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ment was ordered to be printed in the RECORD, as follows:

NEVER PREJUDGE THE PUBLIC

I've never had that lesson hammered home more clearly than during 11 days of talking with housewives, students, consumer spokesmen and media representatives all across the country.

The consumer's attitudes toward the farmer must be pretty fuzzy—maybe even downright antagonistic. That's how I felt at the outset: uncertain, not knowing what to expect, resigned to the seemingly inevitable confrontation. I had prejudged the public and I'm glad to say, to a quite erroneous degree.

Consumers are much more accessible and willing to listen and much less hostile and antagonistic than I had expected. They are interested; they want to hear what we have to say; and they are more than willing to give American agriculture a fair hearing.

But does that mean all goes well for the farmer in megalopolis? Hardly; it merely means that there is much more potential for genuine, effective communication than many of us had dared to realize. We still have problems; the encouraging thing is that our problems have satisfactory and workable solutions. We can help the public become more accurately and completely informed about American agriculture.

How do we go about it? In my opinion, while consumers do have a generally favorable attitude toward farmers, they do not have enough information about agriculture. They seem generally unaware of what agriculture contributes to the economy of the United States, which really gives them very little direct incentive for wanting that contribution continued.

Because of consumer concern about food prices, there seems to be an increasing tendency to pin the blame on someone. That approach, of course, implies that someone is guilty of making exorbitant profits—which runs contrary to most available evidence. This approach—if permitted to gain sufficient momentum—would divert tremendous public attention and energy away from the more responsible approach of improving the system.

And finally, consumers are perplexed about farm programs. Generally they see the programs as a misguided form of welfare for people who don't need welfare. If the programs serve their intended purpose of contributing toward economic stability, then they need to be explained and debated in that context. Then it becomes possible—just possible—for the consumer to change his view.

His mind is not closed. That, after all, is the real lesson about prejudging the public; it's up to us to do the convincing.

VISION SCREENING OF CHILDREN AND YOUTH

Mr. MONDALE. Mr. President, I ask unanimous consent to have printed in the RECORD materials concerning the importance of vision screening for children and youth.

The first document, entitled "Why the Need for Early and Periodic Screening, Diagnosis, and Treatment of Individuals Under 21," is a statement prepared by the American Optometric Association. This professional organization developed the statement in response to the recent decision of the Committee on Finance to postpone and dilute implementation of the "early and periodic screening" program under Medicaid. The AOA statement outlines clearly the possible effects of undiagnosed visual defects upon the

school performance as well as the health of a child. The statement further notes that late detection of visual disabilities is particularly harmful to youngsters who come from disadvantaged families—the same group which the "early screening" program is designed to aid.

Following the AOA statement, I ask unanimous consent to have printed in the RECORD a series of excerpts from "Vision Screening of Children," a publication of the Public Health Service of the U.S. Department of Health, Education, and Welfare. This publication too notes that:

Visual defects are reported to occur more frequently among children . . . of low socioeconomic levels.

It points out also that—

All children should be tested periodically, regardless of whether signs of possible visual problems are present or not, and that it is important to provide adequate followup of children referred for diagnosis.

This information is being placed in the RECORD in support of my previously announced intention to attempt to reverse the restrictive actions of the Finance Committee on this important program. Specifically, the committee voted to postpone full implementation of the program by 2 years—to July 1, 1975—and not to require all States to provide certain services within the program. Children in as many as 18 States, for example, could be deprived of eyeglasses they need if the Finance Committee's action is allowed to stand.

There being no objection, the items were ordered to be printed in the RECORD, as follows:

WHY THE NEED FOR EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT OF INDIVIDUALS UNDER 21

Good vision is critical to the intellectual and social development of our children and should be given a high priority in any child development program. Vision is at the heart of the learning process and any impairment of this precious resource can seriously impede a child's learning and maturation process.

