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The measures I have joined in sponsoring are:

First. Repeal of the Domestic International Sales Corporation. This would raise $815 million in additional revenues for the Treasury.

Second. Repeal of percentage depletion for oil and gas production. This would raise $1.9 billion in additional revenues for the Treasury.

Third. Imposition of a minimum tax on foreign source income. This would raise $1.2 billion in additional revenues for the Treasury.

Bringing the Federal deficit closer to balance will relieve inflationary strain in several critical ways. By taking the Federal Government out of competition for the billions of credit dollars which would otherwise be needed to finance a deficit, budgetary balance will significantly reduce interest rates and substantially increase the availability of loan money for housing and for expansion of badly needed industrial capacity. Ending the Federal deficit also will eliminate the unnecessary net stimulus to aggregate demand which results from an excess of expenditures over revenues. Nothing the Federal Government can do will be as important or effective in the battle against inflation as restoring balance to the Federal budget. As far as I am concerned, there is no higher priority than the restoration of reasonable price stability without further delay.

OPERATION ANESTHESIA

Mr. McGOVERN. Mr. President, the July 1, 1974, issue of the New Yorker contains a most perceptive commentary on the current impeachment issue facing the Congress and the Nation.

The editors contend that the evidence of Presidential wrongdoing is so overwhelming that it delays the impeachment process. As they put it:

It is as though we had too much evidence to convict, and had been condemned to eternal impeachment.

I ask unanimous consent that this article be printed in the RECORD.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

THE TALK OF THE TOWN

NOTES AND COMMENT

Just about everything that is happening in Washington these days is of such startling strangeness that it seems to be happening for the first time anywhere. Now the White House has hit upon still another unheard-of tactic in the President's defense strategy. It is to beat the public senseless with more news of Presidential wrongdoing than it can endure.

The President's release of his transcripts is a case in point. Recently, two White House aides spelled out the new White House thinking for Philip Shabecoff, of the *Times*. After it had been made known that the President had been named unanimously by a grand jury as an unindicted co-conspirator in the Watergate coverup, and after the President had sent off his letter defying the House Judiciary Committee's subpoena of more tapes, Raymond Price, a speechwriter for the President, said,

"These recent disclosures are not damaging," and added, apparently approvingly, that the public was now "anesthetized." Operation Candor had given way in Operation Anesthesia. Ken W. Clawson, the President's communications director, observed that "the impact isn't there anymore," and he explained, "Last fall, we used to talk about what the next bombshell would be. But now there aren't any more bombshells." If there aren't, the reason, of course, is not that no more bombs are being dropped but that the public's sensibilities have been bombed out.

In the new White House strategy, everything that once hurt the President can now be used to help him. Revelations that were once damaging serve only to promote the supposed public unconsciousness on which the White House is now relying as the President's best protection. (Recent polls, however, seem to show that the unconsciousness is to be found more in the Congress than in the country at large.) What stands between the President and impeachment is not a scarcity of evidence but a mountainous superfluity of it. The evidence is all around us, in the wreckage of our institutions as well as in the Judiciary Committee's thirty-six volumes. The evidence is so pervasive that many of us can barely remember what innocence is. It is as though we had too much evidence to convict, and had been condemned to eternal impeachment. Once, the bombshells harmed the President's cause. For the moment, it seems that the more wrong he does, the safer he becomes.

