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Before leaving office last month, Interior Secretary Stewart Udall finally approved the highway plan, noting that it would not result in the removal of a single redwood. However, both he and the Sierra Club had already created the impression that the developers would be violating a pristine piece of America's wilderness.

NO LONGER KINGS

In fact, Mineral King is not quite that. The skeleton of the abandoned mining town (onetime pop. 500) is still in plain view and at least 60 summer homes now dot the proposed ski valley, which can be reached by an existing dirt road. Moreover, Mineral King is the jumping-off point for summertime pack-horse trips into the wild, mountainous wonder. Disney officials say that the Kaweah River is already polluted downstream from the stable of the horse-renting concession—and promised to do something about it.

No doubt the developers intend to mine Mineral King with the same antiseptic efficiency and imaginative salesmanship that they exercised on Disneyland itself. They promise to ban automobiles from the village and advocate a five-level underground garage. From there, visitors would ride a cogwheel train the last mile and a half. The ski valley would have more than two dozen lifts and tramways leading up slopes. Summertime guests would find fewer trees, but there would be good swimming and hiking.

Still, critics who believe that America's natural glories are seriously threatened today are appalled by the prospect of all that superorganization—and all that cuteness—which could lead to a village of Snow White Synthetic or Plastic Alpine. Moreover, the area around Mineral King would also be profoundly altered as a result of the resort. What seems to bother the Sierra Club most is the prospect that the pack travelers and other outdoorsmen will no longer be the only kings on this hill. Jack Hope, senior editor of *Natural History magazine,* voiced the typical objection. Disney's plan, he said, "conjures up pictures of tourists picking the grounds clean, of skiers watching the white wrapers of their candy bars floating to the ground." The Sierra Club is contemplating legal action on several technical grounds, but there seems little indication that Disney can be headed off at the pass. Nor, considering the need for well-planned recreational development, does there seem much cause for trying.

[From Newsweek, Feb. 10, 1969]

CONSERVATION: MOM VERSUS APPLE PIE

Mineral King Valley squats inside the Sequoia National Forest, surrounded by the towering, snow-capped peaks of California's High Sierra, 7,800 feet up in the kind of spectacular ski country that makes rank snow bunnies itch to do the slalom. Eight vast, natural snow bowls curve upward from the valley floor and offer uninterrupted downhill runs that are judged the equal of Europe's best. Most important of all to snow-hungry southern Californians, now thoroughly bitten by the skiing bug, the valley is only 170 miles north of Los Angeles.

So there were fervent cheers last week when the U.S. Forest Service, after two decades of pondering various plans to develop the valley, finally approved one of them. And there were more cheers from some quarters over the choice of developer. Who better to build a people's paradise in a serene mountain wilderness than Walt Disney Productions, creator of Disneyland?

The Disney plans were nothing short of supercalifragilisticexpialidocious. Disney proposed to invest some $35 million in Mineral King, much of it for an "Alpine Village" of steeply pitched and many-gabled roofs designed to house some 3,300 good family folk. Horse-drawn sleighs would ply the streets while cars remained hidden away in a 5-acre underground garage 1¼ miles from the village; an electric cog railway would carry visitors from vehicle to ville.

TO COURT

And who could possibly knock such a Technicolor scheme? The Sierra Club, that's who. No sooner was the Forest Service's OK official than the militant conservationist group announced it would go to court to stop the development. The 70,000-member club argued that the Federal government exceeded its authority in permitting construction of such "heavy facilities" as the Disney installation and a paved highway leading into it through Sequoia National Park.

The Disney proposal has the backing of California's Gov. Ronald Reagan and Sen. George Murphy as well as key Federal agencies and major ski groups, but few who have ever been up against the Sierra Club are ready to call the spunky organization outgunned. In the past, the cantankerous amalgam of rugged outdoorsmen and urban nature lovers has challenged the water interests of seven states—and come off the winner by almost singlehandedly halting the building of two dams that would have flooded parts of the Grand Canyon. Just last September, the club's fervent efforts to save California's redwoods finally paid off in a 58,000-acre addition of redwood stands to the National Park system.

The club's first article of faith is that the nation's remaining wilderness areas should be protected from all forms of outside incursion. Toward this end, it has been led for the past sixteen years by its arrogant and dynamic executive director, David R. Brower, 56. Although the 77-year-old group has grown nearly ten-fold under Brower, the white-thatched director has himself lately become almost as much of a controversial figure for club members as a runaway logger in a redwood grove. Brower has sponsored a succession of elaborately illustrated book productions extolling the U.S. wilderness—and recently announced a new line of international books. Many of his critics think the book program has got entirely out of hand while other members think he has simply grown too big for his hiking britches. He infuriated even some of his friends recently when on his own he ran a page-and-a-half club ad in The New York Times that called for viewing the globe as a sort of Earth National Park.

TEST

To the building furor over his iron hand in the organization's affairs, Brower replies: "I think the issue is whether the Sierra Club . . . continues to grow in its scope and competence." He plans to test his own aggressive personality and philosophy in April by running for the first time for a position as one of the club's fifteen board members. If he does not get elected, he says that he will quit as executive director.

It just may be that the internecine battle over Brower will distract the club from its declaration of war on Disney. But don't count on it. There is nothing like a threat to America's dwindling wilderness to rally the membership. And barring any further internal upheavals, it promises to be quite a battle. For if a Disney production is as difficult to oppose as apple pie, nearly the same has been said of the Sierra Club. In the fight between club and logger over the redwoods, one lumber spokesman lamented: "We think they're wrong, but we're not going out to fight motherhood." When apple pie comes smack up against motherhood, it is plainly anybody's ball game.