Because reading is the primary educational skill, it is estimated that over 80% of all learning takes place through the visual process, resulting in a direct relationship between reading skills and adequate vision. Yet, millions of children suffer from child related visual defects such as binocular visual impairment, amblyopia or lazy eye blindness, strabismus or cross vision, and unsatisfactory muscle coordination all of which, if undetected and untreated, have an adverse effect upon his reading skills and, consequently, his educational development.

Proper binocular vision is especially critical for the achievement of a child's maximum reading potential. Yet, thousands of children, even those with so-called "perfect vision" of 20/20 visual acuity, have not learned to maintain binocular visual performance so as to make effective use of the impulse signaled by the eyes to the brain. This impairment, according to a study by the U.S. Public Health Service in 1965, affects 7.4% of the American children at age 6 and grows to 17.2% at age 11.

Another child related visual defect is amblyopia or what is commonly known as "lazy eye blindness." This visual defect which is a result many times of nutritional deficiencies and is therefore prevalent in economically and socially deprived areas, leads to a general dimming of vision in the child. Unfor-

tunately, it occurs without any external manifestation so, unless a child's behavior is radically affected, it usually is undetected until it reaches an advanced stage. An article in the *American Journal of Public Health* in 1965 estimated that amblyopia may affect 6% of the American children, with the majority affected being of pre-school age.

These particular disorders, along with strabismus and unsatisfactory muscle coordination do not necessarily have to result in the tragedy of impeding a child's educational and social development. All of these visual disorders, if detected early, can very often be corrected or at least ameliorated by the techniques and devices of modern visual science.

Vision care practitioners, such as optometrists, have long pioneered in the area of learning theory as it relates to visual disorders and from this long involvement has developed techniques and instruments to treat these damaging defects.

The tragedy, then, of child visual disorders and their consequent effect upon learning and development, lies not in the fact that they can be detected and corrected, but in the fact that, for thousands of our children, such disorders go undetected, particularly in children of pre-school and early school ages and especially in children from economically and socially deprived circumstances. Although this tragedy is an individual one for the particular child suffering from a visual disorder and stunted development, it is easily translated into a larger social tragedy when these children experience the frustrations of impeding intellectual and emotional development.

For the child or youth hampered with a vision problem which adversely affects his ability to read or learn becomes, quite naturally, frustrated, and more often than not, he vents this frustration on his teachers, school, parents, community and general society. It is not coincidental that up to 80% of delinquents and semi-delinquents studied by the White House Conference on Juvenile Delinquency had learning difficulties, especially in reading, and poor vision was found to be a contributing factor in 50% of these cases.

Nor is it coincidental that the same White House Conference found that inner-city ghetto children appear to have a much higher—in some cases almost twice as high—incidence of learning disabilities, perceptual difficulties, and developmental visual problems than do the more advantaged children in other parts of the city.

Clearly, the dimensions of childhood visual disorders should represent a challenge to all of us. If it is so acceptable to state that every American has a right to adequate health care, then it should be acceptable to state that every American child has a right to the unimpeded attainment of his educational potential, and, where anything interferes with this attainment, a child should have a right to services which can correct such interferences.

IMPORTANCE OF VISION SCREENING

Impaired vision in children can seriously impede learning and contribute to the development of emotional and behavior problems. If vision defects are discovered and treated early, however, serious impairment and its consequences can often be prevented. In recent years a considerable amount of knowledge has accumulated on vision problems and their early detection through vision screening. This report summarizes the main principles, problems, and methods in vision screening and briefly reviews the estimated prevalence of eye problems among children.

Unlike adults, children with impaired vision are often unaware of their handicap and so do not complain or seek help. It is up

to the adults responsible for their health care and supervision to uncover these problems. Ideally, each child should have a professional eye examination in infancy and at regular intervals thereafter throughout childhood. But lack of public awareness of the value of such examinations, insufficient trained personnel, and the high cost of professional care are some reasons why this goal is more ideal than practical.

Vision screening is less satisfactory but it will identify children who are in need of professional eye care. Screening of preschool children is especially important because amblyopia ("lazy-eye blindness"), which is reported to occur in 1-6 percent of children can often be prevented if the condition is detected and treated in the first years of life.