Not long ago, it was reported that the Democratic Party, by making a show of opposition to calls for the President's resignation which had come from within the Republican Party, was trying to use the issue of impeachment for political advantage. Now, as the House Judiciary Committee moves toward a vote on whether or not to recommend articles of impeachment to the full House, there have been reports that some of the Republicans on the Committee may, for political reasons of their own, vote against any articles of impeachment. If all these reports are correct, it means that both parties are maneuvering around the issue of impeachment purely for short-term political gain. There is another school of thought in the matter, however. It holds that the members of the House Judiciary Committee will rise above petty political interest, because they know that the eye of history is on them. According to this school, the members will reflect that whereas everything they have done as representatives so far is likely to be forgotten, this one vote will surely be remembered. And since on this single occasion the spotlight of history will penetrate the convenient obscurity in which representatives normally act, the committee members will be on their best behavior. This school of thought, no less than the school holding that the vote will reflect poltical calculation, belittles the members of the Judiciary Committee. "History," in this connection, is nothing more than the future's image of the present. By invoking the judgment of history—a judgment that, in any case, is unknowable to us—we rely on a deferred form of public relations in which the images are merely more lasting than contemporary images. In doing so, we pass the buck to the future. We mentally remove ourselves to a point outside the corrupt present, as though by this operation we could gain access to a fund of wisdom unavailable to us in our time and could use the future to gain moral leverage on the politicians of the present. But in performing this trick we overlook the fact that the representatives in our era have mental and moral equipment, too. The men and women of the House Judiciary Committee, who will have to cast the first votes on the question of impeachment, have minds and consciences of their own to consult, and need not try to peer into unwritten history books. The evidence is spread out before them, the vastness of the stakes is inescapably plain, and the decision is theirs—to be made not in remote periods by reasons unknown but here and now by the thirty-eight members of the Judiciary Committee.

CHILDREN'S HEALTH

Mr. MONDALE. Mr. President, as we look toward the enactment of national health insurance legislation, no element should concern us more than the health of America's children.

The Federal maternal and child health program conducted under title V of the Social Security Act has shown that adequate medical services to children and expectant mothers can dramatically improve child health—cutting infant mortality rates by 50 percent and more, and sharply reducing the incidence of serious illness and hospitalization. But these programs—funded at less than $250 million in the last year—are only a drop in the bucket.

The facts are shocking:

As many as 10 million children each year fail to see a doctor at all.

A recent survey conducted in Washington, D.C., found that more than 25 percent of children aged 6 months-3 years suffered from anemia, more than 25 percent had untreated vision problems, and 20 percent suffered from middle-ear disease. And while poor children suffered most, rates were high for all children.

I am deeply concerned that the proposals now before the Congress contain serious shortcomings in the area of child health, and I hope to soon introduce provisions designed to assure American families of access to quality health care for their children.

Mr. President, the health status of this Nation's children was recently explored in two excellent and eloquent Reader's Digest articles by Lester Velie, "The Shocking Truth About Our Children's Health Care" and "Needed: Quality Health Care for All Our Children." I believe these articles will be of interest to the Senate, and I ask unanimous consent that they may appear in the RECORD at the conclusion of my remarks.

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

THE SHOCKING TRUTH ABOUT OUR CHILDREN'S HEALTH CARE

(By Lester Velie)

Seven-year-old Philip has a strange family doctor. He doesn't know Philip or his family, and they don't know him. The best time to see him is at midnight. Sometimes he plays blindman's buff with patients, for, not knowing their full medical history, he diagnoses and treats by guess and by hunch.

Philip's family doctor is the emergency clinic at Jackson Memorial Hospital, in Miami. Few of the 33,000 children treated there yearly are accident victims. Most are sick youngsters whose mothers have nowhere else to turn.

There's a doctor three blocks from Philip's home and a private clinic a mile away. But they charge $10 cash in advance, plus the cost of lab tests and prescriptions, which the family can't afford on the father's $100-a-week take-home pay. So when Philip or either of his two sisters suffers a scrape, fever, diarrhea or any ailment short of a true emergency, his mother heads for the county hospital—eight miles, two buses and one hour away. Most of her 30-odd visits over the last three years have been in the

middle of the night; at other hours, she has found, the waiting can take the better part of a day.

Ours is a two-class medical system. First class is for those who can pay, directly or with insurance, for private care. The others, like young Philip, rely on a subsystem of emergency rooms, "free clinics" manned by volunteers, and federally funded neighborhood health centers—or get infrequent health care or none at all.

Price is one barrier to adequate health care. Some 25 percent of children under 21—about 20 million in all—are "medical indigents": their families earn less than $6,000 a year. In big cities, the percentage is higher. Of Baltimore's 320,000 children, fully half are medical indigents.

To this, add the barrier of acute doctor scarcity in inner cities and rural areas. The Kingsman Park section of Washington, D.C. (population 85,000), for example, has no pediatrician. Its only general practitioner has a case load of 9,500 patients, who must make appointments three months in advance! As for rural areas, the American Medical Association reports 140 counties (total population, a half-million) with not a doctor among them.

