistical testimony given at the food additives hearings in 1958. They are as follows:

| | |
|---|---|
| Allergic diseases | 20,000,000 |
| All other diseases of the nervous system | 16,000,000 |
| Glaucoma | 1,000,000 |
| Psychosis and psychoneurosis | 16,000,000 |
| Mental deficiency | 3,000,000 |
| Arteriosclerosis and heart disease | 10,000,000 |
| Arthritis | 11,000,000 |
| Epilepsy | 1,500,000 |
| Diabetes | 2,000,000 |
| Vascular lesions | 1,000,000 |
| Malignancy | 700,000 |
| Tuberculosis | 400,000 |
| Multiple sclerosis | 250,000 |
| Other congenital deformities | 150,000 |
| Acute poliomyelitis | 68,000 |
| Ulcers of stomach and duodenum | 8,460,000 |
| Nephrosis | 534 |
| Muscular dystrophy | 100,000 |
| Subtotal | 91,959,534 |
| Plus alcoholism | 4,000,000 |
| Plus obesity | 32,000,000 |
| Total | 127,959,534 |

Budgeted proposals for 1961 show that Federal tax funds for medical research in the U.S. Public Health Service Division have soared from $52 million in 1950 to $400 million in 1960. If these figures are combined with other medical research funds from Federal sources the total is somewhere in the area of $500 million. These enormous sums have long since begun to register on the public awareness.

Serious questions were asked in many quarters last year when the proposed figures were abruptly advanced for cancer research to the extent of $281 million. The Dulles and the Arthur Godfrey cancer misfortunes were pointed out as examples that pleaded for stepped up cancer programs.

To anyone who has made an objective study of related factors it is quite impossible to see how such staggering sums can be used effectively to the real benefit of the cancer threatened taxpayer. The application of unlimited research funds to the unfortunate problem of cancer cannot be the sole answer anymore than it has been with the other disease categories shown in the above figures. Rapidly stepped up research appropriations since 1950 have not stayed a correspondingly rapid rise in health statistics.

We believe the time has come when the question must be asked "where are the results?" There is altogether too much at stake here both in the public health and the colossal expenditure of Federal tax money for medical research. It is also our belief there is an increasing responsibility on the Congress to erase the vagueness in this matter as related to actual accomplishment.

Privately financed sources have spent princely sums to convince Congress of the need for increased expenditures in medical research projects. In justice it would appear to us as encumbent on the Congress to insist that the health agencies compile some sort of factual brochure supported by compilation of results that will be understandable to any average taxpayer.

To this should be appended a forecast of future needs and future expectations that will lead to a moderate decrease yearly, if not complete eradication of such ailments as heart disease and cancer. This is no more than the logical and reasonable future that every generous American has been led to expect.

WITNESS

HON. JOHN A. BLATNIK, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MINNESOTA

Mr. FOGARTY. We will now be happy to hear from Congressman Blatnik concerning water pollution control, a field in which he is looked to for leadership by all of us who are really interested in doing something about this problem.

Please proceed Mr. Blatnik.

Mr. BLATNIK. Mr. Chairman, I certainly appreciate this opportunity to appear here today and testify in behalf of appropriations for the construction grant program under the Federal Water Pollution Act. I want to commend you, Mr. Chairman, and the members of your subcommittee for the sincere interest you have taken in this program and the fine support you have lent to it. Without your support the great accomplishments made as a result of this program would not have been realized.

The fact that there have been great accomplishments in the field of waste treatment plant construction since the initiation of Federal grants is a matter of record. During the 5-year period from 1952 through 1956 immediately preceding the Federal grants program, contract awards for sewage-treatment works construction averaged $222 million annually. In the first full year of the program, 1957, construction expanded 58 percent over the previous annual average to reach $351 million—an increase of 58 percent. The second year of the program brought an even greater increase in construction, with contract awards reaching $389 million—75 percent over the earlier 5-year average. Although construction totals for 1959 are not expected to reach the 1958 level due to the steel strike and a general cutback in public works construction still the total will far exceed the previous 5-year average and equal approximately the 1957 level.

This is a solid record of achievement, Mr. Chairman. To minimize it, opponents of the program argue that it is unfair of us to use the 1952–56 average and compare it to the level of construction since that time. They argue that the Korean war cut down on construction during that time. Mr. Chairman, I invite anyone who wishes to do so to take any 5-year average period in all our history and compare the construction of sewage-treatment plants during that time to the construction record of the past 3 years. The only time we have come close to the present level of construction was during the depression days when, as now, Federal funds were available to assist communities in the construction of sewage-treatment plants.

As you know, Mr. Chairman, our attempt to increase the authorization for this program from $50 million to $90 million a year was vetoed by the President and our attempt to override that veto failed. Interestingly enough the opponents of that bill, who also opposed the existing program, argue that "the defeat of the measure obviously does not mean an end to antipollution programs." How do they reach this obvious conclusion? They point out that "at present, the Federal Government plans to spend some $50 million a year through 1966 to assist States to clean up the wastes which poison rivers and streams."

These arguments, Mr. Chairman, are being used to justify the veto of H.R. 3610 and are being distributed to candidates who voted against the bill and who voted to sustain the President's veto in the form of confidential background material. Nowhere is it pointed out that as a matter of fact the President has requested only $20 million for this construction grant program and has actually advocated its outright repeal. Pending before this committee is a request not for the authorized $50 million for fiscal 1961 but only $20 million.

I urge you, Mr. Chairman, to ignore the President's request and appropriate the fully authorized amount of $50 million.

Mr. FOGARTY. Thank you very much. I hope we can do what you request.

## VOCATIONAL REHABILITATION AND CONTROL OF TUBERCULOSIS

### WITNESS

### HON. J. W. TRIMBLE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARKANSAS

Mr. FOGARTY. Judge Trimble, I understand you have two of your usual concise and to-the-point statements. We will be pleased to hear them.

### CONTROL OF TUBERCULOSIS

Mr. TRIMBLE. Mr. Chairman and members of the committee, it is my understanding the President requested about $1 million less for the tuberculosis program of the Public Health Service than was provided last year.

It is my information this disease is far from being conquered. It is a highly communicable disease and a person may have it for months before he knows it. In my State in 1958 there were 205 persons who died from tuberculosis and there were 1,045 new cases discovered.

Great strides have been made in controlling this killer, but this is no time to relax in our fight against it. It is my urgent plea that the committee give every consideration to providing at least as much for the tuberculosis program as was made available for the current year. To reduce expenditures on an item like this is to risk the health of our Nation for generations yet to come.

Mr. FOGARTY. Go right ahead with your other statement, Judge.

### VOCATIONAL REHABILITATION

Mr. TRIMBLE. Thank you, Mr. Chairman.

The Nation's vocational rehabilitation programs have been of inestimable value in restoring the usefulness of many of our handicapped people. The various States work with the Federal Government on this problem as they do in so many of the areas that are vital to our well-being.

If my information is correct the budget request for vocational rehabilitation called for an allocation base of $63 million and an appropriation of $53 million for fiscal 1961. If these figures are approved there will be approximately $4 million spent by the States whch will be over and above the amount required to match Federal funds.

If the needs in some of the States are urgent and those States are spending $4 million of their money without any Federal matching funds it seems to me the Federal Government should be willing to shoulder some additional responsibility.

It is my recommendation to the committee that an allocation base of $70 million and an appropriation of $54.7 million be provided for vocational rehabilitation. Even with this the States will be spending near $3 million which will be unmatched by Federal funds.

I think we should make every possible effort to help restore usefulness to our handicapped people. I shall be grateful for every consideration the committee can give this request.

Mr. FOGARTY. Thank you for two good statements.

## VOCATIONAL EDUCATION

### WITNESS

### HON. CLIFFORD G. McINTIRE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MAINE

Mr. FOGARTY. We will now hear from Congressman McIntire regarding the very important program of vocational education.

Mr. MCINTIRE. Mr. Chairman, it is disturbing to observe that there is a budetary recommendation for what is essentially a $2 million cut in vocational education funds for fiscal 1961. This develops because although the budget has recommended an increase of $8,675 in Smith-Hughes funds, it has, on the other hand, suggested a $2 million reduction in George-Barden expenditures.

This recommended cut in George-Barden funds would have a decidedly negative effect on several vocational education functions in my State of Maine.

It would, for instance, result in a reduction of funds for vocational education in the fishery trades and industry, including distributive occupations therein. Because the State of Maine's eastern shoreline is exposed to the waters of the Atlantic Ocean, the fishing industry has proved a natural enterprise for the State. Such an industry is, however, one that demands the services of properly trained and highly competent personnel, and without these the industry can never operate at high levels of productive efficiency. Vocational education in this area, then, is important to the State of Maine, for only through this type of training program can the fishing industry hope to be so constituted as to make a dynamic contribution to the State's economy.

Mr. Chairman, the State of Maine has exercised initiative in advancing programs of fishery training. The State university has, for instance, already incorporated fish and wildlife courses into its programs of study. In addition, the State of Maine Legislature has been giving serious consideration to the establishment of a school for vocational training in fishing, hoping that sometime in the future such an institution can be located in one of the communities along Maine's coastline.

The practical nurse training program, too, would suffer under the cuts recommended in the budget. This is unfortunate, for here is a program that operates to accommodate the very real need that exists today for nursing skills. This type of training has proved particu-

larly helpful to those States, like Maine, that are made up of many small communities scattered over vast State areas. It does not seem in tune with justice to deprive these small communities of the full measure of benefit they could derive from an amply implemented practical nurse training program.

Many State universities have included nurse training courses in their curriculums, and the University of Maine is one of these. This is a step forward in closing the gap that exists today between the available supply of and demand for nursing skills, and the Federal Government's interest should be directed toward narrowing rather than widening this gap.

Without going into greater detail, I would like to remind this committee that budget cuts have also been recommended for vocational training in agriculture, distributive occupations, home economics, and trades and industry.

Mr. Chairman, ours is an expanding economy—one that is developing along highly specialized lines—and the curbing of vocational training is not consistent with this great growth.

If our commercial complex is to operate and expand in accord with the standards of maximum efficiency, it will have to do so on a base of competent personnel that is properly trained and adequately skilled.

There is also a humanitarian consideration involved in all of this, for in this highly technical age, any individual without some form of specialized training is apt to find himself hard pressed to gain employment and to maintain a position of dignity in the high-standard society in which he lives.

In short, then, vocational education is an important citizen service, acting to fill in the training gap that would otherwise exist between the high school and college levels. And, in a like manner, it is also a society service, for an application of these acquired skills to any community complex can have no other effect than to make for dynamics in social existence and productivity.

Because the benefits to be derived from vocational education are many, it would behoove us to give this training program our unstinted support. The first step in this direction is to restore those cuts recommended by the budget, being mindful that funds used to promote an efficient operation of the vocational education program represent not an expense but an investment.

Mr. Chairman, I deeply appreciate having this opportunity of presenting my statement for the examination of the members of this committee.

Mr. Fogarty. Thank you, Congressman. I think this committee will do something to correct that $2 million cut.

## Hospital Construction and Social Security Research and Training Grants

### WITNESS

### HON. BYRON L. JOHNSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Mr. Fogarty. We will now be happy to hear from Congressman Johnson, of Colorado.

Mr. JOHNSON. Thank you, Mr. Chairman. I have two subjects which I consider quite important that I would like to talk to the committee about.

Mr. FOGARTY. You may proceed in any way you wish.

### HOSPITAL CONSTRUCTION

Mr. JOHNSON. It is my conviction, backed by communications from towns in my district, that the President's budget request of $1,26,200,-000 for hospital construction is too low, and that only by appropriating the maximum amount possible under law—$211 million—can we make it possible for local communities to solve some of their medical problems. It is incredible that a nation which prides itself on putting the welfare of the individual on the highest level could overlook the obvious needs and demands of this program. There is a great and compelling need for hospitals and other health facilities in every corner of the Nation. A huge gap exists between the available facilities and those which are actually needed to take care of our rapidly increasing population.

Many hospitals and hospital beds are becoming obsolescent. Our States and local communities are not only ready to go forward and put up their part of the funds for the building of these new hospitals and health facilities; they are also ready to do far more than the President's recommendation would permit.

In the name of ordinary common sense, then, I request the full amount of $211 million, which is still ridiculously small when viewed in the light of the enormous need across the country for increased and improved hospital facilities.

### RESEARCH AND TRAINING IN SOCIAL SECURITY

And now, Mr. Chairman, I wish to address myself to two other items which are encompassed in this comprehensive appropriation bill. I refer to the administration's request for $700,000 for cooperative research in the field of public welfare and $1 million for the training of public welfare personnel, the approval of which I hope will redound to the everlasting credit of the 86th Congress. I was, I must acknowledge, profoundly disappointed that the Congress failed to include these sums in the appropriation for 1960.

The various units of government—Federal, State, and local—are now spending some $3 billion on public assistance every year. Much of this is dispensed through staff members who are not adequately trained to give the help to the recipients that they need; they are not able to help rehabilitate and restore these persons to self-sufficiency; yet, surely, it is the intent of Congress that they be so helped. Instead, the staff helps to process the applications month after month and year after year without the professional help and counseling that the recipients need.

From my own experience in years past in this field, I know that these training programs do help make the staff members more efficient. They more than pay for themselves in improved service and in lower costs, and certainly our public assistance programs are in great need of reexamination. If, through cooperative research and study, the

program can be improved, the taxpayers as well as the recipients will be benefited.

Actually, the amount here requested is but a fraction of the amount originally authorized in the 1956 amendments to the Social Security Act, which envisaged $5 million for cooperative research and another $5 million for training of welfare personnel.

Measured against the current Federal and State expenditures for public assistance alone, which, as I mentioned earlier, run to $3 billion a year, the amount here requested represents 0.05 percent, which to my mind constitutes an extremely modest proposal.

Of these funds $700,000 is to be used for financing projects of local welfare departments, voluntary agencies, and universities designed to provide the administrators of these public assistance programs with evaluation of methods for preventing and reducing dependency, for improving the coordination between public and private welfare agencies and for demonstrating ways and means of improving the administration and effectiveness of public assistance programs. These cooperative research funds would make it possible for a number of important questions to be examined and some methods developed for testing how people can be more effectively and significantly served in our public welfare programs.

Surely it is incumbent upon a government which spends billions of dollars for public assistance, to invest this relatively small amount in order to ascertain, with the aid of qualified agencies and universities, how our public assistance program can better fulfill its humanitarian purpose by more effectively serving these millions of dependent individuals.

Research needs to be conducted as well on ways and means of reducing administrative costs in public assistance through study and examination of procedures that will provide assistance and services as efficiently as possible without, however, any violation of human dignity. Fortunately, the costs of public assistance are beginning to level off as the old-age and survivors and disability insurance program has broadening impact. This is, therefore, both the time and occasion to develop methods for significant help to the lowest income group in the country—the sick aged, the disabled and handicapped, and children who are not protected by survivors' benefits. This investment of $700,000 could be one of the wisest appropriations the Congress can make.

An appropriate and necessary parallel program to cooperative research is one for training of the employees of public welfare agencies who are called upon to administer grants and services to that section of our population with the highest complex of problems—social, economic, and psychological. Whether in teaching the young or serving the sick, there is no substitute for qualified professional personnel in the area of services to people. For a variety of reasons, including of course salary levels, recruitment of public welfare personnel is confined largely to residents of a particular State. Many of these public welfare staff members who have had no professional preparation for their jobs have a strong desire to be more helpful to the people they serve, and would like to prepare themselves through inservice training and graduate training to fulfill that desire. The $1 million requested here would make it possible for something like 350 of these in-

dividuals throughout the country to secure some degree of training, ranging all the way to full graduate training in a school of social work. There are about 29,000 caseworkers handling grants to the needy, of whom only 20 percent have had graduate training. There may well be at least 1,000 individuals who are prepared now to take advantage of proposals for further preparation to perform their jobs more effectively.

It must be recognized that until more skilled professional personnel are made available for the administration of grants and services in our public welfare program, the public assistance rolls will continue in many parts of the country to be analogous to a community equivalent to the back wards of our mental institutions. The mental health field has made significant progress in this direction by demonstrating that one of the key factors in preventing a chonic and nonreversible condition is sufficient and well-qualified personnel.

Modest as this request is for cooperative research and training of public welfare personnel, it can, in the course of time, make a significant contribution to the reduction of the cost of public assistance to the Federal Government and, of course, to the States.

I respectfully urge that the committee give favorable consideration to this very modest appropriation of Federal funds for so worthwhile a purpose and program.

Mr. Fogarty. Thank you, Congressman, for a fine statement. As you know, I agree with you on these things.

## Assistance to Schools in Federally Impacted Areas

### WITNESS

### HON. WILLIAM J. RANDALL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

Mr. Fogarty. We are pleased to have now before the committee, Congressman Randall. Please proceed, Congressman.

Mr. Randall. Mr. Chairman, I appreciate the privilege you have given me to make a few observations in support of a full appropriation of Public Law 874.

I must say to you that I did not fully appreciate the importance of this measure until the 1960 deficiency bill, H.R. 10743, came up for consideration on February 29, 1960. Over the weekend preceding consideration of this bill, I made a careful study of the report of the Commissioner of Education which dealt with the administration of Public Laws 874 and 815. It was then that I discovered that in the Fourth Missouri District, approximately 35 school districts were recipients of aid under the provisions of Public Law 874. In the flood of telegrams which reached my office, I discovered that one of the principal complaints, which I respectfully submit to the members of this subcommittee is a valid complaint, is that there is a formula of entitlement set up in the framework of the bill. Now it appears that each of these school districts is affected by Federal activities. They apply this formula and make an effort to anticipate the moneys which, according to the formula, can be expected. Accordingly, they include this assistance from the Federal Government as an integral part of their school budget. They come to rely upon it because the formula

has been provided for in advance and it is just a matter of computing what they think will be their total entitlement.

I feel sure you can see the effect that an insufficient appropriation beneath the amount called for in the formula of entitlement would have upon each of these districts. Of course, they do not spend the money until they receive it, but on the expectation that the amount received will be somewhere near the amounts they expected to receive.

For your consideration, I submit that if there is much of a departure from the appropriation for the provisions of entitlement as set up under Public Law 874, it will certainly work a hardship on these districts which are laboring under a problem—not of their own creation or making—but one which has been fully covered by an action of the Federal Government.

I respectfully urge the members of this subcommittee to provide sufficient funds to advance the anticipated entitlement and if in the application of the formula the districts cannot comply, they, of course, will not receive the money. But in those circumstances where they do comply and the Congress has failed to make an adequate appropriation, we have in reality denied the benefits that we had previously granted under provisions of this law.

Mr. Fogarty. Thank you for a good statement.

Mr. Randall. Thank you, Mr. Chairman and members of the committee.

## Library Service Program

### WITNESS

### HON. JOHN BRADEMAS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA

Mr. Fogarty. The next witness is Congressman Brademas of Indiana. Congressman Denton had to leave for another important meeting but asked that you be given full opportunity to say whatever you wanted to because you have a matter to discuss that is of vital importance to his and your State of Indiana.

Mr. Brademas. Mr. Chairman, I deeply appreciate the opportunity to appear before the distinguished members of this subcommittee today to urge that the full amount of $7.5 million authorized under the Library Services Act of 1956 be appropriated for the fiscal year 1961 rather than the $7.3 million recommended in the President's budget.

As the only Indiana member of the Education and Labor Committee, within whose jurisdiction this legislation comes, I wish not only to express the hope that your committee will approve the full $7.5 million figure, but I want also to take this occasion to voice the strong support of Members of the Indiana delegation in Congress for the participation of our State in the rural library program.

Due to the irresponsible and shortsighted attitude of our Republican Governor, Harold W. Handley, the State of Indiana has refused to accept Federal funds under this act.

Mr. Chairman, the astonishing fact is that Indiana is the only one of the 50 States and 3 territories not participating in this fine program.

It is my understanding that a total of $193,574 is available to Indiana for fiscal 1960 for rural library services and that, if Indiana should now decide to participate during fiscal 1961, the 1960 allot-

ment would still be available to our State under the carryover provision in the act.

Governor Handley's opposition to Indiana's taking part in the rural library services program can only be described as an irresponsible giveaway of the money of Hoosier taxpayers to the other 49 States.

But, Mr. Chairman, I am glad to say that Indiana is beginning to return to the Union. It gives me great pleasure to be able to report to you that our distinguished junior Senator, the Honorable Vance Hartke, and seven Democratic Representatives in Congress from Indiana have advised me of their strong support of Indiana's participation.

I should like to include their letters at this point in the record.

Not only do an overwhelming majority of Indiana's delegation in Congress agree that our State should not turn its back on the rural library program, but I am also pleased to be able to tell the members of this subcommittee that I have personally talked by telephone with all four of the announced candidates for the Democratic nomination for Governor of Indiana in the November 1960 elections and that each of them has assured me that, if he is elected Governor, he would favor Indiana's participation in the benefits provided by this program. I have, moreover, been told by the Honorable Birch Bayh, Jr., of Bloomington, speaker of the Indiana General Assembly, of his support of the program for our State.