Screening activities have expanded considerably, particularly in regard to preschool children, for whom there was little screening being done a few years ago. Vision screening in the Head Start projects, for example, means many more thousands of children are being reached (about 650,000 children were in Head Start in 1968, of whom most were screened for visual acuity). Preschool screening programs that are reported to the National Society for Prevention of Blindness have been growing rapidly (from 86 projects screening 52,500 children in 1963-64 to 289 projects screening 156,000 children in 1965-66). Nevertheless, in relation to the total 3- to 6-year-old population, it would appear that only a small fraction is being screened.

Vision tests should be a part of the periodic physical examination, and vision screening should be incorporated into any program undertaking the total health care of children. Vision screening should also be conducted in those places where children can be reached as captive groups, such as day care centers, nursery schools, and elementary and high schools.

When vision screening programs are established in a community, every effort should be made to call the public's attention to their existence and to encourage their use. It is also important that the difference between a professional eye examination and a vision screening test be explained to the parents of children tested. Parents should be instructed to seek professional help whenever they have any doubt about their children's vision, regardless of how recently the child has had a vision screening test with normal results.

PREVALENCE AND TYPES OF VISION PROBLEMS

A survey by Crane et al. in St. Louis found that 27 percent of the school children had eye problems which required treatment or observation. On the basis of this study, the Children's Bureau estimated that, in 1960, 10,200,000 children between 5-17 years of age had eye conditions requiring special care. The number projected for 1970 is 12,500,000.

The prevalence of visual problems among preschool children is more difficult to determine, for there has been no entirely satisfactory means of screening children in this age group, and what constitutes normal vision in the preschool years has remained to some extent a controversial subject. The rate of referrals from various screen programs among preschool children ranges from 1 to 30 percent.

Of the 156,252 preschool children who were screened during July 1965-June 1966 in projects reported to the National Society for the Prevention of Blindness, more than 8,700, or about 5.5 percent, were referred for professional eye care. Analysis of the results of professional examinations of the children referred from 109 projects revealed that 75 percent of those examined were in need of eye care, giving a defect rate of 29 per 1,000 screened. Of the children for whom a specific abnormal condition was reported, refractive errors were diagnosed in 87 percent, muscle

imbalance in 22 percent, and amblyopia in 11 percent. Since these findings are based on incomplete reporting of results, they probably underestimate the proportion of preschool children with visual problems. The rapidly expanding vision screening programs for preschool children should result in better knowledge about vision in this age group.

Visual problems are more prevalent among older children than among younger children. In the St. Louis study, 31 percent of the sixth grade students required eye care or observation, while only 23 percent of the first grade students needed such attention. In the Orinda (Calif.) study visual problems were found in 18 percent of the children between 5 and 7 years of age and in 31 percent of the 13-15-year-old-group. Partially seeing children, defined as those with a visual acuity of 20/70 or less in the better eye after the best correction possible, are estimated to number 1 in 500 in both the preschool and school-age groups. Children who are legally blind (defined as visual acuity of 20/200 or less in the better eye after correction, or acuity better than 20/200 but visual field in the better eye restricted to less than 20 degrees in the widest diameter) number about 1 in 8,000 in the preschool group and 1 in 1,400 in the school-age group.

The two major correctable visual defects among preschool and school age children in the United States are refractive errors and muscle imbalance, both of which are considered causative factors of amblyopia. In the St. Louis study, refractive errors were found in 20.5 percent of the children examined (hypermetropia, hypermetropic astigmatism or both in 12.3 percent, and myopia or myopic astigmatism or both in 8.2 percent), and muscle imbalance in 4.4 percent.