The consequences? A recent Health, Education and Welfare poll of 40,000 households, ranging from poor to middle class, found that 29 percent of the children had not seen a doctor for a year, and 14 percent not for two years.

To break the cost and scarcity barriers, then, more and more of the poor, near-poor and even lower-middle-class have turned to "emergency-room medicine" as a stopgap. Use of emergency rooms more than doubled during the 1960s. At the Children's Hospital Medical Center in Boston, it nearly tripled in a decade. And what kind of health care does this mean for children?

OUT OF GEAR

"I come here so often I feel I own the place," said one mother of five, who lives 17 miles from Jackson Memorial. "But I don't ever get the same doctor or nurse. So each time we start all over."

A young intern said, "I've taken an oath to give quality care. But how can I, without more observation and knowledge of the child? I don't know if this is a kid whose sore throat turns into something more serious, or whether his mother is hysterical and runs to the doctor every day. We have to discount so much, and guess so much."

"No doctor should work more than six hours straight in an emergency room," said a resident (a medical-school graduate studying a specialty). "But I work 24, with every other day off, and interns work a 15-hour day. A tired doctor cuts corners, misses symptoms. It's hard to spot typhoid after you've seen 50 cases of diarrhea in one day."

From observing emergency rooms in Los Angeles, Washington, D.C., Chicago, Miami and Brooklyn, I've learned that many children come in with diseases that are supposed to be obsolete—measles, mumps, sometimes diphtheria and polio. Why? Because only a minority of children who come have received their immunization shots.

Last year, only 43 percent of preschool children in inner-city areas had been fully immunized against polio, according to Dr. John J. Witte, director of the Immunization Division of the U.S. Center for Disease Control. Only 55 percent had been immunized against measles, diphtheria, whooping cough and tetanus. Crisis-oriented, emergency-room medical care is simply not geared to medical-history keeping. Says Dr. Witte, "A child with a dog bite or puncture wound will get a tetanus shot. But a parent who brings a child with a rash or stomach ache is not likely to be asked what immunizations the child has had or when."

Neglect of pregnant mothers—on whose health the health of the newborn child depends—compounds the problem. In Wisconsin, the state Division of Health and Academy of Pediatrics found that some 70 percent of all obstetrical emergencies in 1970 could have been predicted—and many of them averted—with proper prenatal care. Yet in some low-income areas in Brooklyin, Chicago and Washington, D.C., almost 33 percent of pregnant mothers get *no* prenatal care. So a baby born in Iceland, Japan or any of 12 other countries has a better chance of surviving its first year than one born here.

Even more scandalous: The U.S. mortality rate for children in their first year who were born to poor or near-poor parents is twice as high as for middle-class children. Further, some 200,000 children a year are born blind, or deaf, or with muscular dystrophy or impaired hearts—many for want of proper care prenatally and at birth.

Who is to blame?

Curiously, we have the best-equipped hospitals, the best-trained doctors, the most advanced biomedical research in the world. All these are a part of a $94-billion health-care industry. The trouble is, as Dr. George Silver of Yale University Medical School says, "This giant industry relies on an inefficient, corner-grocery distribution system." Or, as former U.S. Surgeon General Dr. Jesse L. Steinfeld puts it, what we have is "not a medical system, but high-priced chaos." No group—whether the doctors, hospitals, health-insurance industry or federal government—takes responsibility for the distribution of medical resources, or for setting a national health strategy that would include health care for all our children.

FEDERAL CRUMBS

Consider the federal government, which via Medicare, Medicaid and other programs foots the biggest share of our country's total hospital and doctor bills —40 percent. (Private insurance covers about 27 percent, direct cash payments cover the remaining third.) Who heads the line for the federal dollars? Not the children. The aged and the war veterans shared more than half the 1973 federal health budget of $24.6 billion. The children, one third of our total population, got the crumbs—12 percent. For every 65 cents spent on an elderly person, the government spent a nickel on a child. The elderly do not have to take a means test to qualify for Medicare, but children must be paupers to qualify for Medicaid or for care in the federally funded neighborhood health centers.