The four gubernatorial candidates to whom I have referred are: State Senator Nelson Grills, of Indianapolis; State Auditor Albert Steinwedel, of Seymour; Secretary of State John R. Walsh, of Anderson; and State Senator Matthew E. Welsh, of Vincennes.

I should like to request that their communications to me on this matter be included in the record at this point.

Mr. Chairman, I should also like to have included in the record the following letter from Mr. Roger B. Francis, director of the public library of South Bend; a telegram from Leon I. Jones, director of the public library of Muncie, and a letter from Miss Maxine Batman, director of the public library of Vincennes.

Because of the strong support for Indiana's participation in the Library Services Act program, Mr. Chairman, I hope very much that your subcommittee will see fit to approve the full $7.5 million appropriation for fiscal 1961.

Mr. FOGARTY. We will place all of the letters you referred to in the record.

(The letters referred to follow:)

U.S. SENATE,
COMMITTEE ON FINANCE,
*March 1, 1960.*

Hon. JOHN BRADEMAS,
*House of Representatives, Washington, D.C.*

DEAR JOHN: I know you are going to testify before the Subcommittee on Health, Education, and Welfare of the House Appropriations Committee with regard to the Federal-State rural library program.

It has been a source of consternation to me for some time that our State is the only one which does not participate in this worthwhile program. Of some $7.5 million appropriated by Congress to be shared by 50 States and 3 territories, only Indiana's $193,574 remains unused.

It is for this reason that the President's budget for fiscal 1961 has recommended a reduction of $200,000 in the $7.5 million authorized per year in the

5-year program. Your appearance before the committee will be to ask restoration of that amount in the hope that Indiana will become a full participant in the program during the coming fiscal year.

There certainly is a need for this sort of service in Indiana. A survey made in 1955–56 showed 800,000 Hoosiers without library service and another 1 million with inadequate library service. Thus, it cannot be argued that the State is doing the job without Federal assistance. When the Library Act was passed, it was designed to encourage the States to provide library services in areas which were largely without them.

I wholeheartedly endorse the rural library program. I urge the committee to approve the full $7.5 million for complete operation of it in all 50 States and 3 territories. I do so in the anticipation that the next State administration in Indiana will participate, allowing our State to draw the funds which it would have had in fiscal 1960 and its full share for fiscal 1961.

I commend you personally for your efforts on behalf of this worthwhile program.

Sincerely,

VANCE HARTKE, *U.S. Senator.*

---

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C., March 4, 1960.*

Hon. CLARENCE CANNON,
*Chairman, Appropriations Committee,*
*House of Representatives.*

DEAR MR. CHAIRMAN: I wish to join with other of my colleagues from Indiana in urging the Appropriations Committee to report favorably on the $7,500,000 requested toward carrying out the provisions of the Library Services Act.

Several sessions ago I sponsored this legislation, but on a rollcall vote in the House it failed by but a few votes. Since that time the American public has become more familiar with the outstanding work and services that this program extends to the people, especially in suburban and rural areas. It is, in fact, a necessary program which will greatly aid in the education and intellectual advancement of the people in all walks of life throughout our country.

Sincerely yours,

RAY J. MADDEN,
*Member of Congress.*

---

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C., March 2, 1960.*

Hon. JOHN BRADEMAS,
*New House Office Building.*

DEAR COLLEAGUE: It has been a matter of embarrassment for me to know that Indiana is the only State in this Union of 50 States not participating in the rural public library service. I am thoroughly in favor of this program, which the present administration in Indiana has rejected.

I trust that during the year 1961 those selected to guide the destiny of Indiana will share my own conviction that Indiana should participate in the rural public library program, which lends itself so well to the advancement of knowledge and culture in our rural areas.

With kindest personal regards, I remain,

Yours sincerely,

J. EDWARD ROUSH,
*Member of Congress.*

---

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C., February 29, 1960.*

Hon. JOHN BRADEMAS,
*New House Office Building, Washington, D.C.*

DEAR JOHN: This will inform you, and the Subcommittee on Health, Education, and Welfare of the House Committee on Appropriations, of my whole-

hearted support of maximum participation by the State of Indiana in the Library Services Act.

With kindest personal regards,

Sincerely,

FRED WAMPLER,
*Member of Congress.*

---

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C., March 1, 1960.*

Hon. JOHN BRADEMAS,
*House Office Building, Washington, D.C.*

DEAR JOHN: As you know, included in last year's appropriation was $193,000 for Indiana under the Library Services Act. Those are 2-year funds and, should Indiana within the fiscal year 1960 decide to take advantage of this act, these funds would be available. However, the budget recommendation for the rural library service for this year is $7.3 million; $7.5 million could be appropriated. The deduction of $200,000 is made because Indiana is not taking advantage of this program.

I agree with you wholeheartedly that we should try to increase this appropriation from $7.3 to $7.5 million so that if Indiana takes advantage of the act, money will be available. As you know, Indiana is the only State which is not taking advantage of this program. It has been highly successful. The people of Indiana are paying the taxes just as those of other States are doing, and I think it is disgraceful to think the people in our State are not being given the advantage of this program.

We have discussed this many times in our Appropriations Committee, and you may be sure of my wholehearted support of this program.

Sincerely yours,

WINFIELD K. DENTON,
*Member of Congress.*

---

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C., March 1, 1960.*

Hon. JOHN BRADEMAS,
*House Office Building, Washington, D.C.*

DEAR JOHN: I am addressing you as a member of the Education and Labor Committee of the House of Representatives, urging you to do all within your power to see that the State of Indiana is given an opportunity to participate in the Library Services Act.

It is my understanding that our President has asked for $7.3 million in appropriations to carry on the project for fiscal 1961. I firmly believe that the sum of $7.5 million appropriation should be sought, for I am certain that Indiana under a different administration would wish to take advantage of the program. Certainly the door should be kept open.

Thanking you kindly and with best wishes, I am

Cordially,

EARL HOGAN,
*Representative in Congress.*

---

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C., February 29, 1960.*

Hon. JOHN BRADEMAS,
*New House Office Building, Washington, D.C.*

MY DEAR COLLEAGUE: Thank you for your letter of February 26, 1960, in regard to the Library Services Act which was passed by the Congress in 1956 (Public Law 84–597) and a copy of the letter written to you by the American Library Association.

I most certainly am in favor of Indiana participating in this program and will do whatever I can to support it.

With kind personal regards,

Sincerely yours,

RANDALL S. HARMON,
*Congressman, 10th District, Indiana.*

STATE OF INDIANA,
*Indianapolis, March 3, 1960.*

Hon. JOHN BRADEMAS,
*Congress of the United States,*
*House of Representatives, Washington, D.C.*

DEAR JOHN: In reply to yours of February 26, I am very happy to inform you of my opinion concerning the Library Services Act.

I hope that you and your colleagues see fit to reenact this legislation. I feel that it can be a tremendous benefit to our State. My only regret, to date, in this matter is that so far the administration of our State has not seen fit to utilize the provisions of the act to benefit our State. This is ridiculous and I hope that with the 1960 elections we rectify this injustice. I am certain the Democrats of our State would take a much wiser course.

Keep up the good work and if I can ever be of assistance, let me know.

Sincerely,

BIRCH E. BAYH, Jr.,
*Speaker, House of Representatives.*

---

SENATE,
STATE OF INDIANA,
*Indianapolis, February 29, 1960.*

Hon. JOHN BRADEMAS,
*Congress of the United States,*
*House of Representatives, Washington, D.C.*

DEAR JOHN: I appreciate very much your consulting me concerning the Library Services Act. It is my understanding that Indiana and many other States are without library facilities for persons in rural areas. The letter of the American Library Association indicates that there are 800,000 people in Indiana without library facilities. I understand that it is the intent of Congress not to engage in the permanent support of library services, but to provide a sum to each of the States for the purpose of encouraging the development of rural library facilities.

I know that you realize that I am opposed to the extension of the Federal Government into the areas of local government except under conditions of temporary emergencies when local government is unable to provide necessary services.

In this enlightened age, I believe that library facilities are a necessary service to the people of our State. I believe a program of providing library facilities to rural areas to be desirable, and I see no objection to the Federal Government providing funds temporarily for the purpose of encouraging the development of this type of program. Should I be elected Governor of the State of Indiana, I would encourage the State of Indiana to participate in the program you described.

Sincerely yours,

NELSON G. GRILLS.

---

STATE OF INDIANA,
*Indianapolis, February 29, 1960.*

Hon. JOHN BRADEMAS,
*House Office Building, Washington, D.C.*

DEAR JOHN: I would like to take this opportunity to tell you that I favor the participation of Indiana in the Library Services Act program.

I know that you are doing an excellent job in Congress and I am confident that the Third District will send you back again so you can continue your fine work.

Very truly yours,

ALBERT A. STEINWEDEL,
*Auditor of State.*

---

INDIANAPOLIS, IND., *March 1, 1960.*

Hon. JOHN BRADEMAS,
*U.S. Congressman, U.S. House of Representatives, Washington, D.C.:*

I wholeheartedly endorse the proposed appropriation for the Library Services Act. Governor Handley was wrong in not allowing the State of Indiana to accept funds for rural public library services. Indiana will participate if I am elected Governor of Indiana.

JOHN R. WALSH, *Secretary of State.*

SENATE,
STATE OF INDIANA,
*Indianapolis, February 29, 1960.*

JOHN BRADEMAS,
*Member of Congress,*
*House Office Building, Washington, D.C.*

DEAR JOHN: Thank you for your letter of February 26 and you certainly can quote me as favoring participation by Indiana in the Library Services Act program. The failure of our State to take advantage of this opportunity to strengthen our entire education program strikes me as being very shortsighted and I sincerely hope that our party can lead Indiana back into the union next year.

Very best regards.

Sincerely,

MATTHEW E. WELSH.

---

PUBLIC LIBRARY,
*South Bend, Ind., March 2, 1960.*

Hon. JOHN BRADEMAS,
*House of Representatives,*
*Washington, D.C.*

DEAR JOHN: I am personally extremely grateful to you for your interest in public libraries in general as well as your feeling of fondness for the South Bend Public Library. Your personal enthusiasm for libraries quite naturally leads you to favor extension of the Library Services Act which apparently is gaining impressive support from Members of Congress because of the success of the program in other States where great things apparently are being done by cooperation of Federal and State Governments in supporting library development in rural areas.

As I wrote you earlier we had hoped that Indiana would participate in the Federal program, and the State library had worked on a plan to propose for our Hoosier library development. Unfortunately, the State of Indiana has not followed through on its suggestion to take care of itself and immediate prospects do not appear very hopeful.

The subject of Federal aid is, of course, one on which people do not agree in principle, and here in Indiana we have some librarians and library trustees who are suspicious of any program in which the Federal Government is involved. Those who have apprehension because of Federal dictation about the use of aid money should have their fears allayed if they could hear some of our colleagues from other States who have stressed the latitude State library agencies have had in developing their own unique State plans.

Recent issues of library periodicals have summarized experiences of other States in using the Library Services Act, and the variety of programs, I think, is impressive.

Not only have libraries of Indiana, citizens in rural areas without direct library services, and the State library been deprived of the possibility of developing and expanding their programs, but what is even more regrettable is the fact that the State library actually suffered a reduction in the current appropriation In the current biennium for book purchases, so that its book-lending program has had to be curtailed during this present biennium.

When one examines how much the Library Services Act has done for public library service in all the other States, it is apparent that Indiana has lost the opportunity which our colleagues elsewhere have put to good use.

I am very grateful to you for adding your support to the apparently significant endorsement of your fellow Congressmen for continuation of appropriation to the full extent of the original act.

Sincerely yours,

ROGER B. FRANCIS, *Director.*

---

MUNCIE, IND., *March 3, 1960.*

Hon. JOHN BRADEMAS,
*House of Representatives,*
*Washington, D.C.*

DEAR SIR: Library Services Act is best answer yet discovered for bringing books into unserved rural areas. We believe law is soundly conceived, protecting adequately rights of local community and also providing for careful

expenditure of funds. Whether Indiana shares or not the program merits full financial support.

LEON I. JONES,
*Library Director, Muncie Public Library.*

---

VINCENNES PUBLIC LIBRARY,
*Vincennes, Ind., March 2, 1960.*

Hon. JOHN BRADEMAS,
*House Office Building,*
*Washington, D.C.*

DEAR MR. BRADEMAN: I have just learned that you will appear before the House Appropriations Subcommittee Thursday in the interests of the Library Services Act. I have also learned that you are interested—and are contacting other Indiana Congressmen—in Indiana's participation in the act. I should like to thank you for this active interest in Indiana libraries and to urge that you will continue to work for the best interests of library service in our State.

I am sorry—as are many other Indiana librarians—that we are not getting the benefits of the Library Services Act. The widespread evidences of its benefits certainly indicate that the act should be renewed. I hope you will continue to work toward this end.

Again, I am particularly pleased that someone in your position, and someone outside the library profession in Indiana, is working to improve library service in our State.

Sincerely,

MAXINE BATMAN,
*Librarian, Vincennes Public Library.*

Mr. BRADEMAS. Thank you very much, Mr. Chairman and members of the committee, for the privilege of appearing before you.

Mr. FOGARTY. You and Mr. Denton have made such a good case for this that I think the committee may seriously consider putting in funds for Indiana on the basis you folks can get your State in this program. Mr. Denton has been working pretty hard on us to do that.

## CONTROL OF TUBERCULOSIS, INDIAN SANITATION PROGRAM, AND ASSISTANCE TO SCHOOLS IN FEDERALLY IMPACTED AREAS

### WITNESS

### HON. THOMAS G. MORRIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW MEXICO

Mr. FOGARTY. Congressman Morris of New Mexico is the next witness. I understand you would like to give your views on two or three subjects of importance to your people.

Mr. MORRIS. Yes, if I may, Mr. Chairman.

Mr. FOGARTY. You go right ahead.

### CONTROL OF TUBERCULOSIS

Mr. MORRIS. Mr. Chairman, your committee has earned the gratitude of the entire Nation for your efforts to maintain the highest standards in the field of health. Over the years you have probed deeply into the testimony of officials to discover the real needs often cloaked by the administration's budget requests. I appear today to plead that one particular cut in the budget for fiscal 1961 must not go unnoticed. I refer to the drop in the appropriation for tuberculosis control activities from the $6,452,000 appropriated in fiscal 1960

to $5,430,000 this year. I am particularly grieved at the $1 million slash in the funds available for State programs, from about $4 to $3 million. It is my sincere hope that the committee will restore these State funds to $4 million at the very minimum.

Our State suffers a special hardship from this decrease in funds. As you know, we have had large numbers of tubercular patients move to New Mexico because our climate is recognized to be conducive to recuperation from tuberculosis. We have found it necessary to maintain more than the usual facilities for this reason. We are not alone in feeling the burden of this illness, however. Every State in the Union reports a substantial number of new cases each year. Every citizen in the country stands to gain from the stamping out of this disease enemy through constant prevention and control.

Smallpox no longer plagues our shores. The death rate for this and many diseases including tuberculosis has been sharply reduced through improvements in public health. But we do not consider this happy statistic an excuse to ignore the danger of smallpox or other diseases. We must not be fooled into believing that a decrease in death rates means an elimination of a health problem.

Indeed the Senate committee in raising the appropriation for the tuberculosis control program last year stated:

> The committee does not believe that these reductions should be allowed to occur when testimony reveals that there has been no appreciable drop in the incidence of this dread disease, even though the death rate is slowly declining.

Furthermore, for persons aged 65 and over there has actually been an increase in the number of new cases. About 1 out of every 4 persons is infected with TB germs and it is estimated that 1 out of every 20 of these people may develop active TB in his lifetime. It is, of course, a communicable disease, endangering anyone with whom an infected person has close contact. It is a long-term illness requiring from 9 to 12 months of hospitalization followed by home treatment under medical supervision.

This is a national problem, and we must be grateful that we have it in our power to control this disease and to treat it effectively. We will continue to watch the death rate decline and I hope to shorten the hospital stay and to close outmoded tubercular hospitals. But at the same time we must remain vigilant. We must continue our research efforts with the ultimate hope of developing a successful vaccine for immunization to tuberculosis. We must continue our program of early detection, for it is only in this way that we will be able to protect uninfected persons and to shorten the treatment for the infected. The public must be informed of this health danger and instructed as to the value of good health as a guard against tuberculosis.

The States have been doing a wonderful job, in cooperation with the U.S. Public Health Service, to control tuberculosis and I do not think we dare cut short their efforts. The price paid in life and happiness for carelessness is too high. In the end we will save the taxpayer money only by cutting short need for expensive treatment and by returning useful citizens to their occupations.

May I close with the words of the president of the American Public Health Association, an individual noted for her work in this field throughout the country, Dr. Leona Baumgartner:

Tuberculosis continues to present the most serious public health problem of any communicable disease in terms of frequency cost, and the personal suffering it produces. Combined action and increased research by voluntary and official agencies are needed more than ever for the prevention and control of this relentless enemy.

I strongly urge the committee to increase the senseless reduction in a strong and vital program for tuberculosis control.

Thank you.

INDIAN SANITATION PROGRAM

Mr. FOGARTY. You may proceed with your statement on the Indian sanitation program.

Mr. MORRIS. Mr. Chairman and members of the committee, it is a privilege to appear before you today in behalf of Indian sanitation projects which I regard as highly vital and necessary for the coming fiscal year.

The passage of Public Law 86–121 on July 31, 1959, marked a real achievement for the cause of Indian health and Indian sanitation. It makes possible, for the first time in history, the appropriation of funds urgently needed for the construction of adequate sewage disposal and safe water systems for Indian communities all over the United States. It makes possible the assumption of responsibility for maintenance of modern sanitation facilities by the Indians themselves where they have become accustomed to this standard of living and up-to-date health insuring facilities. Now the time approaches when we can make use of this great advantage acquired through law for the betterment of conditions for our Indian fellow citizens.

I am requesting that sums be appropriated during fiscal 1961 for the following Indian groups:

Zuni: $350,000 for modern sewage disposal.

Tesuque: $89,000 for safe water pumping water main and equipment.

Navajo: $160,000 for 12 low-pressure rural water systems.

Sandia: $100,000 for a modern sewage disposal system.

Domingo: $300,000 for developing four wells and a sewage disposal system.

Now, I would like to run over these various items one by one indicating the nature of the need involved and something tangible concerning the urgency for early action in each case.

Zuni located in western New Mexico near the Arizona border, is our largest pueblo and is in fact one of the largest Indian communities in the United States. It presents, by reason of its large population, a major and urgent sanitation problem. There are over 800 families at this pueblo and more than 4,000 people who are managing to exist in most unsanitary conditions. The pueblo has recently been marked by a rise in diseases of the gastrointestinal tract directly traceable to the lack of effective means of disposing of sewage and waste. This pueblo is in great need of a modern sewage system, and, since it is the largest of the pueblos, will by acquiring such a system set a most desirable example for the many smaller Indian communities. I understand it meets all of the criteria of need established by the U.S. Public Health Service for the highest priority in Indian community sanitation projects.

Secondly, there is Tesuque, which is situated in the middle part of the Rio Grande area of New Mexico and where the same conditions

prevail and the same urgency exists as at Zuni. However, as it is a smaller community, the sum of money required to put it on its feet sanitation wise is not as large as at Zuni.

Thirdly, a minimum of 12 low-pressure water systems has been determined to be vital to health and welfare of the Navajos. As is well known, the Navajo Reservation covers hundreds of miles and at least 12 water systems will be necessary to service such an extensive area.

Fourthly, there is the pueblo of Sandia lower down the Rio Grande Valley than Tesuque. Here there is great congestion and better supplies of safe drinking water are required. In this case I feel that there is also need for immediate action this coming year.

Fifthly, there is the pueblo of Santo Domingo, on the Rio Grande above Sandia a large settlement like Zuni where lack of modern sanitation has led to a serious condition relative to amoebic dysentery and other disorders. The need for action this year at Santo Domingo is, I believe, extremely urgent, both in safe water systems and in sewage disposal.

The President's budget allocates $1,800,000 for sanitation facility construction in Indian communities for fiscal 1961. I say that this is much too low in view of the needs involved and as expressed by the Indian communities themselves. It is my firm conviction that we should appropriate at the very least $3,500,000 for this purpose during fiscal 1961. During the last year it was possible for the Public Health Service to meet immediate and emergency sanitation construction needs through appropriation of funds under the Mutual Security Act at Laguna, Acoma, and Zia Pueblos of New Mexico. This coming year let us meet the Indian sanitation needs through direct appropriations for this purpose, as the law now authorizes us to do it.