Visual defects are reported to occur more frequently among children with mental retardation, cerebral palsy, or hearing loss, and among children of low socioeconomic levels. Fletcher et al. reported that 76 percent of 102 mentally retarded children who were given a complete eye examination had abnormal findings. The rate of referral in a vision screening program conducted by the Michigan Health Department among a group of mentally retarded children was three times that found among regular classroom children. In a group of 98 children with cerebral palsy, age 4 to 10 years, Schachat et al. found that 68 percent had either an ocular defect or a refractive error, or both. Suchman reported that 58 percent of a group of 103 children with impaired hearing had some visual abnormality. Of considerable significance is the fact that although 90 percent of the visual defects found in this group of children were considered correctable by the authors, 87 percent were not even partially corrected. A study conducted by the Michigan Health Department indicated that children from low socioeconomic areas have twice as many visual defects as children from high socioeconomic areas.

Defective color vision, which is hereditary in most cases, occurs with much greater frequency among boys than girls in the general population. The reported prevalence varies considerably among the surveys. According to "Services for Children with Eye Problems" published by the American Public Health Association, about 8 percent of boys and one-half of 1 percent of girls in the average school population have evidence of defective color vision. Higher and lower figures have been quoted by other sources. Color blindness varies with race; for example, red-and-green blindness is reported by Pickford to be more frequent among whites than among Negroes.

Until recently the prevalence of color blindness and the male-female ratio of cases were thought to be the same for the mentally retarded as for the general population. Studies now indicate a substantially higher prevalence in the retarded and a nearly even male-female ratio among the cases. It is pos-

sible, however, that the higher rate found among the retarded derives from their difficulty in comprehending the test and in following the directions, and further studies are needed of this question.

BASIC PRINCIPLES OF VISION SCREENING PROGRAMS

PURPOSE AND SCOPE

The main purpose of a vision screening program is to identify children who are in need of special eye care and to refer them for diagnosis and therapy.

Although it is not included in the definition of screening per se and not discussed here in detail, a referral system through which children who are found to require eye care can be properly channeled should be included in all vision screening programs. Of equal importance is a followup system to ensure that recommendations made for children who need eye care are carried out. Followup will also indicate the efficiency of the screening procedures in terms of the number of over-referrals and under-referrals. A vision screening program which does not include referral and followup procedures cannot be considered complete, for without them much of the effort directed at screening will be wasted.

Vision screening procedures should thus be regarded only as part of an overall program, the ultimate aim of which is the provision of complete diagnostic and therapeutic eye care services for those who need them.

COMPONENTS OF SCREENING

Vision screening should consist of two parts: screening by clinical history and screening by vision test or tests.

CLINICAL HISTORY

A carefully taken history will often provide invaluable clues to the diagnosis of visual problems in children. The Michigan Health Department reported that half of the preschool children who failed its vision screening tests had either a family history of eye disease or clinical signs or symptoms suggestive of eye problems. Yet clinical history is sometimes overlooked as part of a screening program. While histories taken by trained personnel may be more accurate, where this is not feasible questionnaires may be distributed to parents to be answered before vision screening tests are conducted.

Clinical histories which include any of the following circumstances would classify a child as high risk: (1) family history of visual defects such as defective color vision, refractive errors, strabismus, and congenital cataract, of inborn errors of metabolism like diabetes, galactosemia, lipidoses, albinism, and retinoblastoma; (2) a history during pregnancy of the mother of rubella, toxoplasmosis, syphilis, or toxemia; (3) birth history of prolonged or difficult labor or low birth weight; (4) difficulties in the neonatal period, particularly respiratory difficulty which required prolonged oxygen therapy; and (5) evidence of mental retardation, deafness, or cerebral palsy.

Complaints such as frequent headaches, dizziness, sensitivity to light, and blurred vision, or actual signs such as crossed eyes, eyes turned out, constant rapid movements of the eyes (nystagmus), red, swollen, or encrusted eyelids, watery eyes or discharges, haziness in the pupils, etc., should of course be given professional attention.