Few would suggest that we diminish our health care for the aged. But should a country put its past—the retirees—first, and its future—the children—last?

It is clear that children don't vote but adults do. The elderly have two principal sets of lobbyists, maintained by the National Council of Senior Citizens and the American Association of Retired Persons. They also have an effective policy-making voice in government through HEW's Administration for the Aging, headed by ex-HEW Secretary Arthur Fleming. Meanwhile, the Children's Bureau, which spoke for children and handled all federal child-health programs from 1912 onward, was gutted in 1969 and its functions were scattered throughout HEW.

The Office of Child Development, which inherited some of these functions, has had no permanent director since June 1972. The Maternal and Child Health Service, which was supposed to administer the health programs, was slashed last year from a staff of 130 to a staff of six. This is the agency that conceived and nurtured the model maternity-and-infant-care programs as well as the comprehensive health programs for preschool and school-age children acclaimed by the American Medical Association and the American Academy of Pediatrics. In July, the federal funds earmarked for children's-health projects will be replaced by formula health grants, which give the states some freedom in spending. To date, the states have been notoriously neglectful of child health.

DEPRESSING PERCENTAGES

Nobody is minding the children of the poor and near-poor in health insurance, either. Of families earning between $3000 and $5000 yearly, only about 42 percent are even partially covered (usually with health insurance purchased by employers). Among families earning between $5000 and $10,000 the figure is about 77 percent. But, as the American Academy of Pediatrics recently charged, "Insurance programs are designed primarily for the care of adults." Most policies provide for hospital care only. What children need chiefly is "well-care"—checkups, treatment of minor ailments before they escalate. Since most policies don't cover doctors' visits, children of the working poor are unlikely to see a doctor until they become seriously ill.

Meanwhile, our medical schools are not providing enough "primary child-health caretakers" to keep pace with the rising population. Of 10,391 medical-school graduates in 1973, fewer than ten percent are training in pediatrics. And the combined number of general practitioners and pediatricians per 100,000 children has declined since World War II.

Furthermore, the supply of U.S. medical-school graduates flows to where the most dollars are—in the suburbs and middle-class neighborhoods. Inner-city parents, turning to county-hospital emergency rooms, find these largely staffed with the products of medical schools in such underdeveloped countries as the Philippines, Korea, India, Pakistan.

TOWARD "WELL CARE"

As noted, what children mostly need is preventive care. (For example, early attention to strep throat in children could markedly reduce cases of heart-damaging rheumatic fever.) But medical-school emphasis is not on prevention; it is on treatment and cure. "Physicians contribute little to good health," Dr. Marvin Cornblath of the University of Maryland Medical School said to me, "We're trained to treat sickness."

"Our medical system is able to meet with high efficiency the kind of medical problem that was dominant until about 40 years ago," says Dr. William E. Glazier of the Albert Einstein College of Medicine. But the diseases that once killed us have been brought under control. Today we need a new approach, an improved health-care-delivery system to deal with today's problems. Specifically, we need a medical system geared to periodic checkups, screening, early intervention, maintenance care—*i.e.*, a system in which we pay the doctors to keep us well. Such a system would help put our children first instead of last.

When it comes to environment and energy resources, concern for our future results in national action. Our children, our most precious resource, deserve the same.

NEEDED: QUALITY HEALTH CARE FOR ALL OUR CHILDREN

(By Lester Velie)

Millions of our children—perhaps as many as half of them—are trapped in a cruel paradox. Most of the child cripplers and killers of the past—polio, diphtheria, measles, influenza-pneumonia—have been conquered. But not necessarily for the children of the poor, near-poor and even lower-middle-class. These families may lack the price of admission to a private doctor's office or live in medical wastelands in our inner cities and rural areas where few doctors can be found. Instead of the preventive "well care"—the immunizations, checkups and attention to minor ailments—that these children need, many get "crisis care" only, obtained chiefly in overcrowded, understaffed emergency rooms of public hospitals.

Almost a fourth of our pregnant mothers don't get the prenatal care that could significantly reduce premature births and other birth-time emergencies. And the mortality rate for children in their first year of life who are from poor or near-poor families is double what it is for those from the middle class. Later, children may die prematurely because they are denied the preventive care that would nip rheumatic fever, chronic infections or asthmatic attacks.