Allow me to remind you that Public Law 86–121 makes it possible to save much time and expense of the Congress, already overloaded with work in a year when it hopes to adjourn early, by a general authorization in place of many individual enactments for each Indian community.

I spoke about this feature last year when, together with my esteemed colleague from New Mexico, Joe Montoya, I advocated the enactment of 86–121, the Indian sanitation bill, before the Interstate and Foreign Commerce Committee of the House.

If, by the expenditure of $3,500,000 for Indian sanitation during fiscal 1961, we can save the lives of many Indian mothers and children who would otherwise be condemned to die from respiratory and gastrointestinal diseases arising from unsanitary conditions, isn't it fully worth it? If we can preserve children from the crippling blight of disease through an expenditure of more money, now rather than later, isn't it our duty to do so? I have seen the distressing conditions of which I speak. And it is my considered opinion that it will be money well spent if we can protect our Indian children from disease and infirmity which will cause them to become the public charges of the future. For, in addition to wiping out the cause of endless human suffering now, we are making it possible for our country to have healthy, self-sustaining citizens of the future.

The Public Health people have stated that disease rates in Indian children rise greatly between the first month of life and the age of 1

year. Why is this so? Because the children are mostly born in hospitals under sanitary regimes but within a short time are brought into the unsanitary environment of their native communities where the sickness and death rates are bound to rise and cut off many promising young lives. If we can now change this environmental factor which is adverse to the infants by appropriations for construction of Indian sanitary facilities, we are achieving something eminently worthwhile and bringing our Indian fellow citizens into the main stream of 20th century living. An ounce of prevention now, on our part, is worth inestimably more than a pound of cure later, both from an economic and a humanitarian standpoint.

The Congress has provided us with the authority to construct adequate sanitary facilities to save many lives and avoid preventable disease. But the job is barely half done. We need the money to carry out the express purposes of the Indian Sanitation Act and to carry them out now. The purpose of Congress in passing the Indian Sanitation Act last year was quite clear. Is it not equally clear that the purpose of Congress cannot be achieved unless we appropriate adequate amounts to carry it out? We have a job well started and we should not linger and dawdle with relatively small amounts of money to make this Sanitation Act effective. If we are earnest in this matter, if we really want to save the lives of women and children who will surely die or become hopelessly disabled by illness under present conditions, we will make available now the money needed to wipe out the worst of these conditions.

I feel strongly that the President's budget estimate for Indian sanitation is much too low. We cannot give wide publicity to sanitary conditions in each and every Indian community without giving rise to unnecessary anguish on the part of the people concerned. In my opinion the President's budgetary estimate is governed by expediency rather than a sense of the full worth of human lives and human health. For these Indian men, women, and children suffer pain; they feel the effects of disease and labor under its disabilities just like anybody else. If we can do something to really lighten the burden of these things on their lives, let us by all means do so as early as possible and not make such sums available on a basis of expediency only. In such matters as these, humanitarian sentiments should merit the same consideration.

We are moving forward in matters of Indian health, but we are not moving half fast enough. The Public Health Service can furnish us with most unbelievable statistics and facts on sanitary conditions among Indians but, between knowing the facts and making an all-out assault upon an ominous situation in Indian sanitation, there seems to be somewhat of a lag on our part. I would say that information about an approaching tornado would be the signal for almost instantaneous and extensive precautions. Why not so in the case of Indian sanitation where the effects are equally disastrous to human lives? Knowledge about a problem which is not fully used is about as valuable as no knowledge at all. In other words, we know for a certainty that sanitation in Indian communities is bad and it will be our responsibility to do all we can about this matter right away. I ask you, therefore, to do as much as you can to alleviate a situation which is in its way as menacing as an approaching tornado.

Someone has remarked that "to see which is good and not to do it is to lack courage." We have the facts of need in the Indian communi-

ties for sanitation improvements and we must roll up our sleeves and really tackle the problem. It is indeed appalling to know what there is to be done and to allow other considerations to prevail over us and drag us away from our course of duty. In this case, the course of our duty is clear: We must appropriate in our first year under the new Indian Sanitation Act enough money to really make a good start in wiping out filth-borne diseases in Indian communities.

By making an adequate appropriation in this first year of operation of the Indian Sanitation Act we show that we are in earnest in our determination to assist the Indian in freeing himself from the agelong ignorance and disease which has plagued the human race for so much of its history. I come from a part of the country where Indians are friends and neighbors. Their great potentialities are known to me. I also know what holds them back and it is this latter knowledge which makes me feel that adequate appropriations for Indian sanitation constitutes a goal worth fighting for. In this fight for humanity and for justice I know that I have the support of many of my esteemed colleagues in the House, all of whom are keenly aware of the Indian's urgent need for sanitary improvement with resultant bettering of Indian health and improving their welfare.

Thank you.

ASSISTANCE TO SCHOOLS IN FEDERALLY INSPECTED AREAS

Mr. Fogarty. Those are good statements, Congressman. Go right ahead and give us your opinions regarding assistance to schools in federally impacted areas.

Mr. Morris. I am extremely grateful to the committee for the opportunity to be here today and to indicate to you my concern for the inadequacy of the President's budget request for Public Laws 815 and 874, as amended. This request reduces funds available to schools in federally impacted areas so substantially that it would seriously affect the quality of education in these areas.

In my opinion, a cutback in funds for the program is extremely shortsighted at this time. Certainly we all realize the need not only for maintaining but also for improving the quality of our schools throughout the country. Therefore, I see no equitable reason why the funds for federally impacted school districts should be reduced.

It is imperative that these programs not be curtailed in any way where the Federal Government's activities continue to place an additional financial burden on local school districts. I know that this committee is fully aware of the fact that when the Federal school assistance programs for federally impacted areas were enacted by the Congress, the basic principle underlying the original legislation—as well as its several amendments and extensions—was that the Federal Government should recognize and accept its responsibility to assist in the support of public elementary and secondary education in those school districts where swelling enrollments were related to Federal activity. In fact, in 1950 the Congress literally declared that it would be a policy of the Federal Government to "bear a portion of the cost of maintenance and operation and construction of free public elementary and secondary schools in those areas where the U.S. Government placed added financial burdens upon the schools." There is no indication that this burden has diminished. For example, according to the latest annual report on these two programs in fiscal 1959, for the ninth consecutive year the number of eligible school districts and the total

amount of their entitlements increased for Public Law 874, as amended.

Where a Federal impact still exists, and clearly it does, there continues to be a Federal responsibility according to the law. In my opinion, there is a definite need for more money than is being requested for the programs in the President's budget. We have only to compare the total estimated need for 1961 for both of the programs which is $250,572,000—with the President's request for only $171,085,000. In the light of the need, it seems hardly the appropriate time now to so limit the payments to the federally impacted school districts. It most certainly is not the appropriate time to place additional financial burdens upon already ailing school districts.

A closer look at the funds requested for each of these program further underscores the reduction of income to these districts. The President's request for fiscal 1961 for Public Law 815, as amended, is $44,390,000 whereas the estimated need has been placed at $63,372,000. Therefore, the President's request represents a reduction of 30 percent below what is needed. Moreover, the budget request for Public Law 874, as amended, is $126,695,000 or 32 percent below the estimated need for 1961 under this part of the program which is $187,200,000. If the President's request for Public Law 874, as amended, were to be the amount appropriated by the Congress, it would mean that only 68 percent of each State's entitlement would be available.

In my own State of New Mexico, for the fiscal year 1961, the estimated amount of funds needed under Public Law 815, as amended, is $3,196,054. The budget request would only provide for New Mexico $2,091,000, which is 35 percent below our estimated need under the school construction part of this program. Furthermore, for Public Law 874, as amended, New Mexico's estimated need for 1961 is $4,329,000, but under the budget request New Mexico would only receive $2,646,000 or almost 40 percent below the need for operation and maintenance assistance.

Most of New Mexico's school districts already are making the maximum effort to support education that is allowed under State and local laws. Most emphatically this reduction in funds would seriously increase the already heavy financial burden of New Mexico's federally impacted school districts, which means practically every town of any size in the State.

Thousands of schoolchildren in New Mexico and millions of schoolchildren throughout the country would be affected by the drastic reductions in federally impacted area funds as proposed by the President.

It is my conviction that continuous and adequate Federal financial support for federally impacted school districts is an essential throughout the Nation, particularly in view of the present emergency situation in which we find ourselves.

I trust that this committee, after serious consideration of the facts, will deem it essential to increase the amounts of money to be appropriated for fiscal 1961 for the federally impacted school districts in order to insure that no additional handicaps be placed in the way of the continual strengthening of American education.

Thank you.

Mr. FOGARTY. I think that you know already that I agree with you on these things and hope we can do something about correcting some of the inadequacies in the President's budget.

## DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE APPROPRIATIONS

### WITNESS

### HON. LEE METCALF, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MONTANA

Mr. FOGARTY. This is a case of last but not least. Mr. Metcalf, you are the last of our congressional witnesses, and I know you have several subjects you would like to discuss. We have only one more witness who is not scheduled to be here for 15 or 20 minutes, so you take whatever time you want to discuss these important matters.

Mr. METCALF. Mr. Chairman, I appreciate this opportunity to speak for Montanans on the fiscal 1961 budget requests for the Department of Health, Education, and Welfare. Senator Murray and Senator Mansfield have gone over my statement and asked me to associate them with my remarks.

In summary, we seek restoration of administration—proposed cuts in funds to clean up our lakes and streams; build hospitals; construct, operate and maintain schools in federally impacted areas; control venereal disease and tuberculosis; build health research facilities; train medical research personnel, and support vocational education.

Among the increases we support is the one for extension and improvement of rural library service. We propose increases for several items, including construction of Indian sanitation facilities, maternal and child health, crippled children's and child welfare services.

Mr. FOGARTY. Go right ahead and tell us why you think all of these things are important.

### WATER POLLUTION CONTROL

Mr. METCALF. For the third straight year, Senator Murray, Senator Mansfield, and I, in the continuing fight for clean water, oppose the President's proposal to reduce by $25 million, to $20 million, the appropriation to help local communities to build State-approved sewage-treatment facilities.

Montana's allocation this year was $516,425. If the cut stands, our allocation for next year will be $211,440.

Once again, the President is part of a drive—spearhead by the Chamber of Commerce of the United States, the National Association of Manufacturers and trade associations representing certain polluting industries—to cut this program back to the point of uselessness, then end it.

I must admit that we are $20 million better off than I anticipated we would be. A year ago, the budget message given us said the President would trim this program to $20 million, then terminate it. In reply, Congress voted $45 million.

As of January 31, 1960, Federal grant offers totaling $168.7 million, have been made on 2,017 projects to cost an estimated $977.6 million. Of these, 875 had been completed, 596 were under construction, and 441 were awaiting construction.

The 2,017 approved projects will provide adequate treatment of municipal wastes equivalent to a population of more than 30 million.

They will reduce the pollution from municipal wastes in more than 20,000 miles of streams to a level acceptable to the State water pollution control agencies for the areas involved. This does not include the many miles of lake and ocean shorelines which will be improved, but for which estimates cannot be made.

Also, as of January 31, there was a backlog of 570 applications from local agencies for $55.8 million in Federal grants to help finance an estimated $385.7 million worth of construction. In addition, at least another 700 applications were in preparation in the States.

To date, 11 projects have been completed in Montana, 12 more are under construction, an additional 14 have been approved, 10 more are in process either in the State health department or the Public Health Service's Denver regional office.

Under date of February 9, 1960, Dr. G. D. Carlyle Thompson, executive officer of the Montana State Board of Health, wrote me about this program as follows:

> With $211,440 available to us next year, we face fairly certain prospects of 10 communities with projects requesting $769,000 as the Federal share on the basis of 30 percent with $250,000 maximum. One additional large city project is under discussion, but its eligibility at this time is doubtful. However, it would add another $229,000 Federal grant request if ultimately determined eligible. In addition, there are a number of community projects that may develop during the year of certainly in the following year. These have not been evaluated.
>
> It is clear that we could readily use the $516,425 available to us this year. These projects are all important projects to the cleaning up of Montana streams either through the elimination of existing pollution or the establishment of treatment facilities for some communities that are installing, for the first time, a sewer system with disposal into a stream.

A matter of previous record with this committee are statements in support of this program from the Director of the Montana State Department of Fish and Game, mayors of several of our leading cities, the Montana Municipal League, and spokesmen for health and conservation groups.

FEDERAL IMPACT SCHOOL AID

For years, we have been treated to platitudes about how education was for children. And for years we have received budget recommendations which would provide for less education for fewer children. This year is no exception. The President proposes cuts of more than 20 percent each in Federal appropriation under Public Laws 815 and 874, under which Federal aid goes direct to local school districts for construction, maintenance, and operations—including textbooks and teachers' salaries—in areas of Federal impact, such as military bases or Indian reservations.

In the 8 years that these laws have been on the books, the Federal Government has spend more than $901 million on some 53,000 classrooms to house about 1.5 million pupils. More than 768 million Federal dollars have been appropriated for operation and maintenance of schools in more than 4,000 districts with a total enrollment of 8.6 million children. If those children were in classrooms averaging 30 pupils to a teachers, then Federal funds have helped pay the salaries of more than 286,000 public schoolteachers in the past 8 years.

The President proposes that Congress appropriate $44,390,000 for school construction in federally impacted areas in fiscal 1961. This

would be a reduction of $16,745,000 from the appropriation for this year. This Congress will not go along with such a reduction.

Nor will we vote a $37,262,000 reduction, from this year's $163,957,000, for school maintenance and operation in districts where enrollments are affected by Federal activities. In his budget, President Eisenhower himself admits that his request would provide only 68 percent of the entitlement of eligible districts, estimated this year to number 4,275.

I know this committee is not about to go along with a proposal that we abandon the Federal responsibility in more than 4,000 school districts in all 50 States, Guam, Puerto Rico, Wake, and the Virgin Islands.

VOCATIONAL EDUCATION

I also oppose the President's request for a $2 million cut (to $31 million) in the appropriation for the grassroots vocational education program.

Vocational education services now functioning in Montana under competent State and local leadership are vocational agriculture, vocational home economics, distributive and business education, trade and industrial education, vocational guidance, industrial arts, practical nursing, and technician training.

Currently more than one-third of Montana's high schools help farm youngsters with vocational agriculture or home economics courses. If the President's cut stands, these are the two programs which will be reduced in Montana. Our allocation under title I of the George-Barden Act this year was $158,274. If the budget is adopted as submitted, this allocation will be reduced to $151,110.

Among the letters I have received in support of this position is one from Miss Flora Martin, a home economic teacher in Helena, Mont. She wrote in part that "educating our young women in home and family living is a most important phase of education no matter how many scientists and mathematicians we need. The home is still the backbone of the Nation."

HILL-BURTON HOSPITALS

Again this year, the President would cut deeply into this program under which Federal funds are provided on a grant or loan basis to help States, other public agencies, and nonprofit organizations build hospitals, rehabilitation facilities, diagnostic or diagnostic and treatment centers, nursing homes, public health centers, and related health facilities.

Montanans appreciated the action of Congress last year in rejecting the President's proposal to cut this program to $101 million from $186 million. They urge that you give the same treatment to this year's budget request for $125 million.

In this fiscal year, a total of $898,392 was allotted to Montana under the five categories of the Hill-Burton Act. This represents 40 percent of the cost of this construction in Montana; the other 60 percent coming from State and local sources. So the fiscal 1960 allotment represented not only more than $2 million worth of needed health

facilities but also jobs in a State until recently depressed by a shutdown in our major industry, mining.

From the Public Health Service I have the following table showing the appropriations for hospital construction, including allotments to Montana for fiscal 1959, 1960, and for 1961 as proposed in the budget:

| | Fiscal year | Total | Part C, hospitals |
|---|---|---|---|
| Appropriations for hospitals | 1959 | $185,000,000 | $150,000,000 |
| | 1960 | 185,000,000 | 150,000,000 |
| | 1961 [1] | 125,000,000 | 95,000,000 |
| Allocations to State of Montana | 1959 | 851,056 | 551,056 |
| | 1960 | 898,392 | 598,392 |
| | 1961 [2] | 677,960 | 377,960 |

| | Fiscal year | Diagnostic and treatment centers | Chronic disease hospitals | Nursing homes | Rehabilitation facilities |
|---|---|---|---|---|---|
| Part G. Medical Facilities | 1959 | $7,500,000 | $7,500,000 | $10,000,000 | $10,000,000 |
| | 1960 | 7,500,000 | 7,500,000 | 10,000,000 | 10,000,000 |
| | 1961 [1] | 7,500,000 | 7,500,000 | 10,000,000 | 5,000,000 |
| Allocations to State of Montana | 1959 | 100,000 | 100,000 | 50,000 | 50,000 |
| | 1960 | 100,000 | 100,000 | 50,000 | 50,000 |
| | 1961 [2] | 100,000 | 100,000 | 50,000 | 50,000 |

[1] Based on President's budget.
[2] Tentative allocations based on population figures now available.

Here is the statement of Dr. G. D. Carlyle Thompson, executive officer of the Montana State Board of Health, to me under date of February 9, 1960, on this program:

With the $377,960 available in the proposed budget, we face three projects that are currently quite definite for being ready for construction in the next fiscal year, and if approved at the full rate of 40 percent under the Hill-Burton provisions, would require $1,070,000. We are aware of other hospital projects in various stages of planning and fund raising with one of them possibly being ready during the next year, and at the full rate would require $1,200,000.

Up to this time Montana has not granted the full rate to any of the larger projects, but even should this policy continue, it is clearly evident that hospital construction in Montana under provisions of part C of the Hill-Burton Act, would be delayed substantially from that which is possible because of local development in the State.

If this year's amount of $598,392 were continued, it is probable that we could schedule these projects and bring them under contract in the next fiscal year with the provision that some of them would need to await subsequent congressional appropriations for completed financing.

As you know, the other categories of Hill-Burton construction grants are the same for the next year as we have had in the past since they are on a minimum basis. Except for the rehabilitation category, these funds will be wholly used without any difficulty in meeting construction grant requests, because of the provision for intercategory transfer and the substantial interest in Montana communities in developing better nursing homes.

If the President's cut stands, Montana will receive a Federal allocation of $677,960 for these facilities in fiscal 1961, or $220,432 less than this year. Instead of being decreased, funds for the Hill-Burton program should be increased to the full authorization of $210 million.

52696—60——37

LIBRARY SERVICES

As far as I am concerned, the bright spot in an otherwise resource deficient budget is the request for $7.3 million to carry out the provisions of the Library Services Act in 49 States and 3 territories.

I served on the subcommittee which held hearings and put this bill into final form. The act was aimed at stimulating the States to extend and improve their public library services in rural areas, defined as those with less than 10,000 population.

In the 3 years it has been in operation, remarkable progress has been made in Montana. In addition to reports already a matter of record before this committee, I point out that by June 30, 1961, four federations of libraries in as many large areas of a sparsely populated State will be in operation, and the hope is that they will be self-supported with local tax money by that date. As a result of this federally aided program, 104,256 Montanans in Montana who formerly had very limited library service now have access to a large, attractive array of books and to good reference service.

By the end of the coming fiscal year, five bookmobiles will be in operation. Federal funds have provided a cooperative library film circuit.

In support of the budget request, I note that many of our small libraries are operated by local clubs with a tax income as low as $100 a year. No area in the State approximates the American Library Association standards for good library service. Many areas, stimulated by this Federal program, are now working toward good service and adequate support, but there remains a total of 265,018 people who either have no library service at all or who have service that can only be called token. The film library has only 61 films on hand to serve the entire State which has a population of some 600,000.

I estimate Montana's needs, under this program, to be at least $300,000 to triple the supply of good books in the State agency, Montana's "book bank"; $6,000 to double the supply of films in the film library; $37,000 to put six additional bookmobiles on the road for two new federations already planned and the hope of four more in the future.

Although it probably goes without saying, I have already cosponsored legislation to continue this program beyond the present expiration date of June 30, 1961.

INDIAN HEALTH

As you know, Public Law 85–151 authorized the Federal Government to meet its responsibility for hospital facilities for ward Indians by chipping in to help build community hospitals to serve both Indians and non-Indians. The Surgeon General of the Public Health Service is authorized to adopt this alternative approach when he finds it better and more economical than building Indian hospitals.