Certain types of behavior are suggestive of visual problems: holding books unusually close to or far from the eyes while reading, frequent blinking, squinting, or rubbing of the eyes, abnormal head tilting or turning inattention in blackboard, wall-chart or map lessons, poor alignment in written work, unusual choice of colors in art work, confusion of certain letters of the alphabet in reading such as o's and a's, e's and c's, b's and h's, n's and r's, inability or reluctance to participate in games requiring distance vision or visual accuracy, irritability when doing

close work, or difficulty in doing work which requires visual accuracy, etc. Teacher observations are often valuable and should be included in the history as available.

Vision testing

Theoretically, many components of the visual sense should be tested—central visual acuity (distance and near), peripheral vision, binocular vision, color sense, etc. However, procedures which cover numerous visual components are too time consuming and complicated to be practical for mass application. Many authorities agree that a test for central distance visual acuity is the single most important test of visual ability in children. Programs based on this test have identified more children in need of eye care than those based on any other vision test. This test and a clinical history should be considered the basic *minimum* procedures in any screening program. Whenever possible, tests for accommodative ability, muscle balance, and color vision should also be given. It should be noted, however, that tests of accommodative ability are considered by some to be not very useful for the early years of childhood, when almost all children have great powers of accommodation and are characteristically still somewhat hyperopic. The investigators in the Orinda study concluded that the Modified Clinical Technique was the most accurate means of screening. However, this technique consists of a battery of tests ("visual acuity, objective estimate of refractive error by means of skiametry and lens bar with motion-picture cartoon for fixation, cover test far and near, observation and internal examination for pathology and anomalies is indicated") that must be administered by professional examiners.

To be applicable as a screening procedure, a vision test should be relatively simple so that it can be reliably administered by non-professional personnel after appropriate training and supervised practice. The test should not be time-consuming, since a relatively large population is to be screened within a short period of time. It must nevertheless be sufficiently sensitive so that neither over-referrals nor under-referrals occur with undue frequency, although some such referrals are unavoidable. Between over-referrals and under-referrals, the latter have a more serious implication. On the other hand, too many over-referrals are likely to diminish public confidence in such screening programs and result in poor cooperation. In order to reduce the number of over-referrals, it has been suggested that children who do not pass a vision screening test be retested on another day, and that only those who fail the screening test twice be referred. Spot checks of the screening might be done by an optometrist or ophthalmologist acting as consultant for the program. Lastly, equipment used in screening should be relatively inexpensive and simple. In short, vision screening tests should be reasonably accurate and yet permit economy in manpower, time, and money.

SCHEDULE FOR SCREENING

Although it is desirable that screening programs provide each child with a thorough vision screening every year, this is often not possible. It has therefore been suggested that each child be given the basic minimum screening procedure once a year, and a more comprehensive screening every 2 or 3 years. Where a lack of resources makes such a schedule impossible, a schedule aimed at screening children during certain critical periods may have to be adopted. After an initial screening in the preschool years, the children should be tested again at 9-10 years of age because refraction in many school children gradually changes from slight hyperopia to myopia at this age, and the rate of referral in most school screening programs increases abruptly at the fifth grade level. Adolescence, a time of rapid growth and development, is another period when vision

screening should be done. Color vision should be tested, preferably in the preschool years, but at least before the end of the intermediate grades (4th to 6th). Although defective color vision is not correctable, those affected should be aware of their limitation. Awareness of the defect is especially important when children begin considering occupations to prepare for.

NEED FOR COOPERATIVE EFFORT AND PUBLIC EDUCATION

A successful large-scale vision screening program for children requires the coordinated effort of ophthalmologists, optometrists, pediatricians, nurses, social workers, school authorities, teachers, public educators, interested public and voluntary agencies and groups such as local health departments, education departments, and PTA's. The various professions and groups will need to work together in planning screening programs that will be readily available to all children in the community. Attention must be given not only to the actual screening procedures, but also to careful selection and training of the testers, preparation of the public for such a program beforehand, and adequate followup of children referred for diagnosis.