Does this mean we don't know how to provide the lower-income and rural child with quality health care? Not at all. Indeed, models abound. Two of the most successful involve local-federal partnerships in neighborhood health centers:

FOR INFANTS: M&I'S

When Social Security Act amendments in 1965 made federal matching funds available, local health departments, medical schools, hospitals and community groups set up demonstration Maternal and Infant Care Centers (M&I's) to serve low-income neighborhoods. Unlike the present medical system that waits for patients to knock on a doctor's door, the M&I's made all of the neighborhood's expectant mothers and infants their concern, reaching out to bring them in if necessary. The doctor's reach was extended, too, by use of pediatrics nurses, medical social workers, nutritionists and family counselors. These medical teams offered comprehensive well care aimed at bringing sound babies into the world and keeping them that way through the first, hazardous year of life.

Florida's Dade County M&I, for example, funded cooperatively by the federal and state governments and the county health department, provides anyone eligible—for a family of four, the annual income can be no more than $6300—with person-to-person concern along with the latest in medical technology. We met six-months-pregnant Mrs. Alma M when she came in for her regular monthly checkup. An obstetrician found her overweight and counseled a diet high in nutrition for the baby, low in calories for Alma. A nutritionist then explained the diet and told her how to cook it; for example, broiling instead of frying to reduce calories by half. If Alma had been a "high risk" mother—one suffering from venereal disease, diabetes or hypertension—faculty members of the Miami University Medical School were available as a back-up advisory team. After delivery, Alma's baby would get the same quality care from the M&I health team as that available to the well-to-do child.

The Miami M&I has achieved a remarkable turnaround. In 1965, infant mortality in the neighborhoods it serves was 96 per 1000 live births; since last July, that rate has dropped to 3.6 per 1000. Unfortunately, there are but 56 such M&I's scattered through 34 states—caring for only ten percent of the country's eligible mothers and infants.

FOR KIDS: CHILD-CARE CENTERS

Local-federal cooperation has also shown how children of the poor and near-poor can be cared for beyond infancy. At San Francisco's Mt. Zion Hospital, a comprehensive child-care project has aided some 3600 youngsters from birth to 18 years old, and their families as well. Here, too, emphasis is put on preventive care. Says project director Rosalind Novick, "We call up our families to remind them to bring in their children for checkups and immunizations."

For Anne Bryant, her husband and their seven children, the Mt. Zion program has been "family doctor, counselor, advocate and friend." Last year, for example, when the Bryants' six-year-old entered school, he was so disruptive that Mrs. Bryant was told he would have to be put in a class for problem children. She took the child to her project center, where doctors and psychologists found that he was of above-average intelligence but hyperactive. Mt. Zion social workers and the boy's teacher worked out a special comprehensive program, and he was soon doing well in a regular class.

Another system of preventive care, Child & Youth Health Centers (C&Y's) has, in the last six years, reduced by half the hospitalization of children in the program. Together with the use of paraprofessionals, this has lowered the taxpayer cost per child to about $10 a month—less than the cost of membership in most prepaid group-health organizations.

But, as in the case of the Maternal and Infant Care Centers, the C&Y's provide token relief. There are only 59, scattered through 28 states and the District of Columbia, and they reach fewer than five percent of the eligible children. In 1973, the Nixon Administration proposed that support for C&Y's (all M&I's and C&Y's cost the government some $111 million this year) be shared by the states, as called for in the original legislation. Only the vigorous lobbying of the M&I and C&Y program directors and by the American Academy of Pediatrics won extension of the federal grants for the child health centers for another year. As of July, the states must match a lower federal quota. The doctors argued that good health is the right of every child and that the centers were a historic beginning toward achieving that right—with more desperately needed.

DOCTORS' COUNTEROFFENSIVE

Meanwhile, the doctors of one state have shown that the medical profession itself can mobilize against maternal and infant deaths. Five years ago, the Wisconsin Academy of Pediatrics and the state health department surveyed 35 hospitals and found that 15 of every 1000 infants born live there did not survive the first four weeks of life. Dr. Stanley N. Graven of the University of Wisconsin Medical School, who headed the survey team, then helped launch a low-cost statewide "newborn program" that reduced the newborn death rate to nine per 1000.