The 1959 appropriation for construction of Indian health facilities included $1,750,000 for participation in the construction of community hospitals serving Indians and non-Indians. Here is a report

from the Public Health Service (as of January 29, 1960) on the funding and status of these projects:

| Hospital | Amount | Project status |
|---|---|---|
| Hotel Dieu Hospital, Polson, Mont | $161,019 | Project under construction. |
| Trinity Hospital, Wolf Point, Mont | 127,534 | Do. |
| North Shore Hospital, Grand Marais, Minn | 29,114 | Completed. |
| Cook Community Hospital, Cook, Minn | 60,798 | Do. |
| Mahnomen County Village Hospital, Mahnomen, Minn | 85,922 | Do. |
| Hoopa Community Hospital, Hoopa, Calif | 180,000 | Project under construction. |
| Garrison Memorial Hospital, Garrison, N. Dak | 244,000 | Offer accepted, amendment in process. |
| Fremont County Hospital, Lander, Wyo | 233,559 | Project under construction. |
| Riverton, Wyo | 22,538 | Completed. |
| Poplar Community Hospital, Poplar, Mont | 265,000 | Offer accepted, amendment in process. |
| Contingencies | 11,241 | |
| Total commitments | 1,420,725 | |
| Balance available for further commitments | 329,275 | |
| Total | 1,750,000 | |

The President did not request additional funds under Public Law 85–151 for the coming fiscal year. In Montana, we have at least one needed project remaining to be built. According to Dr. G. D. Carlyle Thompson, executive officer of the Montana State Board of Health, it—

is at St. Ignatius, Mont., involving the Holy Family Hospital which is currently classified as nonacceptable, and which is prepared to proceed with a new facility in the next fiscal year. In our joint planning with the Public Health Service, this is set up for 12 beds under Public Law 85–151 and we are currently estimating $240,000 Indian health funds. This, of course, is outside of the Hill-Burton portion on the remaining part of the hospital, and as I understand it, will require special appropriation to the Public Health Service as the last appropriation is either expended or obligated. The Public Health Service and we have not agreed on the amount of funds required, but the 12 beds are in the plan of agreement. This will complete the needed beds for the Flathead Indian Reservation.

I asked the Public Health Service about this project, and under date of January 29, 1960, received the following report from Dr. James Shaw, Assistant Surgeon General, Chief, Division of Indian Health:

The Holy Family Hospital has been under consideration as a potential project under the provisions of Public Law 85–151 since the first analysis of Indian hospital bed needs. At that time, the Holy Family Hospital was recognized as the major source of hospital beds for the Flathead Indians, and it was known that it was operating with a rating of "acceptable" by the Montana State Hospital Authority under temporary permit only. A total of 21 beds was considered needed for the total Flathead Reservation, of which 8 were assigned to the Hotel Dieu Hospital in Polson, Mont., as indicated above. It was believed that most of the remainder should be held for consideration of use at St. Ignatius whenever the State hospital authority withdrew the temporary acceptable rating.

Use of the Holy Family Hospital for Indian Health beneficiaries has been consistent. The average daily patient load paid for by the Public Health Service has been as follows:

*Fiscal year and average daily patient load*

| | |
|---|---|
| 1957 | 14.6 |
| 1958 | 14.8 |
| 1959 | 11.0 |
| 1960 (July-November) | 6.3 |

Data furnished the Division of Hospital Facilities of the Montana State Board of Health for the calendar year 1959, used in the current Montana State hospital plan, show a total average daily patient load of 18, including 5 patients for replacement by a facility to contain 20 general medical and surgical beds and 10 nursing home beds. The community has an A priority for nursing home beds but only a B priority for general and surgical beds.

The provisions of Public Law 85–151 do not permit participation in the construction of nursing home beds. The Indian Health Area Office has recommended after a study of the situation that the Public Health Service should consider participation in construction of the general medical and surgical portion to the extent of 12 beds for Indian use whenever the State agency and community should determine to proceed on the remainder of the project. In the absence of specific information, our tantative estimate for the Public Health Service share of this project would be $275,000. The most recent information available here does not show any construction scheduled at St. Ignatius under the provisions of the Hospital and Medical Facilities (Title VI) Act.

To build this one project in Montana would require between $240,000 and $275,000. I don't know how many of the other States with substantial Indian populations are bringing along plans for similar hospitals. But I feel the committee should at least appropriate $500,000 to continue this program which only is used where the Surgeon General determines after consultation with the Indians involved that participation in the community hospital is more desirable and effective for providing needed health services to the Indians than direct Federal construction would be.

Even a cursory review of the budget raises other serious questions. The $2 million increase for Indian health is all for personnel and services at newly opened hospitals. There is no increase for contract patient care, to which the administration has been urging the Indians to shift. I believe there should be an increase of at least $1 million in this item.

The $1.8 million for construction of Indian sanitation facilities is minor. The need is for at least $3 million to start a program which should have immediate and dramatic results in lowering the hospital bed occupancy, the outpatient load, and the mortality rate, particularly among small children. There is no provision in this bill for increased personnel to handle the construction of these facilities, which should be at least $500,000.

### MISCELLANEOUS

Due to the internal realinement in the National Institutes of Health, there is more money for medical research projects, but there is less

for training research people. I think this is extremely shortsighted, because the Institutes have started the most realistic training program that I know of.

I also note that the item for health research facility construction has been cut to $25 million from $30 million. This cut should be restored.

The budget provides $2 million, to be divided equally among three programs—maternal and child health, crippled children's services, and child welfare services. Each of these needed and worthwhile programs would still be $3½ million below the authorized ceiling.

Some additional health appropriations are of interest to me as well as to the committee. I note with disappointment that the administration has requested reduced grants to States for control of tuberculosis and venereal disease. The fact that both are communicable diseases makes it obvious that the Federal Government must retain its interest and continue to assume a logical responsibility for health programs designed to bring these diseases under control. I urge this committee to increase the grants to States for tuberculosis to $4 million and for venereal disease control to $2,400,000, in each instance equal to last year's appropriation.

I hope that the amount of money requested for health for the aged and chronic disease activities of the Public Health Service, $1,354,100, does not indicate the size of their interest in this now tremendous and ever-growing problem. It seems to me that considerable additional money and effort are needed in this specific area of national concern.

I am pleased at the increase which has been requested for radiological health activities. I believe additional funds are needed for grants to States for these purposes, however, in order that the States can more quickly initiate programs keyed to protect the health of our citizens from this growing health hazard.

One other item of activity by the Public Health Service is causing me some concern, as I am sure it is causing concern to members of this committee. This is the foreign quarantine activities which are to receive an increase of approximately $150,000 for fiscal year 1961. I wonder if the provisions for safeguarding the health of the American people from the introduction of diseases from abroad are being adequately financed and staffed by this appropriation. The phenomenal advances made each day in the air travel of persons and objects pose a problem of monumental proportions. I do not know if the Public Health Service has studied this matter, but it seemed to me of sufficient import to draw to the attention of this committee.

Mr. Fogarty. Thank you, Mr. Metcalf, for a very fine and comprehensive statement.

Mr. Metcalf. Thank you, Mr. Chairman and members of the committee, for affording me the opportunity to discuss these matters with you today.

INDIAN HEALTH SERVICES

LETTER FROM GEORGE M'GOVERN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF SOUTH DAKOTA

Mr. FOGARTY. I have received a letter from Congressman McGovern relative to the recommendations of the Governor's Interstate Indian Council's recommendations, which we will place in the record.

(The letter referred to follows:)

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C.*

Hon. JOHN FOGARTY,
*House of Representatives, Washington, D.C.*

DEAR JOHN: Knowing of your heavy workload, I hesitate to impose on you further, but I would appreciate your consideration of the attached letter from the chairman of the Governors' Interstate Indian Council, relative to budget recommendations for Indian health services.

Thank you for your courtesy in this regard.

Sincerely yours,

GEORGE MCGOVERN.

GOVERNORS' INTERSTATE INDIAN COUNCIL,
*February 26, 1960.*

Hon. GEORGE MCGOVERN,
*House of Representatives, Washington, D.C.*

DEAR CONGRESSMAN MCGOVERN: Thank you very much for your letter of February 8, in which you enclosed a copy of the letter from Congressman John E. Fogarty.

Since writing you and asking for your support of Resolutions 7 and 8 adopted by the Governors' Interstate Indian Council, I have additional information as to the needs for the Division of Indian Health.

I hope it will be possible for you to contact Congressman Fogarty again and ask that the following increases be provided in the Indian health budget. It is my understanding that the President's budget recommends the following amounts:

| | |
|---|---|
| Hospital health services | $29,195,000 |
| Field health services | 8,482,000 |
| Contract patient care | 8,418,000 |
| Program direction | 1,431,000 |
| Total activities | 47,526,000 |
| Construction | 6,964,000 |
| Total request for Division of Indian Health appropriations | 54,490,000 |

It is my further understanding that the recommended increases to the 1961 President's budget are as follows:

| | |
|---|---|
| Health services | $29,695,000 |
| Field health services | 9,482,000 |
| Contract patient care | 9,418,000 |
| Program direction | 1,431,000 |
| Total activities | 50,026,000 |
| Construction | 8,664,000 |
| Total aid | 58,690,000 |

As you can see, this indicates a need for an increase of $4,200,000 in the budget for the Division of Indian Health.

I feel that such appropriations are justified and, also, that the Governors' Interstate Indian Council would favor supporting these figures. I am going to make some contacts on these sometime quite soon but I need someone I can depend upon to make contacts with people such as Congressman Fogarty, of Rhode Island, and Congressman Marshall, of Minnesota. I hope it will be possible for you to do something on this; it is something that will be greatly appreciated by our organization and I feel it would be a very fine gesture on your behalf in meeting the health needs for Indian people.

Respectfully yours,

JOHN ARTICHOKER, Jr., *Chairman.*

## WATER POLLUTION CONTROL

LETTER FROM HON. WILLIAM H. MEYER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VERMONT

Mr. FOGARTY. Then we will place Congressman Meyer's letter in the record. It indicates concurrence with a statement on the same subject we have already inserted in the hearings record.

(The letter referred to follows:)

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C.*

Hon. JOHN E. FOGARTY,
*Chairman, Subcommittee on Labor and Health, Education, and Welfare Departments, House Appropriations Committee.*

DEAR COLLEAGUE: This is to advise of my strong and continuing support for full and adequate appropriations to assure continuation of water pollution control programs. In particular I want you to know of my complete concurrence with the statement filed with the subcommittee by Reinhold W. Thieme, commissioner of water resources in Vermont, in connection with these appropriations.

This program has been extremely successful in Vermont, and as you will note, Vermont has been a leader in going ahead to implement this needed protection of our water resources. Be assured of my interest in the appropriation measure, and I trust that the full $50 million as authorized will be recommended.

With best personal regards.

Sincerely yours,

WILLIAM H. MEYER.

## ARCTIC HEALTH RESEARCH CENTER

LETTER FROM HON. RALPH J. RIVERS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ALASKA

Mr. FOGARTY. We have a letter from Congressman Rivers of Alaska that we will place in the record at this point along with the Governor's statement.

(The letter and statement referred to follow:)

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C.*

Hon. JOHN E. FOGARTY,
*Chairman, Subcommittee on Departments of Labor, and Health, Education, and Welfare Appropriations, the Capitol, Washington, D.C.*

DEAR COLLEAGUE: I am writing to you as chairman of the Subcommittee on Appropriations for the Department of Health, Education, and Welfare to express to you and the other members of your committee the urgent need for an additional

appropriation of $250,000 for fiscal year 1961 to the Public Health Service for the operation of the Arctic Health Center in Anchorage, Alaska. Said sum is over and above the $496,000 requested in the President's budget.

The Arctic Health Research Center, first established by the Public Health Service in 1948, has made a successful start in the accumulation of knowledge about arctic and subarctic environment and its effects upon human beings; but the program is being throttled by tight budgetary policy. This center is the only facility of its kind under the American flag, and needs strengthening as a very important part of our total health research effort.

Of the proposed additional $250,000 for fiscal year 1961, $103,000 is for establishing basic support for epidemiology studies, $32,000 for restoring support to physiological studies, and $115,000 for two projects in sanitation. The first project is a study of infections and other diseases, and embodies establishment of a study section as part of the basic support of the Arctic Health Research Center, in addition to reinstating the bacteriology laboratory with two positions lost in January 1959. Funds needed for this project amount to $103,000.

The second project, "Physiological Adaptation to Cold Environments," proposes to restore Arctic Health Research Center support to these studies, and the cost would be $32,000.

A third project, titled "Arctic Water Supply," would be developed by the sanitation section in collaboration with the Alaska Department of Health and Welfare, the Alaska Native Service, and the military. The purpose of this project is to find methods of keeping water liquid in earthen storage throughout the winter in central and northern Alaska. The cost of this project would be approximately $72,000. The need is to determine the feasibility of providing winter storage facilities to secure winter water supply for small communities and institutions in the Arctic by means of natural or artificial impoundments of water.

The fourth project, titled "Waste Disposal," is a project requiring approximately $43,000 to investigate the function of septic tank systems in central and northern Alaska to formulate methods and operating criteria.

In view of the importance of the program of the Arctic Health Research Center, as I have stated in the first paragraph of this letter, I urge that the Appropriations Committee consider favorably this request that the total amount of $250,000 required in fiscal 1961 for the operation of the above programs be included in the appropriations for the U.S. Public Health Service as it is finally approved by the Congress.

In addition, I am enclosing with this letter a statement by the Honorable William A. Egan, Governor of Alaska, concerning the appropriations for the Arctic Health Research Center, and submit this letter together with said statement for inclusion in the record.

With appreciation for your consideration in this matter, I am

Sincerely yours,

RALPH J. RIVERS,
*Member of Congress, Alaska.*

STATE OF ALASKA,
OFFICE OF THE GOVERNOR,
*Juneau, February 12, 1960.*

Hon. RALPH J. RIVERS,
*Representative for Alaska,*
*New House Office Building, Washington, D.C.*

DEAR RALPH: An original and one copy of a statement by myself on behalf of an increase in appropriations for the Arctic Health Research Center is enclosed.

It would be appreciated if you could find it possible to arrange for its submission to the appropriate Appropriations Subcommittee.

Regards,

WILLIAM A. EGAN, *Governor.*

STATEMENT OF GOV. WILLIAM A. EGAN, OF ALASKA, ON BEHALF OF INCREASED APPROPRIATIONS FOR THE ARCTIC HEALTH RESEARCH CENTER

As Governor of Alaska, it is not my intent to burden the Appropriations Committees of the Congress with a series of pleas on behalf of individual projects or programs. There is much that Alaska needs, much to which it feels entitled, and much, I might add, which we feel is overdue.

It is my feeling that Alaska, in both branches of the Congress, has representation which is quite capable of making our views known. Secondly, I am fully cognizant of budgetary considerations which, in the overall national interest, make it impossible for Alaska to "catch up" overnight, so to speak, as desirable as I might feel this to be.

It is in the overall national interest, however, as well as that of Alaska specifically, that I urge you to give every consideration to granting not only the full $496,000 asked in the President's budget for the Arctic Health Research Center but an additional amount—up to $250,000—to permit the undertaking of vitally needed research into problems incident to life in cold weather climates.

To point up the national interest involved, I cite the following contained in a statement by the Department of Health, Education, and Welfare.

"Unless we expand our present knowledge (of cold weather problems), the level of public health in Alaska will in the next decade fall far below any other part of the United States. Other Nations with arctic land areas, principally Russia, are now better able to populate and utilize these areas on a substantial scale than is the United States. Our goal is to eliminate this discrepancy and make possible the use of this vast land area."

The Arctic Health Research Center is the only such facility on the North American Continent. It has accomplished much since its establishment in 1948. Among these advances are the invention of insect control devices now widely used for relief of small areas such as camps and homesites, and the devising of effective mosquito control operations applicable to much of Alaska. The distribution system for city water worked out for the city of Fairbanks has saved residents of that community thousands of dollars in thawing bills. Each of these developments is capable of use in other areas.

It is true that the $496,000 asked by the President for the year beginning July 1 is an increase of $9,000 over that appropriated for the current fiscal year. But it is equally true, as the result of inflation, that this $496,000 is the equivalent of only $446,000 in the dollars of 1952 when appropriations for the center totaled $466,000. In other words, your approval of the appropriation request still would leave the Arctic Health Research Center behind where it was 8 years ago when the need was less urgent.

I will not burden the record with details of what the Arctic Health Research Center would undertake should you see fit, as I hope you will, to provide additional funds above the request. I am certain your committee has access to these documented facts.

Briefly, however, these would include a study of the physiological adaptation of humans to cold environments ($32,000); epidemiologic research on the occurrence and nature of certain diseases in low-temperature areas ($103,000); inquiry into feasible means of providing liquid water, by storage in earth impoundments, for small arctic communities and institutions during the winter cold ($72,000), and experiments to develop a guide for the operation of septic tanks and tile fields under arctic or near-arctic conditions ($43,000).

We—the United States as a whole, not just Alaska itself—need this knowledge now if we are to keep pace with what other nations are doing.

It is not likely that Alaska can in the near future engage in research activities such as are now so successfully carried on by the center. We realize that operations of government, as well as industry and business, must carry on research in order to make progress, and this we are doing to the limit of our ability. We are determined to exert every effort to maintain and continue the development of health protection for our people. In so doing, however, we need the help and encouragement of progressive scientific personnel and programs of basic study such as are available from the Arctic Health Research Center.

## Crippled Children's Services

### Letter from the Honorable Harley O. Staggers, a Representative in Congress from the State of West Virginia

Mr. Fogarty. We also have a letter from Congressman Staggers on a subject I consider to be most important and one that I feel the budget before us does not properly support. We will place it in the record at this point.

(The letter referred to follows:)

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C., March 9, 1960.*

To: Hon. John E. Fogarty, Chairman, Subcommittee on Labor and Health, Education and Welfare, Committee on Appropriations, House of Representatives.

From: Representative Harley O. Staggers, Second District, West Virginia.

Subject: Appropriation for crippled children's services program, 1961.

As Representative of the Second District of West Virginia, and personally, I trust your committee may see fit to favorably report out the full amount of $20 million authorized by law for crippled children's services in 1961.

Our Nation is only as strong as its weakest link. It is to the children and youth of our country to whom we look as our forthcoming builders, teachers, fighters, and formers of the world. No one can deny that their leadership is being formed at the present time.

To have a healthy nation we must have healthy children. We must see that they are properly fed, clothed, and educated.

Going beyond the basic necessities, I sincerely believe we must provide for the unfortunate, crippled, and handicapped children. There are thousands of children in West Virginia and the other States of our Nation who do not have the physical or financial means of overcoming the hardships they must bear. West Virginia is doing its best to help these youngsters, but because of insufficient funds it has been unable to provide many of the needs for our handicapped children.

Unfortunately the burden is not lessening. For instance, West Virginia's program of services for children with congenital heart deformities has increased enormously; in 1948, 2 children were treated; in 1959, 233 were provided treatment. These cases are urgent and expensive. The State needs more funds for additional diagnostic cardiac clinics and for medical care and hospitalization.

There is no adequate program of services for children with rheumatic heart disease; if these children could be treated in the acute state, perhaps much cardiac crippling could be prevented.

The child with seizures has long been neglected, but it is now known that in most cases seizures can be controlled with proper treatment and these children so enabled to attend school and to become self-supporting instead of public charges. West Virginia has one seizure clinic covering only a few counties in one area. This program should be expanded to cover the entire State but funds are not available.

There is a great need for more physical therapy treatment centers. During the year 1959 treatment was provided for 560 children afflicted with polio and for 425 children afflicted with cerebral palsy. The majority of these cases, as well as the amputees, could benefit from more intensive therapy.

Another urgent unmet need is a program of services for children with speech and hearing defects. It is impossible with funds available to initiate this type of service.

During the past 10 years in West Virginia, there has been an increase of 41 percent in the total number of children provided care on the crippled children's program. During this same period, there has been a 46 percent increase in the average cost per case per year for hospitalization alone with similar increases in other costs of services and materials. Particularly during the past 2 years, there has been a very marked increase in the number of applications for treatment and in the number found financially eligible for care on the State program—a reflection perhaps of the depressed economic conditions in West Virginia.

In the wisdom of your committee, I sincerely hope you will see fit to favorably consider the full appropriation of $20 million authorized by law for crippled children's services in 1961.

It would be deeply appreciated if you would make this statement a part of the committee record.

Respectfully submitted,

HARLEY O. STAGGERS.

WITNESS

MRS. FITZHUGH W. BOGGS, PRESIDENT, NATIONAL ASSOCIATION FOR RETARDED CHILDREN

Mr. FOGARTY. We shall hear next Mrs. Fitzhugh W. Boggs, president, National Association for Retarded Children.

Dr. Boggs.

Dr. BOGGS. I am Mrs. Fitzhugh Boggs, president of the National Association for Retarded Children

I have a statement here that we have prepared and I will be happy to make available.

(The statement referred to follows:)

RECOMMENDATIONS REGARDING APPROPRIATIONS ON BEHALF OF MENTALLY RETARDED CHILDREN AND ADULTS FOR 1959–60

(Submitted by National Association for Retarded Children, Inc., New York, N.Y.)