The public, particularly parents, should be made aware of the fact that all children should be tested periodically, regardless of whether signs of possible visual problems are present or not. The importance of early diagnosis of visual defects should be explained. The public's attention should be called to the existence of vision screening programs in the community, and the purpose, meaning, and limitations of these programs should be made clear. Parents and others should be acquainted with the common signs and symptoms of visual problems, and be advised to seek help whenever suspicions of such problems arise, even if the children have just passed a vision screening test. Dissemination of information on what circumstances indicate high risk insofar as vision is concerned will further increase their index of suspicion.

With improved organized effort directed toward large-scale vision screening and increased public interest in such programs, we can expect significant reduction among children of vision loss and impairment from preventable causes.

FEDERAL ELECTIONS CAMPAIGN ACT OF 1971

Mr. MATHIAS. Mr. President, President Nixon recently signed into law the Federal Elections Campaign Act of 1971. This landmark legislation came about, largely, because of a veto and a promise.

The veto—President Nixon's—was given to a bill which was admittedly inadequate and unfair. It purported to cut down on campaign spending but applied only to broadcasting in general elections. It was unfair because it discriminated against broadcasters and, because of its unrealistically low limits, tended to favor incumbent candidates.

The promise—Senator HUGH SCOTT's—was given to the Senate at the time the President's veto was sustained. The Republican Leader pledged to introduce a comprehensive bill in the next Congress which would meet all the problems of modern day election campaigns. That bill dealt with full reporting and disclosure of campaign funds, tax incentives for political contributions and reduced-rate broadcasting and newspaper advertisements. Each of those components was to be included in the bill which Congress finally passed almost 1 year later.

This is only one example of Senator SCOTT's support for clean, honest election laws. I ask unanimous consent to place a list of some of his other accomplishments in the RECORD.

There being no objection, the items were ordered to be printed in the RECORD, as follows:

92D CONGRESS Legislation

S. 956—To revise the Federal Election laws.
S. 1385—To provide for a uniform closing time for polling places in Federal Elections.
S. 3056—To amend Public Law 92-178, the "Revenue Act of 1971."

S.J. Res. 7—Proposing an amendment to the Constitution of the U.S., extending the right to vote to citizens 18 years of age or older.

Amdt. 321 to S. 382 Federal Elections Campaign Act of 1971. To prohibit the extension of unsecured credit, by certain federally regulated industries, to candidates for Federal office.

Amdt. 340 to S. 382 Federal Elections Campaign Act of 1971. To create an independent Federal Elections Commission to oversee campaign spending.

Amdt. 359 to S. 382 Federal Election Campaign Act of 1971. To establish qualification for membership on the FEC.

Notes

Voted to extend the right to vote to citizens age 18 or older—proposed Constitutional Amendments.

Voted for the Federal Elections Campaign Act of 1971.

91ST CONGRESS Legislation

S.J. Res. 59—To amend the Constitution of the U.S. to provide that U.S. citizens shall be entitled to vote nationally without excessive residence or physical presence requirements.

S.J. Res. 147—To amend the Constitution of the U.S. to extend the voting rights to citizens age 18 or older.

S. 2876—To provide Congressional candidates with opponents the opportunity to purchase communications broadcast time at low cost.

Notes

Voted to abolish restrictive residency requirements as a precondition to voting for President and Vice President, and to establish uniform nationwide standards relative to absentee registration and voting in presidential elections.

Voted to reduce the voting age from 21 to 18 years of age, effective January 1, 1971.

Voted to sustain veto of the Political Broadcasting amendment to the Federal Communications Act, which would have discriminated against challengers in elections.

Voted for direct popular election of the President and Vice President.

90TH CONGRESS Notes

Voted to broaden the prohibition against soliciting political contributions from Federal employees, under the Elections Reform Act of 1967.

Voted to require disclosure of gifts and certain compensation by any Senator or by any candidate seeking nomination or election as Senator.

89TH CONGRESS Legislation

S. 3435—Election Reform Act—To require all candidates and all committees supporting candidates to fully disclose details of all contributions and expenses over \$100; to limit to \$5,000 the total amount that can come from any single source to the campaigning of any candidate; to provide for