How? At first, the solution seemed simple. All you had to do, Dr. Graven felt, was set up several centrally located intensive baby-care units and organize a transportation system to get high-risk mothers and newborns there. But then Dr. Graven made two startling discoveries: Outlying hospitals did as well in saving high-risk babies as urban hospitals, where conflicting demands on the time of highly trained obstetrics and pediatrics specialists kept them away when needed most—so that interns and nurses had to cope with emergency-delivery problems. Dr. Graven also found that at least two thirds of such emergencies were due to inadequate prenatal care.

Dr. Graven organized a "flying circus" of pediatricians and obstetricians to barnstorm the state's hospitals, inculcating a team approach to the delivery and care of newborns. This meant training special pediatrics nurses, doctors' assistants and associates to undertake much of the normal-delivery care so that doctors could attend to high-risk cases when they occurred. This, in turn, meant educating doctors to relinquish some of their traditional chores to nurses and paraprofessionals.

Since only a handful of hospitals had the new machines that measure the fetal heartbeat, or the respirators and other equipment needed for intensive care of ill newborns, Dr. Graven negotiated with eight of them to develop themselves as regional centers for high-risk mothers and infants. Then a statewide ambulance service was organized that put pregnant mothers or ill newborns no more than two hours away from a center.

THE OKLAHOMA PLAN

The trouble is that even the most efficient use of medical resources can't deliver health care to mothers and children unless sufficient doctors are available to provide it. Consider Oklahoma, which ranks 41st among states in the ratio of doctors to population: 1 to 900. Worse, 66 percent of these doctors are concentrated in six of the problem of cost. For example, Dr. Graven recalls a $28,000 hospital bill presented to the Wisconsin parents of twins who were maintained in an intensive-care respirator. All but $1800 had been covered by insurance. But for a young couple, $1800 on top of doctors' costs is a financial disaster. And how shall we provide the children of the poor and near-poor with continuing, preventive well care as well as sick care?

Virtually all authorities believe that some form of national health insurance is necessary. But unless we expand medical services to absorb any new medical purchasing power we provide by legislation, we will have more medical-cost inflation. For instance: since Medicare increased medical purchasing power without increasing the supply of medical resources, it helped quadruple hospital costs and triple doctor costs. And since private doctors continue to be scarce in low-income areas, many Medicaid card holders have been unable to purchase care, turning to hospital emergency rooms instead.

Clearly, a new national strategy is needed. One approach, favored by former Secretary of Health, Education and Welfare Wilbur J. Cohen, who was a principal architect of the Social Security Act of 1935 as well as Medicare and Medicaid, is a "junior Medicare." This would not only pay medical bills for all children under six but help make additional health care available with loans from a new insurance fund to community groups, doctors, hospitals and medical schools to set up additional neighborhood health centers. These would then bill junior Medicare for services to children just as doctors and hospitals now bill Medicare for services to the aged. Such billings would also help repay the start-up loans.

Another approach, favored as a minimum measure by the American Academy of Pediatrics, is national health insurance for children under six, requiring employers to buy Blue Cross, Blue Shield and commercial health insurance for the children of their employes. Such coverage for children could be coupled with federal action to expand the present neighborhood health centers and so meet the special needs of poor and near-poor children.

As Congress ponders the various health reform bills now before it, we should all remember that children don't vote and don't lobby. The health needs of almost half our children will continue to be neglected unless we speak up for them.

WORLD HUNGER

Mr. HUMPHREY. Mr. President, a compelling editorial, "II—Hunger in the World," appeared in the July 9 edition of the New York Times.

The editorial quotes Dr. Norman Borlang, father of the green revolution, as recently saying that "only a famine and widespread death of millions would bring the world to an understanding of the enormity of the problem."

Four steps are outlined to deal with the world hunger problem which is barely recognized at the highest Government levels. Clearly, much more needs to be done to alert our citizens and the Government to the extent of the food crisis, and the editorial makes an important contribution in this direction.

Mr. President, I ask unanimous consent that this article be printed in the RECORD.