The National Association for Retarded Children wishes to thank the subcommittee for the privilege of submitting this statement of recommendations on appropriations for the U.S. Department of Health, Education, and Welfare. The committee's work during the past 5 years marks an era. It was in 1955 that this committee first charged the U.S. Department of Health, Education, and Welfare with the responsibility of evolving a comprehensive plan of action to serve the needs of the mentally retarded. It has been decidedly a period of progress: existing programs have been broadened to include the mentally retarded; appropriations to various bureaus have been increased both to stimulate and insure the extension of services without impairing those to other handicapped children and adults; and, possibly most exciting and praiseworthy of all, new concepts and methods have been found and are currently reflected in legislation to help meet the complex needs of the mentally retarded.

For this progress we are profoundly thankful. Thankful on behalf of the 5 million retarded and their families who benefit directly and indirectly from these programs. Thankful, too, that we live in a land and at a time when the needs of people are reflected in the laws of the land.

As we proffer these recommendations we are aware that we do so at a time when many knowledgeable people have given time and thought to the analysis and evaluation of programs and services in which we are vitally interested. There have been reports from the Advisory Council on Child Welfare Services as well as from the Advisory Council on Public Assistance.

Preceding these there was the Bayne-Jones report on the "Advancement of Medical Research and Education."

Shortly to follow will be the many reports from the 1960 White House Conference on Children and Youth, which will chart the course for the Nation's children in the coming decade.

Though we speak for the cause of a single disability, we are committed to the welfare of all children. As a consequent we trust that our recommendations reflect the broad philosophy and understanding as expressed in all these reports on various aspects of social welfare as well as our own particular knowledge and needs of the retarded.

THE U.S. CHILDREN'S BUREAU

As you know this Bureau has a broad mandate to "investigate and report upon all matters pertaining to the welfare of children and child life." This responsibility is carried out through making studies and reports, working with public and voluntary agencies in an advisory capacity, developing standards for service, and administering grants for maternal and child health, for crippled children's services, and for child welfare services.

We do not feel that the budget as submitted by the President will enable the Children's Bureau to accomplish this to a degree which even minimally reflects the importance of its functions.

*Grants to States*

The total amount requested for "Maternal and child health" is $48.5 million, which represents an increase over the fiscal year 1960 of approximately 4.1 percent. Current population estimates indicate that our child population is increasing at the approximate rate of 3 percent a year. It is apparent then, that even without considering such factors as cost of living, the proposed appropriation increase will just about cover the expanding population.

The services of the mental retardation clinics under Maternal and Child Health auspices are directed to very young children and have conclusively demonstrated their effectiveness. Now, funds are urgently needed to extend the clinic work into demonstrations of clinic programs with school-age children and adolescents.

Even without this extension of service, there still remains a particular problem in making clinic services accessible to those living in rural areas in the more sparsely populated States. As a consequence, there are thousands of families to whom all important basic resource of a diagnostic and evaluation service is denied.

Retarded children can be helped, but they must first be found. Only then can the various treatment and habilitating skills be brought to bear on the child and his problem.

The value of the public health nurse in this connection has just begun to be recognized. In her contacts with young families and through her general knowledge of the community she can help find these children and make referrals. Once more inadequacy of funds has limited the Children's Bureau's utilization and developing of this case-finding method.

Once found, we can attempt to save the child from total dependency, give counseling to his family to enable them to better cope with this lifelong disability and possibly prevent the expenditure of thousands of dollars of the taxpayers money incurred when a mentally retarded child is institutionalized.

The $1 million increase in the 1959–60 budget for crippled children's services was utilized primarily for heart surgery for children suffering from congenital heart disease.

NARC has warmly welcomed this support for a new medical program which affects thousands of children.

In past years many crippled children's services have either excluded by law and regulation or else ignored in practice retarded children, feeling that limited funds did not permit consideration of this group. However, as we have greatly improved our techniques in the care, treatment, education, and training of these children, it has become evident that many of these multiple handicapped, severely retarded children are unduly held back in their achievements by physical disabilities subject to corrective medical treatment. In many instances, corrective surgery should be done in earliest childhood. This too, indicates the importance of early case findings.

Along with the Public Health Nurse, Child Welfare workers, particularly those working in the rural areas can play a vital role in case finding so that retarded children will be identified early. Furthermore, in rural areas these workers can do much in terms of parent education and community education toward a better understanding of the needs of the mentally retarded.

*Research activity of the Bureau*

The Bureau needs to support its operating functions through research. Last year, in our statement to this committee, we stressed our agreement with the findings of the Bayne-Jones report on "The Advancement of Medical Research and the Education" and the resulting recommendation that, "The research program of the children's bureau be strengthened by enactment of legislation authorizing the Bureau to support research through grants and contracts and that the funds available for the total research of the Bureau be expanded."

We wish to reiterate our strong support of this recommendation placing emphasis upon research activity that includes the collection of facts relevant to analysis of the adequacy of health services and studies of the health aspects of social services for children. It is essential to evaluate present services to determine future needs.

One of the obstacles to this activity has been the lack of legislative authority permitting the Children's Bureau to make grants to research organizations, institutions of higher learning, public and voluntary social agencies for demonstration and research projects in child welfare. There is legislation pending which, if passed, would rectify this. It is our firm belief that children's programs

as a whole would benefit from this legislative provision which would give specific encouragement and incentive to experimentation and research directed toward new or improved methods. It is to be hoped that this committee will insure that adequate funds are available to activate this proper and necessary function of the Children's Bureau should this bill become law.

The NARC is keenly aware of the need to combine governmental economy with provision for necessary services to children. To appropriate moneys for grants-in-aid demonstration programs to the States without, at the same time, strengthening the basic staff services at the Children's Bureau leads, without doubt, to inefficient and ineffective use of these moneys. We, therefore, recommend that your committee consider carefully the need for additional salary and travel funds for the Bureau.

U.S. OFFICE OF EDUCATION

Under Public Law 85–926, a program for the professional preparation of leadership personnel in educating mentally retarded children, 150 graduate fellowships to State educational agencies and 14 universities have been allocated. This program has become a landmark in the field of Special Education and it is with satisfaction that we note the President's budget proposes to continue the program on the same level in the coming year. Nonetheless, we would like to share with you some of our thinking concerning this program.

One of the "ideas" which loomed large in the original planning was that this type of program would act as a basic stimulant to the development of new programs in academic institutions. The grants to universities were to be made in such a way as to develop programs, personnel, curriculum (and subsequently enable the training of students) in universities, with preference to regions where no such facilities existed. In other words, the hope was that planning of new departments or substantial strengthening of existing programs would result from Public Law 85–926. What has thus far taken place, falls short of this mark in that it consists primarily of providing fellowships for recipients at universities with existing programs in mental retardation. In fact, we are informed of one instance in which a university made an application to the U.S. Office of Education for the development of such a program and it was rejected.

Another concern of the National Association for Retarded Children and relevant to this program is that of services to the deaf, blind or crippled child. What helps all exceptional children helps the mentally retarded, and a lag in service to one of these groups inevitably will affect the others.

We respectfully submit that an extension of this legislation to other areas of exceptionality may well receive priority in the deliberations of your committee. Obviously, the increase, both qualitatively and quantitatively in advanced post-graduate training in special education will benefit and further strengthen the programs now being set up in colleges and universities specifically for the mentally retarded.

The NARC remains gravely concerned about the inadequate staff resources in the Section on Services to Exceptional Children and Youth in the U.S. Office of Education. Both in the number of personnel available, and in its low position within the eschelon of the U.S. Office of Education, this Section is ill equipped to serve the 5 million schoolchildren who, by reason of blindness, deafness, speech defects, mental retardation, mental illness, emotional and social problems and other childhood disabilities require special educational services.

Since the significant developments in mental retardation are of most recent origin, it is of crucial import that the Office of Education have available additional permanent consultant staff to help the various States with planning of these new services to make sure that knowledge gained in one State is made available in practical form to the other States and to provide proper implementation of those public laws which assign to the U.S. Office of Education special projects and the program for advanced training in special education.

The staff resources of the Section of Services for Exceptional Children and Youth need also to be expanded to make possible closer coordination between the education services of primary concern to the U.S. Office of Education and the rehabilitation services of primary concern to the U.S. Office of Vocational Rehabilitation.

Already the public school systems of a few cities have initiated in a number of ways on the secondary level vocational training programs for the mentally retarded. It is of the essence that these programs properly dovetail with the new developments in the field of vocational rehabilitation. Achievement of this

objective will substantially depend on the increase in chances of helping retarded young people to become at least partially self-supporting.

OFFICE OF VOCATIONAL REHABILITATION

The growth in the State vocational rehabilitation programs made possible by the vocational rehabilitation amendments of 1954 has been reflected in an increased number of persons served and rehabilitated, expansion of facilities and workshops, increases in State funds for vocational rehabilitation and expansion of State agency staffs. Along with this there has been an increasing awareness of the special problems of the mentally retarded, not simply at the national level but at the State level as well. Even so, there is a serious discrepancy between the availability of rehabilitation services, and the numbers of mentally retarded who could be helped through various programs. It is significant, for instance, that while of all those eligible to receive social security benefits beyond the age of 18 because they are totally and permanently disabled, 67 percent are mentally retarded; the chart book of the 1960 White House Conference on Children and Youth shows that barely 4 percent of the youth rehabilitated through the State vocational rehabilitation agencies were mentally retarded. Considering the scope of the problem of mental retardation (3 percent of the total population or some 5 million citizens) 4 percent is an extremely small number to receive OVR services.

Obviously, the National Association for Retarded Children does not wish to see an expansion of the services to the mentally retarded at the expense of needed rehabilitation services in other areas of the handicapped; therefore, to enable some progress to be made toward equating those in need of service and the facilities and personnel capable of rendering service, we submit that the allotment base be raised to $70 million. This would enable States to initiate or enlarge services to the retarded.

We have commented earlier on the awareness within the Office of Vocational Rehabilitation of the problems of mental retardation. This awareness, unfortunately, is often not transacted in action on the State level. This points up the need in this comparatively new field of rehabilitation of the retarded for demonstration and research projects that will not only stimulate activity but also provide a learning experience for those in the field. It is our conviction that an increase of $1½ million over the proposed budget for the research and demonstration program of OVR is urgently needed.

An example of the kind of activity needed to be supported by these funds was the conference on research and demonstration in the rehabilitation of the mentally retarded recently held in Texas. This was sponsored by the Office of Vocational Rehabilitation in cooperation with the National Association for Retarded Children. It was composed of OVR project and State agency directors, lay and staff leaders affiliated with NARC, and specialists in mental retardation from National, State, and Federal agencies.

In terms of evaluation, stimulation, and learning this conference was so successful that we feel it should be made an annual event and be supplemented by similar efforts on a regional basis.

The importance of this kind of function—setting up conferences on rehabilitation in relation to specific disabilities—is such that it merits special mention in relation to funds being appropriated for the research and demonstration program of OVR.

As you know, there is legislation pending (H.R. 1119, introduced by Mr. Fogarty, H.R. 3465 by Mr. Elliott, and S. 772 introduced by Senator Hill) all of which embodies the concept that rehabilitation services should be extended to include training for "independent living," which is strongly favored by NARC.

This legislation is designed to assist the States in providing for their handicapped citizens greatly improved programs for the evaluation of rehabilitation potential, rehabilitation services for severely handicapped persons who can profit substantially from such services, but who may not achieve vocational rehabilitations, and facilities where evaluation services and rehabilitation services may be provided.

While this legislation is not as yet a concern of this committee, it must be mentioned here because it is of utmost urgency that the Office of Vocational Rehabilitation be enabled to make the necessary preliminary studies and administrative surveys in preparation for this new program.

More than 90 causes of mental retardation are known and others are suspected. Of these, only a few, stemming from certain causes, can now be treated or prevented. These factors, coupled with the high incidence rate—30 out of every 1,000 children and adults are retarded—cause many families of retardates to follow any lead which they feel might remotely benefit or improve their child's mental ability. There have been claims made for expensive drug therapy and costly cell injection cures which either have not yet been satisfactorily tested by scientific methods or which are out and out quackery.

For the detection of these schemes, their practitioners and purveyors, we are dependent upon the good offices of the Food and Drug Administration and would, therefore, submit that the proposed budget by no means suffices to provide adequate protection to the public and in particular the parents of retarded children.

## THE NATIONAL INSTITUTES OF HEALTH

In 1950 when the National Association for Retarded Children was founded in Minneapolis, the field of mental retardation presented a dismal picture not only by the inadequacies of facilities and the negative attitudes of the public and of educational, clinical, and social service agencies toward work with this group of handicapped people, but there was also an almost total lack of research activity. Today, 10 years later, the picture has undergone a change so revolutionary as to be almost inconceivable. Not only are some of the finest minds in some of our most distinguished universities at work to investigate mental retardation and its causes, we actually have achieved in this short span of time, success in instituting at least the beginnings of definte preventive programs.

To be precise, today successful scientific research has presented us with diagnostic tools and therapeutic procedures to prevent mental retardation in children who 5 years ago would have been so damaged as to require lifelong institutionalization.

This truly miraculous progress is largely due to the courageous farsightedness of your committee in making unprecedented research appropriations to our National Institutes of Health.

Therefore it is with chagrin that we have noted an actual decrease in the administration's budget for the National Institute for Mental Health and the National Institute for Neurological Diseases and Blindness.

Particularly the latter Institute, the youngest member of the National Institutes of Health, would suffer intolerable damage if its growth were to be curtailed at this moment.

More than 10 million Americans are today substantially disabled through neurological disorders among which mental retardation looms large. We urge your committee to effect a substantial increase for this Institute over the administration's proposed budget. We have participated in numerous meetings of the National Committee for Research in Neurological Disorders, of which we are a member, where the needs of this Institute have been most carefully scrutinized, and therefore unhesitatingly endorse and recommended to you the committee's recommendation for a $61 million budget for the National Institute for Neurological Diseases and Blindness.

## HOSPITAL CONSTRUCTION FUNDS

Until early in 1958 an administrative interpretation of the Hill-Burton Act excluded mental retardation institutions from the benefits of the act. Belated recognition of this wholly unjustified discrimination against those suffering from this particular affliction has now revoked this restriction. However here again the National Association for Retarded Children does not desire to prejudice the pressing need in other areas of illness and handicap, and therefore urge that additional funds be made available. We cannot agree with the viewpoint expressed in the administration's budget that this program can now safely be curtailed.

Additional bed space in institutions for the mentally retarded at the rate of 8,000 per year, and the recent progress in prevention and therapy underlines the importance of more adequate medical and research buildings in these institutions so that better diagnosis and early therapy will result in the return to the community of individuals presently requiring lifelong institutionalization.

Dr. Boggs. As you know, we are interested in about eight of the agencies in the Department of HEW which have some special role to play vis-a-vis retarded children. We have tried to make this a careful and thoughtful statement, and I do not propose to read it to you.

I thought if I could take a few minutes and hit some of the highlights it would perhaps be more helpful.

I think practically everything I have to say has something to do in one way or the other with the key question of personnel. I want to say before I get started that all of us have been very delighted at your receiving the Lasker award. It is very proper recognition of the very important role you have played in putting a sound footing under the whole national program of the HEW. I thought you received another fine tribute recently from the head of one of the agencies who said, "The thing about John Fogarty is, no matter how much he may be in favor of the things you are trying to do, or he thinks you are trying to do, he never forgets his duties as a Congressman to insist the programs be properly justified and the facts and figures put forward appropriately." I thought that was also a well-deserved tribute.

I think, on the subject of facts and figures, you have certainly recognized, and most Congressmen have recognized, the Federal Government has a role to play that nobody else can play, that many of us are dependent upon the facts and figures that the Federal Government can collect on a national basis concerning our health and welfare, and that this is important in the period of change such as we are now going through when so many things are growing and expanding.

This is a source of concern to us. Mr. Elliott's committee is holding hearings around the country right now, and his people keep saying to our people and the other voluntary agencies, "Give us the facts and figures." Many of these facts and figures are such that the Federal Government should be collecting them and supplying them and making them available, because for all of us to go looking for them is not efficient; furthermore, it is hard on the people we are asking for the information. I think when the Federal agencies ask the State agencies for information, the State agencies are desirous of cooperating and recognize this as an authority above and beyond any private agency asking for information. I mention this because I recently had a letter from Commissioner Derthick, Commissioner of Education, in reply to a letter I wrote asking why we had not been able to obtain the compilation of the figures I knew that they had collected nearly 2 years ago. He wrote back and I quote:

> We regret deeply the fact that we have not been able to prepare the reporting on statistics of exceptional children which were collected in the spring of 1958. Our difficulty is that the added number of new office programs has taxed our resources so that we have not been able to prepare this report as promptly as we would have liked. We realize that the collection and dissemination of statistics on a nationwide basis is one of our primary requirements. Organizations such as yours should be able to rely on the Office of Education for basic figures that you are requesting.
>
> Let me hasten to reassure you that as soon as the data have been assembled in usable form, they will be made available to your organization and to any others who have requested them.

This pertains very directly to a point that we are making to the department and to this committee, too; and that is, the expanding pro-

grams which are being authorized are splendid, but they require adequate staffing in the agencies themselves. I know Congress is very reluctant to build up a Federal bureaucracy in HEW, and I think the reasons are understandable, but there is a point below which you cannot operate and do the job that the Federal Government alone can do.

This has been particularly true in this area of exceptional children. There has been no expansion of the staff there, but every time I go over there I soon see a new face. I do not see the old face that was there 6 months ago because they have been largely getting along on temporary positions, part-time consultants, somebody that they can borrow for a while. This does not make for continuity. In a matter like this, statistics, you need cooperation with people who are trained and who have an understanding of what you are counting and measuring.

If there is no continuity of personnel, that holds things up and it is an inefficient use of people.

Perhaps your committee should think of doing what you have done several times at the National Institutes of Health; and that is, give them something that they were not allowed to ask for.

I would like to jump from that to another question which is also related to personnel. I am going to quote from the Science Newsletter, of December 5, 1959, which is reporting on a report that the Secretary of HEW and the Surgeon General are planning a survey concerning the people who are receiving grants for research, as to where they came from and what they were doing before they started, and I quote:

> Many thousands of scientists who have received Government grants within the past 10 years will be asked whether or not they were in private enterprise before they received their grant, and what they did when the grant expired. In this manner the Government hopes to be able to determine whether or not doctors, teachers, and other trained persons are leaving their public service duties to do research work or whether these same people would be in research despite lack of grants.

The answer may be that these researchers are being diverted away from other valuable work. In addition, there are areas of specialization composed of too few workers now, and to draw one of these away from research might be undesirable.

I think it is very commendable that they are making a study of the impact on the whole personnel situation of the various Government programs, but I repudiate the inference drawn here that research is a luxury that you can indulge in only after you have done everything else. Research is the essential basis of prevention. This makes me think of the woman who came into her bathroom, found her tub overflowing, and rushed out to get the mop. She said she did not have time to turn off the faucet because she was too busy mopping up the water flowing over. This is about the position we find ourselves in when we take the attitude we are too busy taking care of people now sick to give any thought to preventing their getting sick, or preventing people in the future from getting sick.

So far as where these research people are coming from, let us refer to a testimonial given before this committee in 1959 by Dr. Stewart

H. Clifford, who identified himself as having been for over 20 years the pediatrician of the Boston Lying-in Hospital, who went on to say:

> Until January 1958, I was engaged in the private practice of pediatrics contributing my time to academic teaching and research on a strictly voluntary basis. Since then, I have withdrawn from private practice to devote my full time to the direction of NINDB's collaborative project on cerebral palsy, mental retardation, and other neurological and sensory disorders of infancy and childhood at the Boston Lying-in Hospital.

Personally, my reaction to that is, thank God we have somebody like Dr. Clifford who combines an interest in research with this practical longtime experience derived from his practice with babies, newborn babies, who is willing to take on the job of the NINDB of directing this very important study.

Any inference this is somewhat of less value to the Nation, I think, should be thoroughly repudiated.

I have rather strong personal feelings about the NINDB's perinatal project. I think that you are already familiar with the statistics which show that among the people who are now receiving social security benefits as permanently and totally disabled as a result of disability that originated prior to age 18, more than two-thirds are mentally retarded.

This indicates that long-term disability in our society from mental retardation is a very serious economic, as well as social and human problem. Furthermore, a vast majority of these people become disabled in the perinatal period. That is when the trouble originates.

Now, in testimony given before this committee, I think 2 years ago, reference was made to the fact that even as early as it was in the history of this perinatal study, this collaborative project, they happened on one very significant discovery which was the development of a technique for sectioning and examining the umbilical cord at birth through which they were able to detect incipient infections which might not otherwise be manifest right away, and which could have had damaging effects.

Well, it so happens that our only son contracted just such an infection at his birth in 1945, which was not diagnosed until the symptoms began to become acute when he was about 10 days old, and as a result of this experience he will spend the rest of his life in an institution. I feel that this one single discovery that has now been made by the NINDB can have the potentiality of preventing this happening in other children of other generations and other places and that it is well worth all of Dr. Clifford's time.

Now, however, I want to point out further it is well enough to discover these things, but unless they are put into practice and unless they are applied, and unless this knowledge is utilized in hospitals it does not suffice to have discovered it. This is why I want to speak particularly to the training program of the NINDB.

The National Committee for Research in Neurological Disorders is suggesting an increase of about 10 percent in the appropriation of the NINDB for this particular purpose. This will bring about in part the further development of the departments of neurology in medical schools that do not now have them. This has been a very serious lack so far as we are concerned, the lack of training of other kinds of medical men in neurology as part of their basic medical

training. This is one of the things that has caused really untold suffering to parents whom I know who are very much aware of the fact that the medical people have in the past not been adequately informed on the complexities of mental retardation and the neurological aspects of it, particularly in the newborn child.

I think that that concludes what I want to say.

Mr. FOGARTY. What about the Children's Bureau work in this field.

Dr. BOGGS. You will find that we have mentioned the Bureau in our statement. It is the lead item in the statement that we have prepared. We have been very pleased, of course, with the early childhood activities of the Children's Bureau, the clinics and related projects that have been undertaken. This is a direct result of the interest of this committee which earmarked money for that particular purpose.

We do feel that the Children's Bureau is also like the U.S. Office of Education, somewhat handicapped by limitations on its central staff.

We are also hoping that Congress will follow the recommendations of the Jones committee in their report which suggests enabling legislation be introduced which would permit the Children's Bureau to be a little more active in the research area and to have a little more flexibility in research and demonstration projects.

I think the experience of the Office of Vocational Rehabilitation in the research and demonstration field has shown how the Federal program can interact with the State voluntary programs to produce very desirable effects.

I might say in this connection we are already up against this problem with the demonstration programs that the Children's Bureau now does have in this maternal and child health clinical picture in that there is now a clinic of some sort in most of the States. But this business of one per State takes no account of geography, or population problems. People cannot go halfway, or all the way across the State to get their services. The result is when these programs have been developed people have been stimulated to want them in other parts of the same State and there is a real dilemma here as to how far the Federal Government will feel that its responsibility extends and to what extent it can lend assistance to the States to make this a broader service program which will really reach the people where they are.

I think there is no doubt that this is part and parcel, as I said earlier in my statement, of the prevention of the disease. This early detection which the Children's Bureau engages in is most important.

Incidentally, I think the Children's Bureau is to be commended on the interest they have taken in getting pediatricians and people in well-baby clinics and early child care interested in prevention of PKU through early detection of these cases and making the subsidy on the diet available to families which otherwise could not afford it. I think this is a very good example of a constructive activity on the part of the Children's Bureau. That is one of the biochemical diseases. We know about 10 have been identified already, and there probably will be more because of the intense interest in this theory now. Each of them will probably have some rather complicated treatments which will be necessary. Yet it is like the congenital heart operations which are also being promoted by the Children's Bureau.

52692—60——38

This is really prevention of lifetime disability, and very important for that reason.

Mr. Fogarty. Saving lives.

Dr. Boggs. Indeed, yes.

Of course, in our area we worry that people figure that when they save somebody's life they have done the job. Actually, in so many cases our children are children whose lives have been saved but who have been too damaged in the process.

Mr. Fogarty. One of the big problems, and you mentioned it in your testimony, is the length of time it takes to get the knowledge of these discoveries. Have you any suggestions along that line?

Dr. Boggs. Here again, perhaps I can take a leaf from one agency's book and put it in that of another. You and I recently had some experience with this conference which was sponsored by the Office of vocational Rehabilitation. The important thing about that conference was that it brought people together who are in action in an area where professional training in a normal sense has scarcely been developed because everybody is learning on the job, so to speak. This whole business of sheltered workshops for the mentally retarded is so new that you do not have preparation for it the way you do for becoming a nurse or even a teacher.

The same thing applies, I think, in the public health field. We must bring people together. Very often, while it is important to get things in the literature and get things written, and so on, it is also important to bring people face to face and let them communicate with one another.

I think, therefore, that when the Children's Bureau sponsors, as they did, a conference on the nutrition of the mentally retarded, this is highly valuable, and that perhaps they should be encouraged to sponsor more conferences around the public health aspects of mental retardation and prevention of retardation.

You know that 15 years ago people shrugged their shoulders at the thought of preventing mental retardation, and now we are eating away bit by bit, chopping off little bits of it through surgery, through neurosurgery, and through the discovery of the biochemical diseases, and so on. Here again, some of these neurosurgical procedures are frighteningly expensive. Although the National Foundation has undertaken to subsidize patient care in certain very selected types of cases, we have no real program there to pick these up and get the operations performed.

Mr. Fogarty. Are you satisfied with the progress being made in perinatal studies?

Dr. Boggs. I think it is too early for us to judge. I think you are probably asking me a certain question which I do not feel——

Mr. Fogarty. I have asked that same question two or three times recently of other witnesses.

Dr. Boggs. I think this a tremendously complex program, and it is a program which requires not only expert scientific management, but expert management of people, because it is called the collaborative project for good reason. We are mobilizing 16 or 17 independent, autonomous, high-powered groups of people, each of whom is being asked to subordinate his own ideas to a general plan for the purposes of bringing out what can be brought out only in a general plan.

I think there have been certain problems which have developed out of that fact. It is sometimes hard for these people to see where they fit into this vast scheme of things. Here again, I do have reason to believe that the fairly recent practice of the NINDB of bringing some of these people in to the Institute itself for 2 or 3 days of discussion with people from other centers has had tremendous value from a morale point of view, and also from an ideational point of view, making them see where this is all going.

The proof of this pudding we will not see for another 8 or 10 years when they really begin following these cases up and doing the statistical analyses which will eventually come out of it.

There have been these byproducts which nobody dared count on. I cited one of them, and there are some others coming out of it. There is another by product, I am sure, which is that they are learning a great deal about how to conduct this kind of almost epidemiological research which they did not know before.

Nobody could do this kind of thing excepting the Federal Government.

Mr. FOGARTY. The Federal Government had to do it.

Dr. BOGGS. This is what makes it so very expensive. It is collaborative in the true sense of the word. I have great respect for any and all of the people who have anything to do with it. I think we are extremely fortunate in the personnel we have recruited. I do think they are handicapped out at the Institute in respect again to the central personnel. I think this thing has to have a staff at the Institute which is keeping track of all these things, seeing the signs of something going astray and seeing the picture as a whole in a way no one of the collaborating institutions can do. I think they have suffered somewhat in not having a sufficient number of authorized positions for that work.

Mr. FORARTY. In which Institute?

Dr. BOGGS. The National Institute of Neurological Diseases and Blindness. They are the ones conducting the studies to which I have been referring. There is one on perinatal causes of cerebral palsy, retardation, and things of that kind.

Mr. FOGARTY. I am sure Dr. Masland said he could use some more money in these various areas. I gave him plenty of chance to tell us about his needs.

Dr. BOGGS. You know Dr. Masland was our research director before he went to NINDB. We have great respect for him as well as affection.

Mr. FOGARTY. I think he is doing a good job.

You are going to be a delegate to the White House Conference on Children and Youth?

Dr. BOGGS. Yes, I am a member of the national committee. I plan to be there. I am looking forward to it very much. I shall be very glad to state what I also feel, and that is that the appropriation being allowed to the Children's Bureau for that conference is really pretty niggardly. The White House Conference on Education and the Conference on the Aging, I think, have been much better treated by Congress than the White House Conference on Children and Youth which, after all, started this whole custom.

Mr. FOGARTY. The White House Conference on Aging is running low on money, though.

Dr. Boggs. They are? Well, the only reason the White House Conference on Children and Youth is not running out of money is because they have been bailed out by some other people, and the national committee members are not getting their expenses paid to come here to Washington.

Mr. Fogarty. I think that is a shame.

Dr. Boggs. I am not complaining about that.

Mr. Fogarty. I think they should be paid. The White House Conference on Aging are requesting some of their people to go and work with no pay, too.

Dr. Boggs. I have been working a little bit with the study people on the White House Conference on Children and Youth. I am on the study committee of the national committee. These people are working very hard under extremely difficult conditions.

Mr. Fogarty. It is a big job.

Dr. Boggs. It is a big job. I think the studies which will come out of this will be quite significant and quite helpful.

Something else I might mention in view of the testimony just before me. I do not know anything about BCG, and certainly would like to be quoted less. I will say, first of all, in a positive sense that you have before you in one form or another various kinds of recommendations and suggestions for international activities in the field of health, education, and welfare, and we in NARC are extremely interested in this. We are in contact now with about 50 foreign countries' organizations, many of them organizations comparable to us and some of them simply organizations we are working with, either officials or individuals. We are being helpful in forming a parent group in Indonesia right now. We are also aware that, contrary to popular opinion in this country, we often have more to learn than we have to give, as far as mental retardation is concerned. This is particularly true in the management field. I think what is being done in Sweden, Holland, and England is in many respects 15 or 20 years ahead of what is being done here.

Mr. Fogarty. In this problem of mental retardation?

Dr. Boggs. That is right.

Mr. Fogarty. Is that so?

Dr. Boggs. Their institutional programs and their so-called aftercare programs are something we are just talking about. I think, therefore, that any opportunity this committee has to encourage staff members of the Federal agencies involved in this to get abroad and see some of these things, or to have other people go, would be good.

Mr. Fogarty. What do you think ought to be done in this budget to help catch up?

Dr. Boggs. The National Institutes of Health, of course, has been fairly aggressive in this, and does have a fairly active program of international exchanges. But I am not sure that the other agencies are as able either to get abroad themselves or to send people abroad as would be advantageous to us, to the cause of the American retarded and to advancing our knowledge.

Mr. Fogarty. In all of these areas in which you are interested, as far as the Federal Government is concerned, what do you think about the present appropriations?

Dr. Boggs. I think the Office of Vocational Rehabilitation could use more than $1½ million in its research and demonstration program.

It is always hard for me to understand this business about the allotments to the States, but I think under the basic support program they could use more. They could make good use of more in their aid to the States.

Mr. FOGARTY. I do not know of anyone who understands that allotment formula.

Dr. BOGGS. You relieve my mind.

Mr. FOGARTY. There are not many people in the Office of Vocational Rehabilitation that can explain it.

Dr. BOGGS. Just so long as I do not have to pass an examination on it right now. But I am aware that the State programs are expanding all along, and in many cases are limited by the Federal appropriation. In other words, this kind of keeping step sensation here.

One of the things that was very clearly and graphically stated in one of the preliminary publications of the White House Conference is that so far as youth are concerned, of all the people who are being rehabilitated through OVR activities, only 4 percent fall in the whole mental category. So in spite of the very large numbers of mentally retarded—and I just cited the figures on permanent disability—only a small proportion of those who are getting services from OVR are in this category. So there is room for great expansion there, and our attitude always has been that we do not want to take away from somebody else. We want to get our share.

Mr. FOGARTY. I am not suggesting that we take away from anyone.

Dr. BOGGS. I am pointing out we do not want to take away from anybody. If this is to expand, it must expand by increases of its own.

Mr. FOGARTY. What about the Neurological Institute?

Dr. BOGGS. As far as the Neurological Institute is concerned, the national committee is proposing to you a $61 million appropriation. This makes sense to me. I think it is not possible to categorize just what in the NINDB program you can say is specifically for mental retardation and what is not. There are certain things we can say are not very closely related, but much of what it does deals with this whole problem of damage to the brain, and whether it is cerebral palsy or epilepsy or mental retardation information which comes out of it is secondary. This is the nature of basic research in these areas. We stand ready to work closely with the other organizations which are represented on the committees for neurological disorders. We recognize in our own research program, as far as basic biological causation is concerned, that we have a great deal in common with these kindred organizations, and we exchange information with them.

I just make the point that I sympathize with the people in NINDB when they say they cannot categorize everything they do so neatly.

Mr. FOGARTY. We have been pretty good to that Institute the last 3 or 4 years. If it does not have enough money to take care of this problem of retardation, I would like to know about it because that is one of the things I have been interested in.

Dr. BOGGS. You have indeed.

Mr. FOGARTY. I would hope they would do everything they could in this field.

Dr. BOGGS. You know NINDB is one of the youngest institutes. It has come from scratch, and it has suffered from this neglect of the whole field of neurology and the paucity of expert neurologists. This,

of course, is why they are directing this effort to the traineeship program and the training grants.

Incidentally, I know that Dr. Masland tries to encourage the people who are now coming out—this is the first product of this professional training program, this advanced training in neurology program—to go into university teaching and into research rather than into practice. I think he is absolutely right. We have to use these people as seed people.

Mr. Fogarty. I think someone said yesterday that 80 percent stay in the field of research and training.

Dr. Boggs. It is a high percent, and I think for the time being it is a necessary percent, because otherwise we will not develop the potential for training of clinicians. This is why I am so concerned about the implications of this announcement that people who go into research are depriving the clinical field.

Mr. Fogarty. That is the President's argument.

Dr. Boggs. I know, but I wish to dissociate myself from it.

Mr. Fogarty. What about the Mental Health Institute? This is what their justifications say. I shall read it to you since you have not seen it.

The success of the mental retardation program within the past 4 years is the direct result of a three-way partnership of science, health, education, and welfare services, and the desire of the people to deal with a problem of consequence. Solutions to these problems have arisen out of widely divergent areas and are applicable not only to the mentally retarded, but also to some other chronic ills of mankind.

They have a breakdown of the obligations: $2,356,000 actual in 1959; $2,753,000 estimated in 1960; and $3,195,000 estimated in 1961.

Dr. Boggs. You mean this is what they say they have assigned to mental retardation?

Mr. Fogarty. Yes.

Dr. Boggs. I have not had a chance to examine that, so I do not feel so well qualified to comment upon it. They have been interested in the psychosocial aspects particularly. They have made several important grants—one, for example, to the State of Massachusetts for an experimental program, here again in the early detection and counseling field. They have nursery clinics, as they call them; a preschool program, both group actiivty and individual work. I think they have recently received an NIMH grant to evaluate that and follow it up. This is all to the good.

Mr. Fogarty. Do you think they should have more money?

Dr. Boggs. This is a difficult thing to say, but I think I would be honest in saying I have not evaluated what they proposed, because we did not have the material you have in front of you. I have not seen it, and I do not feel it would be appropriate for me to say, "Yes; of course, they need more money."

Mr. Fogarty. What about the Children's Bureau?

Dr. Boggs. I think the Children's Bureau could definitely use more. For example, the expansion in the crippled children's services which took place last year under the increased statutory limitation went almost entirely for this open-heart operation. That is fine. That was needed. But it has not involved expansion in any of the other types of services.

I have mentioned that in the past we have been quite concerned because mentally retarded children who are also crippled are not getting service for their crippling condition on the grounds that they do not count as much.

Mr. FOGARTY. I was hoping to get that up this year to the authorization of $20 million.

Dr. BOGGS. I could easily imagine that this could be made produce.

Mr. FOGARTY. They are asking for only a $666,000 increase, I believe.

What about the Office of Education? Are they doing as much as you think they ought to be doing?

Dr. BOGGS. I have spoken already to the point of staffing. More money could profitably be spent under the cooperative research program, and also under Public Law 85–926, which is at its statutory maximum at the moment. I would like to come back to that in a minute.

I do feel that the Office of Education should not be given more grant money unless it is also given more salaries and expense items to administer the program effectively and properly, because what is happening now is that personnel who ordinarily would do things like compile the statistics are being siphoned off to administer the National Defense Education Act or whatever. All these are fine programs and well conceived and well thought out, but they do take some extra staff people and competent staff people. This is where the bottleneck has been.

On Public Law 85–926, I will be frank to say we have been somewhat disappointed at the way in which the money which has been available has been apportioned. The National Defense Education Act has its graduate fellowship program setup. Shortly after it was passed, Public Law 85–926 was passed, and I think by the very fact that Congress passed this bill separately and apart from the National Defense Education Act indicated Congress thought there was something more and special that should be done in this area.

What has happened in fact is that the money under Public Law 85–926 is being administered according to much the same pattern and plan as the graduate fellowship program of the National Defense Education Act. This means that they are giving it out in the form of fellowships, a stipend to the individual receiving the fellowship plus an allocation to the university where he studies, which is a kind of tuition grant in lieu of tuition.

This is fine for the moment. I know some of these fellows, and capable people are taking the fellowships. It has taken people who would not have taken this training otherwise and put them in the existing universities which have already established departments of special education. This is well and good, but the testimony before the committee which was considering this bill when it was under discussion made it quite clear that considerable importance was placed by us and others on that provision of the bill which provides for what some people call teaching grants, training grants, to the universities. This is a flat grant so the university can either establish or build up and improve the quality of the program in this specialized field.

The purpose of this, in part, was to even up the geographical balance of these programs. There is just a handful of universities which

are really qualified now to provide proper training for doctoral candidates in this field, and they are very irregularly distributed. The Far West and the South have been behind in this business. It is all very well to have people from California coming to Syracuse University, but this does not make for a total picture.

This part of the law has not been implemented at all. No grants have been made under this particular provision.

A certain number of fellowships, 50, have been given to universities. I think there are 14 universities which have been carefully screened and considered qualified, and they have received these 50 fellowships among them, which are in their gift. With these fellowships they get, on a per-student basis, this tuition grant. They do not get the grant until they get the student. This is putting the cart before the horse. You have to have your program to attract your student.

Then the States have each been given 2 of these fellowships, making a total of 100. So practically all this money has gone to 150 fellowships, 100 of them in the gift of the State departments of education at the rate of 2 per State, regardless of size or population or anything else.

I understand very well the rational behind this. The idea was that you need people in administration, people in supervision—this is true—and that the State departments of education were in a position to identify these people. But quite frankly—I can document this if you want—this is an inefficient way to go about it because the people have to get themselves admitted to the colleges anyhow, so they have to be accepted by the colleges.

In addition, they have to go through the State departments of education to meet their requirements, whatever they are. This is proving, I would say, even a little burdensome to some of the State departments of education who are conscientious. They feel they should set up procedures.

I have with me somewhere here the recent newsletter of the California State Department of Education in which they describe in detail how they are going about setting up the procedures for screening their fellows, selecting them, applications to be in on such-and-such a date, and so on.

The amount of State personnel time going in toward spending this $10,000 total involved in California is out of all proportion, in my opinion, to the importance of allocating just two fellowships.

If instead the San Francisco State College had received a grant to elevate its present master's program to a doctorate program, and then had received these two fellowships along with a couple others, and had used its usual procedures for admitting students and allocating stipends, and so on, the whole thing would have been conducted with a great deal more economy of administrative time and effort and would also have been done with more expedition, because in spite of the fact that the States really knew that this bill had been enacted before the appropriation was made, and that the appropriation had been requested, many of the States last September were caught without candidates for this business, so that a relatively small number of State fellowships, fellowships awarded by the States under this law, were awarded during this first semester. Now the States are

picking up on this and more will certainly come in, quite a number more are coming in in the second semester.

However, in the meantime a very good National Advisory Committee has selected the universities which are now receiving these other fellows and an excellent job has been done there and in my opinion this should suffice for the whole administration of the fellowship program.

Again I emphasize that I think some of the money should be made available as flat grant to start the program or get it over the hump.

This is a pattern with which you are very familiar. We are talking about National Institutes of Neurological Disease. They get a department started, and along with that they feed in some traineeships.

The same thing was done with the National Institute of Mental Health when they started to train clinical psychologists. This has been very successful. They gave them money to start with so that they could engage that new professor they needed or build up their library, or whatever the case might be, and then when they got geared and looked attractive they got the good students and they then had the fellowships to give them.

This situation results in fellowships being refused to universities and colleges which do not now qualify under the standards being set by the Advisory Committee, and I think under the circumstances this is right—they should not give out fellowships until they can promise the students will have a first-class education as a result.

However, this is the way it has happened.

Why the Office of Education could not follow this other pattern I do not know.

Frankly, I think that handing out fellowships is easier administratively and that is my opinion.

Mr. Fogarty. Are there any other recommendations you would like to make?

Dr. Boggs. Since most of the million dollars already is committed and these fellowships should be continuing, the statutory limitation should be raised and an additional appropriation clearly indicated for teaching grants included.

Mr. Fogarty. Why don't you write me a letter giving me some good reasons why they should be raised and legislation changed.

Dr. Boggs. Yes.

I should say once more for the record we believe in this area of training of personnel and special education it would be sounder if this law were to be extended to cover all areas. The pattern of the universities is for a department of special education and this is a sound pattern. We have good reason to be aware of this because the mentally retarded so frequently have hearing defects, poor vision, and something of the sort, and they have speech problems particularly, so people who will be the leaders in this field need to have this variegated grounding. I think the universities would find this more congenial if they had a little more.

Mr. Fogarty. Do you have any other criticisms or thoughts you would like to leave with us?

Dr. Boggs. Our feelings are a combination of tremendous gratification at the very considerable progress which has been made and of very great gratitude to you personally and to this committee for the

leadership which has made this possible. I certainly do not think that the Department would have moved as rapidly or as effectively merely on its own initiative.

Mr. FOGARTY. The reason I ask these questions is that sometimes they get started and then bog down. They need to be reminded that something should be done.

Dr. BOGGS. I found when we were working over this statement that I said to myself that except for the so-called independent living bill we do not have major legislative means outside of appropriation.

I found we got to the point where there are several things that should now be changed in the enabling legislation for the appropriation to move in the right direction.

I will give you a simple example: When Public Law 8926 was passed it had originally been introduced to promote both teaching and research. The idea was to train personnel who would be not only potentially college faculty members and supervisors but people capable of doing research.

All references to research were struck out. I understand the theory was that the research was covered under the cooperative research program.

This is not true. The cooperative research program is a grant program to do research but it does nothing to train people to do research. It is not a research training bill and the bill as presently constituted did not appear to authorize that.

I understand that when this interpretation was made in Congress that we need not have this in Public Law 8926, the Office of Education responded to this interpretation by requesting funds for a research training grant, a program of training research workers under the Cooperative Research Education Act, and were turned down on it. Maybe this is something which would be of interest to your committee to pursue.

Mr. FOGARTY. Would you like to say anything else?

Dr. BOGGS. You have been very generous. I have had a delightful time.

There is a reference to the Food and Drug Administration.

Mr. FOGARTY. Yes.

Dr. BOGGS. This is related to some of the things said to you earlier in the day.

Thus in a field such as mental retardation, where there is so little hope for the child who is past infancy and who is found to be retarded, it is natural for parents to grasp anything and everything. They say, "What is there to lose?"

They do not see it that way if they get involved with expensive and unproven therapy. There are certainly some things on the market, some things being peddled, which the Food and Drug Administration could become quite emphatic about on the basis of present knowledge.

However, we have found ourselves, as an organization which is attempting to be a responsible organization, in a somewhat tight fix when it comes to certain proposed things which have not been adequately tested. I spoke of the good things that have been done in other countries, particularly in Europe. But occasionally some things as reported from Europe have never been tested in this country and we do not feel we can in good conscience propose or recommend them,

even if we can find somebody in this country who is willing to give the treatments.

We feel strongly that the Public Health Service has perhaps been a little dilatory in picking up these things and deciding whether they should be tested and then seeing to it that they get tested, so that we can say "yes" or "no"; this is appropriate or not.

It is pretty hard for us to get letters, which we do, from people who say, "I read in the paper or magazine so-and-so. What about this?"

They look to us for assistance. All we can say is that it has not been tested to our satisfaction.

What we should be able to say is that it has been tested and we believe it is or is not appropriate for thus and such reasons. We cannot say that at the present time.

Occasionally you have somebody who claims a cure who will not give you sufficient data to do the testing on it. I have in mind one particular person in this country of whom that is true.

The other also pertains.

Mr. FOGARTY. We thank you very much.

Dr. BOGGS. It has been a pleasure.

## GRANTS FOR HOSPITAL CONSTRUCTION

Mr. FOGARTY. I think this committee may well do something to correct the budget for grants to States for hospital construction. As on many other items that have been cut back in the budget, there are so many letters that we can't print them all but I have received a letter from the American Hospital Association that I certainly think should be in the record; a letter from our good friend and fellow committee member, Congressman Rabaut, enclosing a letter he received from Governor Williams, and letters from other Members of Congress. We will place these in the record.

(The letters referred to follow:)

AMERICAN HOSPITAL ASSOCIATION,
*Washington, D.C. February 18, 1960.*

HON. JOHN FOGARTY,
*Chairman, Subcommittee on Labor, Health, Education, and Welfare, House Appropriations Committee, House Office Building, Washington, D.C.*

DEAR CONGRESSMAN FOGARTY: We are concerned that the appropriation for the Hill-Burton program requested by the President's budget this year is substantially less than the amount the Congress appropriated last year and less than the maximum authorized for the program.

Since the inception of this program, facilities being constructed throughout the country have just about kept pace with the needs of the increased population. The sizable backlog of facilities needed at the time the program was started, the large number of facilities which are obsolete and should be replaced, and the substantial increase in facilities needed to meet the increased use required by the population are not being met under this program.

We believe it to be most unfortunate that once again this year the proposal of the administration for funds to be appropriated fails to recognize the needs of the country for health facilities.

We are seeing the emergence of a new area of health facility needs which could not be fully evaluated in the past. This is the need for facilities to provide for long-term care of patients—in large part, the aged. As more financing is being made available for the care of aged persons, the facilities required to adequately serve their health needs increase. Such increased financing of care will give great stimulation to construction of nursing home and other long-term care facilities under public and nonprofit sponsorship. Long-term care facilities can be constructed under part C of the program, as well as under part G, and we

feel the need is such that the full amount of funds possible should be made available.

We strongly urge, therefore, that the Congress appropriate the full $150 million provided for under the act for part C of the program and, further, that with respect to part G, it appropriate the full amount allowable under the act at least for the two categories which are devoted to long-term care facilities; namely, nursing homes and chronic disease hospitals.

We would appreciate your including this letter in the record of your hearings.

Sincerely yours,

KENNETH WILLIAMSON, *Associate Director.*

---

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C., February 24, 1960.*

Hon. JOHN FOGARTY,
*Chairman Subcommittee for the Departments of Labor and Health, Education, and Welfare and Related Agencies, House Appropriations Committee, House of Representatives, Washington, D.C.*

DEAR COLLEAGUE: Enclosed is a letter, together with attachments, which I have received from the Governor of Michigan, the Honorable G. Mennen Williams.

Governor Williams' letter is self-explanatory and I will very much appreciate your giving the views he expressed every proper consideration. Also, I will appreciate your including his letter and attachments in the recorded hearings held by your subcommittee.

Thanking you in advance for whatever consideration you may give this matter, I am, with kind regards,

Sincerely yours,

LOUIS C. RABAUT, *Member of Congress.*

STATE OF MICHIGAN,
OFFICE OF THE GOVERNOR,
*Lansing, February 19, 1960.*

Hon. LOUIS C. RABAUT,
*House of Representatives,*
*Washington, D.C.*

DEAR LOUIE: The President's budget for the fiscal year 1960–61 recommends a reduction of $60 million in the appropriation for the Hill-Burton program. Again this represents the largest recommended cut in the Public Health Service budget. It will mean a reduction in Michigan's allotment of $2.058 million or 33 percent.

The President's recommendation would return the program to the levels achieved prior to 1958. It represents a mark-time approach to the problem of providing adequate hospital and other health care facilities to serve our current and growing population. Our health plant must keep pace with the developments in medical science and with changing social phenomena in order to meet most effectively our health needs and to put to use the knowledge now available to us.

Despite the inroads made on the need for acute care beds during the past decade, we need continued construction of general hospital facilities to keep up with population growth, to reduce the backlog of needs, and to expand and modernize existing facilities so that they can be adapted to modern techniques of hospital and health care. The magnitude of our need for nursing home facilities and psychiatric beds is alarmingly acute, and very little impact has been made in these important areas. The enclosed memorandum indicates the extent of these needs in Michigan.

Even though the appropriation for the Hill-Burton program was increased in each of the past 2 years, at no time has the maximum authorized for the total program, $210 million, been provided. The Hill-Burton program is vital to maintaining and improving the health standards of this country, and its importance would justify a level of appropriation consistent with our needs.

Thus, I urge you to work for the maximum authorized under the law for the Hill-Burton program—a Federal appropriation of $210 million.

With every good wish.

Sincerely,

G. MENNEN WILLIAMS, *Governor.*

MEMORANDUM

FEBRUARY 18, 1960.

The President's budget recommends a reduction of $60 million, or 32 percent, in the appropriation for the Hill-Burton program, from the current year. This will represent a reduction in Michigan's allotment of $2.058 million, or a one-third cut.

| Hill-Burton program | Nationwide | | Michigan | |
|---|---|---|---|---|
| | Current fiscal year, 1960 | President's 1961 budget | Current fiscal year 1960 | President's 1961 budget |
| Total | $186,200,000 | $126,200,000 | | |
| A. Research | 1,200,000 | 1,200,000 | | |
| B. Construction | 185,000,000 | 125,000,000 | $6,165,350 | $4,106,918 |
| 1. Part C (original program) | 150,000,000 | 95,000,000 | 5,095,852 | 3,218,675 |
| 2. Part G (1954 amendments) | 35,000,000 | 30,000,000 | 1,069,506 | 888,243 |
| (a) Nursing homes | 10,000,000 | 10,000,000 | 331,462 | 331,462 |
| (b) Rehabilitation centers | 10,000,000 | 5,000,000 | 331,462 | 150,199 |
| (c) Chronic disease hospitals | 7,500,000 | 7,500,000 | 203,291 | 203,291 |
| (d) Diagnostic and treatment centers | 7,500,000 | 7,500,000 | 203,291 | 203,291 |

The Hill-Burton Act authorizes a total nationwide appropriation of $210 million, of which $150 million may be appropriated for part C and $60 million for part G.

WHAT THE PROPOSED CUT WOULD MEAN TO MICHIGAN

1. A cut of one-third in funds available means that five to eight projects will not be able to receive assistance. This represents a total construction volume of more than $6 million, or on-site employment of 240 man-years, which will be delayed until some future date.

2. The cut in funds available for rehabilitation centers will severely limit participation in a rehabilitation project. Because rehabilitation centers are costly to build, it is necessary to accumulate funds for 2 or more years under the present level of appropriations in order to have sufficient money to provide meaningful assistance. While it is recognized that some States have been unable to use funds provided for rehabilitation centers the remedy to this problem is not to cut the appropriation but to permit it to be transferred to other categories.

3. Only a very small portion of the worthwhile projects can be assisted each year within the limits of the Federal appropriation. Thus, projects eligible for assistance and now in planning in Michigan which could be placed under construction within the next 2 years represent $157 million worth of construction work. Full Federal participation in this construction would require $55 million in Federal funds available to Michigan over the next 2 years. (See attached tabulation.)

4. Despite the gains made through construction over the past decade, Michigan's needs for hospitals and health care facilities are not yet satisfied:

| Type of facility | Estimated number of beds needed | Existing suitable beds | Bed deficit | Percent of need met |
|---|---|---|---|---|
| General hospitals | 33,642 | 28,843 | 8,799 | 74 |
| Psychiatric facilities | 39,250 | 14,621 | 24,629 | 37 |
| Skilled nursing homes | 15,643 | 4,260 | 11,383 | 27 |

We have barely begun to provide adequate facilities for skilled nursing home care and psychiatric care. For these categories of health facilities, we are back where we were with general hospitals when the Hill-Burton program began.

### UNMET NEEDS IN GENERAL HOSPITALS

There are still areas of Michigan with gross unmet needs for general hospital construction. Of the 76 hospital service areas, 3 still have no beds in adequate fire-resistive structures, and 16 areas have less than 65 percent of the general hospital beds estimated to be needed.

Increasingly, however, general hospital construction involves not merely the building of additional beds but the expansion and modernization of service facilities to cope with increased patient loads and with modern techniques of hospital and health care. Medical science and hospital utilization have changed so rapidly over the past decade that hospitals which had an adequate plant 10 years ago now face construction needs.

Hospitals are also requesting grants in order to make their facilities more effective and provide a more comprehensive range of care. The development of the progressive care concept, the increasing concern for the chronically ill, and the mounting volume of outpatients have created needs for construction which do not show up in a bed-need estimate.

A special problem concerns the older hospital in a metropolitan area with a substantial building which needs remodeling and replacement of service facilities in order to meet present-day standards. While there has been some feeling that this need should be handled by an appropriation to a special category within the Hill-Burton program, it can be handled within the framework of the present part C appropriation by an administrative policy and the provision of adequate funds. The setting up of special categories, as under the part G amendments, makes for administrative complications, increases paperwork, and creates undesirable rigidities.

### UNMET NEEDS FOR THE CHRONICALLY ILL AND AGED

Skilled nursing home construction represents our greatest unmet need. The country's population contains a growing number of older people who because of chronic illnesses and advanced age require skilled nursing home care. A large portion of existing facilities are obsolete, non-fire-resistive structures and do not provide an adequate level of care.

Considerable additional funds, beyond the amounts provided this year, are needed in the skilled nursing home category to assist counties and nonprofit organizations to construct county medical care facilities and skilled nursing homes. At the present time there are eight counties in Michigan which would like to construct county medical care facilities within the next year; to meet these requests for assistance on a minimal basis would require $1.095 million in Federal funds. Under the President's budget, the funds available to Michigan for nursing home construction (at the same level as last year) would be $331,462—or less than one-third of the amount needed.

### UNMET NEEDS FOR PSYCHIATRIC FACILITIES

With respect to psychiatric facilities, the Hill-Burton program has been concerned only with those units providing active treatment. In this regard, three types of needs are emerging:

(*a*) Psychiatric units in general hospitals to provide short-term intensive treatment. There are now 14 general hospitals in Michigan with such units under construction or in operation, and an increasing number of the larger hospitals are interested in developing psychiatric facilities.

(*b*) Treatment units in the State hospitals system to care for the growing caseload of disturbed children and adolescents.

(*c*) A community-oriented 200- to 300-bed facility providing treatment for both inpatients and outpatients, as part of the State mental hospitals system. Such a unit, both through its small size and community location, could be a more effective facility for treating the mentally ill than the large, remotely located institutions now available.

An adequate level of appropriations would permit greater expenditure of funds for psychiatric facilities.

OFFICE OF HOSPITAL SURVEY AND CONSTRUCTION, LANSING, MICH.

*Summary of approvable construction if there were no limitation on Federal funds*

| | Number of projects | Beds | Estimated cost (thousand) | | |
|---|---|---|---|---|---|
| | | | Total | Federal share | |
| | | | | 1961 | 1962 |
| Part C funds | 58 | 7,595 | $138,103 | $19,302 | $27,508 |
| General hospitals | 48 | 5,723 | 122,493 | 15,895 | 25,391 |
| Schools of nursing | 1 | | 700 | 238 | |
| Psychiatric | 9 | 1,872 | 14,910 | 3,169 | 2,117 |
| Public health centers | | | | | |
| Part G funds | 23 | 2,088 | 19,440 | 4,175 | 4,545 |
| Skilled nursing homes | 22 | 2,036 | 18,240 | 3,875 | 4,545 |
| Rehabilitation center, chronic | 1 | 32 | 1,200 | 300 | |
| Diagnostic and treatment | | | | | |
| Total | 81 | 9,653 | 157,543 | 23,477 | 32,053 |

*Projects which could be approved under the hospital and medical facilities construction program if there were no limitation on Federal funds*

I. APPROVABLE UNDER PART C OF THE ACT

| Category of facility | Location | Name of facility | Type of construction | Beds added | Estimated cost (thousand) | | | Current status | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | Total cost | Federal share | | Priority | Funds | Site | Architect |
| | | | | | | 1961 | 1962 | | | | |
| General | Newberry | Tahquamenon Hospital | New | 38 | $600 | | $330 | A-1 | No | Yes | Yes. |
| Do | Bad Axe | Hubbard Hospital | do | 108 | 1,110 | | 610 | A-4 | do | No | No. |
| Do | Cass City | Community Hospital | Addition | 50 | 500 | $245 | | A-6 | Yes | Yes | Yes. |
| Do | Monroe | New Monroe Hospital | New | 200 | 3,400 | | 1,462 | A-7 | No | do | Do. |
| Do | Ludington | Paulina Stearns Hospital | do | 75 | 1,200 | | 492 | A-9 | do | No | Do. |
| Do | Stambaugh | General Hospital | Addition | 45 | 700 | 329 | | A-10 | Planned | Yes | Do. |
| Do | Northeast Detroit | CHA Hospital | New | 250 | 6,278 | | 2,196 | A-11 | Requested | do | Do. |
| Do | do | Holy Cross Hospital | Addition | 150 | 3,591 | 1,220 | | A-11 | do | do | Do. |
| Do | do | St. John Hospital | do | 125 | 2,805 | 953 | | A-11 | do | do | Do. |
| Do | do | South Macomb County Hospital | New | 200 | 5,000 | | 1,700 | A-11 | do | do | Do. |
| Do | do | Bon Secours Hospital | Addition | 125 | 3,000 | 1,020 | | A-11 | do | do | Do. |
| Do | do | Cottage Hospital | do | 116 | 2,395 | 814 | | A-11 | do | do | Do. |
| Do | Tawas City | Tawas-St. Joseph Hospital | do | 26 | 300 | | 144 | B-12 | No | do | No. |
| Do | Muskegon | Osteopathic Hospital | do | 34 | 300 | 126 | | B-13 | do | do | Yes. |
| Do | Grand Rapids | do | do | 30 | 250 | 92 | | B-15 | Yes | do | Do. |
| Do | do | Blodgett Hospital | do | 66 | [1] 2,000 | [1] 290 | | B-15 | do | do | Do. |
| Do | do | Butterworth Hospital | do | 75 | [1] 1,800 | [1] 216 | | B-15 | do | do | Do. |
| Do | Wayne | Annapolis Road Hospital | do | 125 | 1,427 | 500 | | B-18 | do | do | Do. |
| Do | Livonia | St. Mary Hospital | do | 140 | 1,400 | 490 | | B-18 | Requested | do | Do. |
| Do | Garden City | Osteopathic Hospital | do | 150 | 1,529 | 535 | | B-18 | do | do | Do. |
| Do | Lincoln Park | Outer Drive Hospital | do | 125 | 1,427 | 499 | | B-20 | Yes | do | Do. |
| Do | Dearborn | Oakwood Hospital | do | 140 | 2,202 | 771 | | B-20 | Requested | [2] | Do. |
| Do | Trenton | Riverside Osteopathic Hospital | do | 70 | 750 | | 262 | B-20 | do | Yes | Do. |
| Psychiatric | Battle Creek | Health Center | do | 125 | 2,000 | 720 | | Special | do | do | Do. |
| Do | Grand Rapids | Kent County Hospital | New | 60 | 720 | 266 | | do | Voted | do | Do. |
| Do | Muskegon | Hackley Hospital | Addition | 27 | 500 | | 210 | do | No | do | Do. |
| Do | Detroit | Hawthorn Center | do | 20 | 300 | 105 | | do | In budget | do | Do. |
| Do | Kalamazoo | State Hospital | do | 350 | 2,200 | 770 | | do | do | do | Do. |
| Do | Northville | do | New | 640 | 4,100 | | 1,435 | do | do | do | Do. |
| Do | Ypsilanti | do | do | 100 | 850 | 297 | | do | do | do | Do. |
| Do | Newberry | do | do | | 1,350 | | 472 | do | do | do | Do. |
| Do | Plymouth | State Training School | do | 550 | 2,890 | 1,011 | | do | do | do | Do. |
| Total (number of projects, 9) | | | | 1,872 | 14,910 | 3,169 | 2,117 | | | | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Nursing homes | Hancock | Houghton County | Addition | 100 | $700 | $350 | | A-1 | Planned | No | No. |
| Do | Fremont | Newaygo County | New | 104 | [1] 850 | [1] 275 | | A-2 | do | Yes | Preliminary. |
| Do | Marlette | Community Hospital | Addition | 60 | 500 | | $250 | A-5 | Voted | do | No. |
| Do | Gaylord | Otsego Hospital | do | 40 | 300 | | 150 | A-6 | Some funds | do | Do. |
| Do | Paw Paw | Lakeview Community Hospital [3] | do | 50 | 400 | | 200 | A-8 | No | do | Preliminary. |
| Do | South Haven | South Haven Hsopital [3] | do | 50 | 400 | | 200 | A-8 | do | do | Do. |
| Do | Alpena | Alpena County | New | 100 | 950 | 475 | | A-8 | Planned | do | Yes. |
| Do | Alma | Gratiot Community Hospital [3] | Addition | 40 | 500 | 250 | | A-12 | Yes | do | Do. |
| Do | Ironwood | Gogebic County | New | 70 | 700 | | 350 | A-14 | No | No | No. |
| Do | Manistee | Manistee County | do | 108 | [1] 950 | [1] 325 | | A-14 | Voted | Yes | Preliminary. |
| Do | Tawas City | Iosco County | do | 50 | 400 | | 200 | A-17 | No | No | No. |
| Do | Niles | Pawating Hospital [3] | Addition | 50 | 400 | 200 | | A-27 | Yes | Yes | Yes. |
| Do | Bay City | Bay County | New | 150 | [1] 1,200 | [1] 450 | | A-29 | Voted | do | Preliminary. |
| Do | Petoskey | Emmet County | do | 70 | 700 | 350 | | A-32 | Planned | No | No. |
| Do | Howell | Livingston County | do | 70 | 700 | | 350 | A-33 | No | do | Do. |
| Do | Jackson | Jackson County | do | 125 | 1,000 | 500 | | B-38 | Planned | Yes | Do. |
| Do | Grand Rapids | Maplegrove County Hospital | do | 250 | 2,500 | | 1,000 | B-39 | No | do | Do. |
| Do | Detroit | Presbyterian Village | do | 80 | 900 | 450 | | B-43 | Requested | do | Yes. |
| Do | do | Jewish Home for Aged | do | 200 | 2,000 | | 1,000 | B-43 | do | do | Do. |
| Do | do | Lutheran Social Service | do | 144 | 1,390 | | 695 | B-43 | do | do | Do. |
| Do | Centreville | St. Joseph County | Addition | 35 | 300 | | 150 | B-46 | No | do | No. |
| Do | Corunna | Pleasantview Hospital | do | 80 | 500 | 250 | | C-51 | Yes | do | Yes. |
| Total (number of projects, 22) | | | | 2,026 | 18,240 | 3,875 | 4,545 | | | | |
| Rehabilitation | Ann Arbor | University Hospital | do | 32 | [1] 1,200 | [1] 300 | | A-1 | do | do | Do. |
| Total (number of projects, 1) | | | | 32 | 1,200 | 300 | | | | | |

[1] Additional amount to bring projects on current construction schedule up to full participation.

[2] Completion of shell.

[3] Could be financed out of pt. C funds.

NOTE.—Requested from Metropolitan Detroit building fund.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C., March 8, 1960.*

HON. JOHN FOGARTY,
*Chairman, Subcommittee on Departments of Labor and Health, Education, and Welfare Appropriations, House of Representatives, Washington, D.C.*

DEAR JOHN: It is my understanding that your subcommittee is at present considering appropriation requests for the Hill-Burton program of aid to hospital construction.

On behalf of all voluntary hospitals in the country, may I strongly urge you and the members of your subcommittee to recommend an appropriation of the full $150 million for part C and the full amount possible under part G of the Hill-Burton program.

With kind regards,
Sincerely,

EMANUEL CELLER.

---

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C., March 3, 1960.*

HON. JOHN E. FOGARTY,
*Chairman, Committee on Health, Education, and Welfare,*
*The Capitol, Washington, D.C.*

DEAR JOHN: The hospitals in Baltimore are very much concerned by the reduction for the Hill-Burton program made in the President's budget request.

I sincerely hope that your committee will find it possible to approve at least as much as was appropriated last year so that this very worthwhile program may be continued.

Sincerely,

EDWARD A. GARMATZ,
*Member of Congress.*

---

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C.*

HON. JOHN E. FOGARTY,
*Chairman, Subcommittee on Health, Education, and Welfare,*
*House Appropriations Committee,*
*The Capitol, Washington, D.C.*

DEAR MR. CHAIRMAN: I am enclosing herewith telegram received from the Honorable Edward F. Brantley, mayor, city of St. Petersburg, Fla., in connection with the Hospital Construction and Survey Act presently being considered by your subcommittee.

I would appreciate it very much if you would bring the enclosed to the attention of the subcommittee's members and request that Mayor Brantley's views concerning this vital program and his request for reevaluation and reconsideration of the recommended appropriation receive the committee's serious consideration.

Thanking you, and with best wishes, I am,
Sincerely,

WILLIAM C. CRAMER,
*Member of Congress.*

ST. PETERSBURG, FLA.

HON. WILLIAM C. CRAMER,
*House Office Building, Washington, D.C.:*

I understand the House Appropriations Committee's subcommittee considering the Hospital Construction and Survey Act (Hill-Burton) appropriation is holding hearings on the amount to be appropriated to municipalities to build needed hospital facilities. I respectfully urge you to request revaluation and reconsideration of the administration's recommendation for only $126.2 million for the program when the Hill-Burton Act authorizes an annual appropriation of $211.2 million.

Fast-growing communities such a our Tampa Bay area should be considered on a factual basis as to number of hospital beds available at present and reliable estimate of immediate future needs as necessitated by area growth and population influx. If appropriation for program is reduced, the pro rata amount available for this area will apparently be reduced so that sufficient matching funds for our proposed new Mercy Hospital will not be available.

Best personal regards.

EDWARD F. BRANTLEY,
*Mayor, City of St. Petersburg, Fla.*

---

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C.*

Re appropriations for hospital construction under the Hill-Burton Act.

Hon. JOHN E. FOGARTY,
*Chairman, Subcommittee on Labor, Health, Education, and Welfare, Committee on Appropriations, House of Representatives, Washington, D.C.*

DEAR MR. CHAIRMAN: I am enclosing a letter I have received from Mr. William B. Finlayson, president-elect of the South Carolina Hospital Association, and a statistical table explaining South Carolina's need for additional hospital beds.

I shall appreciate your making this a part of your records.

With kind regards, I am,

Sincerely yours,

L. MENDEL RIVERS,
*Member of Congress.*

P.S.—Please return the enclosures when they have served their purpose. Thank you. L.M.R.

SOUTH CAROLINA HOSPITAL ASSOCIATION,
*Columbia, S.C., March 3, 1960.*

Hon. LUCIUS MENDEL RIVERS,
*House of Representatives,*
*House Office Building, Washington, D.C.*

DEAR REPRESENTATIVE RIVERS: It has been brought to our attention that a subcommittee of the House Appropriations Committee is now considering the amount of money that should be appropriated for hospital construction under the Hill-Burton Act during the coming year.

As I am sure you are well aware, South Carolina is still in dire need of additional hospital beds. The attached statistical table, taken from a compilation of data that was recently mailed to the members of the South Carolina Hospital Association, shows the extent of the current hospital bed needs in the State as calculated under formulas developed by the U.S. Public Health Service. I think the figures speak for themselves.

The American Hospital Association has testified before the subcommittee considering this matter to the effect that the full allowable $150 million appropriation for the basic hospital construction program (identified in pt. C of the Hill-Burton Act) should be authorized, and that a $30 million appropriation should be authorized for the special institutional categories identified in part G of the act. This is $55 million more than the appropriation recommended in the President's budget for basic hospital construction. The amount recommended for the special institutional categories is the same as the President's recommendation. On behalf of the 76 hospitals which are members of the South Carolina Hospital Association, I urgently recommend your support of an increase in the appropriations to the amounts recommended in testimony presented by the American Hospital Association.

Sincerely yours,

WILLIAM B. FINLAYSON, *President-Elect.*

TABLE 4.—*Hospital and nursing home bed construction needs in South Carolina, June 30, 1959*

| | General | Chronic | Mental | Tuberculosis | Nursing home | Total |
|---|---|---|---|---|---|---|
| Beds allowed under population ratios established by USPHS | 10,681 | 4,692 | 11,730 | 1,158 | 7,038 | 35,299 |
| Existing acceptable beds | 6,228 | 126 | 2,112 | 877 | 840 | 10,183 |
| Existing unacceptable beds | 1,248 | 0 | 2,502 | 140 | 603 | 4,493 |
| Total existing beds (line 2 plus line 3) | 7,476 | 126 | 4,614 | 1,017 | 1,443 | 14,676 |
| Additional acceptable beds needed to increase total acceptable beds to total beds allowed | 4,453 | 4,566 | 9,618 | 281 | 6,198 | 25,116 |
| Percent of need met | 54.84 | 2.69 | 18.01 | 75.73 | 11.94 | 28.85 |

Source: South Carolina State plan, 1959–60, Hospital Division, South Carolina State Board of Health.

---

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C.*

Hon. JOHN E. FOGARTY,
*Chairman, Subcommittee on Health, Education, and Welfare, House Appropriations Committee, The Capitol, Washington, D.C.*

DEAR MR. CHAIRMAN: With further reference to the Hospital Construction and Survey Act presently being considered by your subcommittee, I am enclosing herewith, for the attention and consideration of the subcommittee members, letter received from Mr. H. Hochstadt, administrator, American Legion Hospital for Crippled Children, St. Petersburg, and letter received from Mr. Donald M. Schroder, administrator, Mease Hospital, Dunedin.

Your consideration of the views presented in the enclosed will be very much appreciated.

Thanking you, and with best wishes, I am

Sincerely,

WILLIAM C. CRAMER, *Member of Congress.*

MEASE HOSPITAL,
MEASE DIAGNOSTIC AND TREATMENT CLINIC,
*Dunedin, Fla., February 29, 1960.*

Hon. WILLIAM C. CRAMER,
*House Office Building,*
*Washington, D.C.*

DEAR CONGRESSMAN CRAMER: The appropriation hearings for the Hill-Burton program have started in the subcommittee of the House of Representatives. The President's budget requests $95 million for the basic program and $30 million for other categories. This is $60 million less than Congress appropriated for the current year and is $85 million less than the amount allowable under the law.

We would sincerely appreciate any effort that you may feel free to make to urge that the full amount allowable under the law be appropriated for the basic program ($150 million) and that at least $30 million be appropriated for chronic disease and nursing home categories.

Here in Pinellas County, for example, all of our hospitals are filled to overflowing. It is a daily occurence for us to have extremely ill patients lying in beds placed in the hospital corridors. This is most undesirable from the patient's standpoint and from fire safety standpoints. These conditions exist in spite of all the recent building programs undertaken by the hospitals within this county. We are in dire need of Hill-Burton assistance for future construction programs that we know must be undertaken without delay. The funds under this program are so limited, however, and the priority of Pinellas County, in spite of those conditions described, is so low within the State of Florida, that no assistance appears to be forthcoming.

The Hill-Burton program todate has accomplished great things for the people of Florida. It has been adequate for the State to maintain the same or approximately the same inadequate ratio of acceptable beds per thousand population that existed when the program began. It has not been sufficient for us to make any substantial gains in this direction because of our exploding population.

All of us here have a great deal of confidence in you and have seen how you have represented your constituents in the past. We are confident that you will follow this matter and pursue it to your best judgment.

Cordially,

DONALD M. SCHRODER, *Administrator.*

---

AMERICAN LEGION HOSPITAL FOR CRIPPLED CHILDREN,
*St. Petersburg, Fla., February 25, 1960.*

Hon. WILLIAM C. CRAMER,
*House of Representatives,*
*House Office Building, Washington, D.C.*

DEAR CONGRESSMAN CRAMER: It has been called to our attention that appropriation hearings for the Hill-Burton program have started in the subcommittee of the House of Representatives.

I am sure you are also aware of the fact that the President's budget requests $95 million for the basic program and $30 million for the categories. This is $60 million less than Congress appropriated for the current year, and it is $85 million less than the amount allowable under the law.

We are also informed that Congressman John Fogarty, chairman of this subcommittee, has given great support to these appropriations each year.

With the tremendous increase in population in our area and the resultant shortage of hospital beds, we strongly urge that you support an increase in the President's budget to the extent that the full amount allowable under the law be appropriated for the basic program ($150 million) and that at least $30 million be appropriated for chronic diseases and nursing home categories.

Very truly yours,

H. HOCHSTADT, *Administrator.*

---

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C.*

Hon. JOHN E. FOGARTY,
*Chairman, Subcommittee on Health, Education, and Welfare, Committee on Appropriations, House of Representatives, Washington, D.C.*

DEAR COLLEAGUE: I write to indicate my full support for the letters you have received from various Vermont hospitals for the full appropriation for part C of the Hill-Burton program, and also for part G having to do with nursing homes, diagnostic and chronic disease provisions.

Those who have written to me have stressed the importance of maintaining the full level of the Hill-Burton program to the hospitals in our State, and the Vermont Hospital Association itself is on record as testifying to the need for its continuation.

With best personal regards.

Sincerely yours,

WILLIAM H. MEYER.

---

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
*Washington, D.C.*

Hon. CLARENCE CANNON,
*Chairman, House Appropriations Committee,*
*House of Representatives, Washington, D.C.*

DEAR MR. CHAIRMAN: It is respectfully requested the enclosed letter from the president of the board of directors of Scripps Memorial Hospital, San Diego, be made a part of the record.

Thank you for your cooperation.

Sincerely,

BOB WILSON, *Member of Congress.*

SCRIPPS MEMORIAL HOSPITAL,
*La Jolla, Calif., March 4, 1960.*

Hon. BOB WILSON,
*House Office Building,*
*Washington, D.C.*

DEAR MR. WILSON: We are writing you to earnestly solicit your support in obtaining a greater amount of funds than that requested in the President's budget for the Hill-Burton program now starting in the subcommittee of the House.

The budget requests $95 million for part C of the program (the basic program) and $30 million for part G of the program (the categories). This is $60 million less than the Congress appropriated for the operation of the program this year and it is $85 million less than the total amount allowable under the law for the program.

We strongly feel that this year's appropriation should be at least at the level of last year's, and we urge that Congress provide the full $150 million for part C, and that under part G of the program, Congress appropriate the full amount possible, at least for chronic disease and nursing home categories, in the amount of $30 million.

We would deeply appreciate your giving serious consideration to this matter. Thank you.

Sincerely,

OLIVER C. THORNTON,
*President, Board of Directors.*

## BUREAU OF LABOR STATISTICS

### LETTER FROM THE FEDERAL STATISTICS USERS' CONFERENCE

Mr. FOGARTY. We will also place in the record the letter from the Federal Statistics Users' Conference regarding appropriations to the Bureau of Labor Statistics.

(The letter referred to follows:)

FEDERAL STATISTICS USERS' CONFERENCE,
*Washington, D.C., February 29, 1960.*

Hon. JOHN E. FOGARTY,
*Chairman, Subcommittee on Department of Labor and Related Agencies Appropriations, House Appropriations Committee, the Capitol, Washington, D.C.*

DEAR MR. FOGARTY: The budget estimates for the Bureau of Labor Statistics for 1961 which are presently before the Subcommittee on Department of Labor and Related Agencies provide for a continuation of the current year's program together with orderly progress in the work of revising the Consumer Price Index.

Users are looking forward with keen interest to the publication of information now being developed by BLS as a consequence of the new programs on wage and productivity statistics for which additional funds were appropriated for fiscal year 1960. At the Federal Statistics Users' Conference third annual meeting last fall, a roundtable discussion devoted to these programs revealed (1) that there is a broad support for these programs from both management and labor users of this kind of data and (2) that users generally feel that BLS will act responsibly in developing information in areas of potential controversy.

The Federal Statistics Users' Conference urges the committee to continue to extend to the Bureau of Labor Statistics current statistical programs the strong support which has been characteristic of the committee's actions in the past.

The budget proposal for the continuation of work in the revision of the Consumer Price Index also merits the committee's full support. This work is already underway, and there is no need for me to repeat here the arguments describing the need for this activity. The conference hopes that its continuation will be given the financial support which will enable BLS to carry through the program as originally planned.

If there is any way in which the Federal Statistics Users' Conference can assist the committee in its consideration of the BLS program for 1961, please let me know.

Sincerely yours,

PETER HENLE, *Chairman.*

## Proposed Reductions in the Labor and Health, Education, and Welfare Budget

### Letter from the Chamber of Commerce of the United States

(The following letter was received subsequent to the completion of hearings by the subcommittee:)

Chamber of Commerce of the United States,
*Washington, D.C., March 9, 1960.*

Hon. John E. Fogarty,
*Chairman, Subcommittee on Health, Education, and Welfare,*
*House Appropriations Committee, Washington, D.C.*

Dear Mr. Fogarty: The Chamber of Commerce of the United States supports the overall objective of the President's fiscal year 1961 budget, but firmly believes that selective reductions can be made in it.

The recommendations which follow pertain to the Departments of Labor, and Health, Education, and Welfare and related agencies. They have been developed as part of the chamber's comprehensive analysis of the entire budget for the fiscal year 1961.

Reductions of $72,060,000 in funds requested for the Department of Health, Education, and Welfare, and of $2,120,000 in funds for 1961 activities of the Department of Labor, are recommended. In addition, the national chamber urges that your committee oppose the $188,000 requested to cover an increase in the staff of the Federal Mediation and Conciliation Service. The details covering our recommendations follow.

#### Department of Health, Education, and Welfare

##### Office of Education

*Promotion and further development of vocational education*

This function is the responsibility of the State and local governments and should be returned to them. A reduction of $31,702,000 in funds for this activity is therefore recommended.

*Further endowment of colleges of agriculture and the mechanic arts and colleges for agriculture and the mechanic arts*

Funds requested under the two appropriation titles above are for the endowment of land-grant colleges. The need for such Federal contributions no longer exists. Your committee is urged not to appropriate the $5,052,000 requested in the 1961 budget.

*Grants for library services*

Library services are a local responsibility and the chamber recommends gradual curtailment of this grant program. Your committee is urged to reduce the appropriation requested for 1961 by $2,150,000.

*Salaries and expenses*

The funds requested for 1961 provide for an increase in travel costs, staff expansion, and a substantial increase in funds for cooperative demonstration projects. Funds requested for 1961 are almost 50 percent above those appropriated for 1959 and represent a too rapid expansion. Your committee is urged to reduce funds for this program by $627,000.

*Promotion of vocational education*

The national chamber recommends that the program of grants to States for vocational education be discontinued. Responsibility for this activity rests with State and local governments. Approval of this recommendation would result in a reduction of $7,161,000 in funds for the Office of Education.

##### Office of Vocational Rehabilitation

*Grants to States*

The number of clients to benefit from this program is estimated at 321,000, an increase of 7,000 above those estimated for 1960. However, the number of

clients has been consistently overestimated and in recognition thereof the national chamber urges your committee to reduce the funds for this program by $2,600,000 below the $54,500,000 requested.

PUBLIC HEALTH SERVICE

*Grants for waste treatment works construction*

The national chamber recommends that the program of grants to local municipalities for construction of sewage treatment plants be terminated. Responsibility for the construction of these purely local projects rests with the State and local governments, and your committee is urged not to appropriate the $20 million included in the proposed budget for this program.

*Indian health activities*

The hospital patient load was estimated by the Service as 2,600 for 1960 and funds of $43,500,000 were requested. The inpatient load for 1961 is estimated as 2,365 and $47,526,000 has been requested. In view of the decrease in patient load your committee is urged to recommend an appropriation of $45,500,000 for 1961, a reduction of $2,026,000.

SOCIAL SECURITY ADMINISTRATION

*Cooperative research and demonstration projects in social security*

Although this activity has been authorized since 1956, this is the first time funds have been requested. In view of the demonstrated lack of need for these funds, the entire amount of $700,000 is opposed and your committee is urged to act accordingly.

*Salaries and expenses, Office of the Commissioner*

The request for this program includes $42,000 for administration of the cooperative research program mentioned above. This amount will not be necessary if the cooperative research program is not approved.

DEPARTMENT OF LABOR

The national chamber recommends reductions of $2,120,000 in the requests for the Department of Labor, as detailed below.

BUREAU OF LABOR STANDARDS

*Salaries and expenses*

This request provides for activities in the area of reducing industrial accidents which is the responsibility of industry and of the individual States. The request also provides for enforcement activities relating to disclosure of welfare and pension plan data, although such activities are not authorized by law. The national chamber urges the elimination of these two activities which would permit a reduction in funds of $971,000.

BUREAU OF VETERANS' REEMPLOYMENT RIGHTS

*Salaries and expenses*

The national chamber does not believe it necessary to continue this Federal program of providing assistance to veterans and reservists in connection with their reemployment rights. It is urged that this program, for which $596,000 has been requested, be discontinued, as adequate services are available in this area from other sources.

BUREAU OF EMPLOYMENT SECURITY

*Salaries and expenses*

The budget request provides for a staff expansion of 33, and increased funds for the general administration of the employment service and unemployment compensation programs. Present economic conditions and trends do not indicate the need for such expansion. Your committee is urged to reduce the appropriation requested by $318,000.

*Compliance activities, Mexican farm labor program*

Since there is no increase in the scope of the Mexican farm labor program, there is no justification for a 27-percent increase in compliance activities. Your committee is urged to deny the requested increase in the amount of $235,000.

FEDERAL MEDIATION AND CONCILIATION SERVICE

The request for 1961 includes provision for a staff expansion of 15 employees. The slight increase in workload at the end of 1959 does not justify the increase in staff. The national chamber urges your committee to reduce this request by $188,000.

We would appreciate it if you would make this letter a part of the record of hearings on the appropriation bill for the Departments of Labor, and Health, Education, and Welfare, and related agencies.

Cordially yours,

CLARENCE R. MILES,
*Manager, Legislative Department.*

# LIST OF WITNESSES

Library
National Institutes of Health
Bethesda, 14, Maryland

LIBRARY
NIH
Amazing Research.
Amazing Help.

http://nihlibrary.nih.gov

10 Center Drive
Bethesda, MD 20892-1150
301-496-1080

NIH LIBRARY
4 0057 2614

NOV 2 2 1960