[From the San Francisco Examiner, Jan. 29, 1969]

MINERAL KING

The U.S. Forest Service has approved the Disney organization's plan for recreational development of the Mineral King Valley area of Sequoia National Forest, provoking threats of a suit by the Sierra Club.

We recall that 20 years ago three skiers surveyed Mineral King's potential, remaining there from October until May, and came out with the report, "Take half a dozen Sun Valleys, line them up and you'll have some idea of Mineral King."

The site is indeed magnificent, not only for winter but summer recreation. It will provide in particular new opportunities for winter sports for Southern Californians who in growing numbers already crowd existing facilities.

We stand with the Sierra Club on the issue of protection of wilderness resources, but this viewpoint must be balanced against the legitimate recreation needs of increased population.

Disney was only one of six bidders for Mineral King. The bid would not have been accepted, nor the project initiated at all, if in the government's opinion it held prospects of destructive exploitation. This is especially true since the program was overseen by one of the most conservation-minded national administrations in American history.

Obviously there can be a slip twixt the drawing board and the execution. The Agriculture Department and, where concerned, the Interior Department, must see to it that this does not occur.

Constructive monitoring by conservation groups as the development proceeds will be of great value.

TOWARD A SOCIAL REPORT: HEALTH AND ILLNESS

Mr. MONDALE. Mr. President, on January 5 I introduced the Full Opportunity Act of 1969—S. 5. The bill, which establishes a Council of Social Advisers and a Joint Committee on the Social Report, provides for an annual social report to be given by the President on advice from the Social Council. I firmly believe that a social report will enable us to direct our efforts toward the realization of the goal of S. 5—full opportunity for every American. As I noted on February 4, the Department of Health, Education, and Welfare has recently published "Toward a Social Report." At that time I placed into the RECORD the introduction and summary of the report. The report, which caps a 2-year effort, should be seen not as a final model of the social report but rather as a preliminary working model.

Today I should like to invite attention to the first chapter of the report: "Health and Illness." Preliminary research has resulted in several sets of "hard data" which point to as yet unsolved and in many cases unconfronted public policy questions. We are aware that present medical care financing provides an incentive for "underuse of preventive care" as opposed to curative care. Yet we are presently unaware as to whether or not the Nation "can provide health services in a manner which will not discourage preventive care, and which will insure that all persons have access to health services which are reasonably comprehensive." We are aware that since the turn of the century life expectancy at birth has increased 20 years; at 5 years of age it has increased 9 years; whereas, at 65 years it has increased less than 3 years. However, we are not yet aware as to how best to

allocate our Nation's health resources among people in the prime of their life, in the early years of their life, or in the later years of their life. We are aware that between June 1967 and June 1968, hospital daily service charges rose 12 percent and doctors' fees 5 percent. We are not as yet, however, aware of how we can "find new ways to meet the challenge to the health status of the population" which is posed by these and other sharp increases in medical costs. There are, of course, numerous other instances in the report in which preliminary collection of "hard data" points to complex problems. In the future I will note some of these.

Mr. President, I ask unanimous consent that the first chapter of "Toward a Social Report" be printed in the RECORD.

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

CHAPTER I. HEALTH AND ILLNESS—ARE WE BECOMING HEALTHIER?

Good health and a long life are among the most elementary requirements for human achievement and enjoyment. The primary concern of this chapter is to review and appraise both the measures of change in health and life expectancy among groups in our society and the factors which have retarded improvements in the Nation's status.

The satisfactions a positive state of health can bring are matters for other chapters. Further, such important matters as the absence of pain or minimization of discomfort are neglected because they cannot be measured at this time.

Are we getting healthier?

Long Run Gains

The advance of medical science and rising standards of living in the Twentieth Century have brought about major improvements in health and life expectancy. Some diseases, like polio and diphtheria, have almost disappeared. Others, like tuberculosis and measles, are far less common than they used to be. The "miracle" drugs have reduced the danger from pneumonia and other infectious diseases to an extraordinary degree.

The increase in life expetcancy has been striking (Table 1). At the turn of the century, the average life expectancy at birth in the United States was 49.2 years; in 1966, it was 70.1 years. Women have gained more than men. In 1900, women lived two years longer than men on the average; they now live seven years longer.

TABLE 1.—AVERAGE NUMBER OF YEARS OF LIFE REMAINING AT SPECIFIED AGES, UNITED STATES, 1900-1902 AND 1966

Age at beginning of year	Average number of years of life remaining		Increase in average remaining lifetime (in years)
	1900-1902	1966	
Birth	49.2	70.1	20.9
1	55.2	70.8	15.6
5	55.0	67.1	12.1
25	39.1	48.0	8.9
65	11.9	14.6	2.7

The gain in expectation of life at birth has occurred mainly because of the reduction in the death rates among infants and children. In 1900, the average child, age five, could expect an additional 55 years of life; now a five year old can expect to live an additionaly 67.1 years, or a gain of 12.1 years. In contrast, life expectancy among 25 years olds has increased 8.9 years, and a typical 65 year old can expect another 2.7 years of life.

Life expectancy at older ages has not improved greatly because medical science has not yet developed the knowledge needed to control the degenerative diseases of old age. As more people survive long enough to become vulnerable to these diseases, death rates from the chronic non-infectious diseases have continued to increase. In 1966, heart disease, cancer, and stroke accounted for two-thirds of all deaths, compared to less than 20 percent in 1920. (However, with the recent breakthrough in drug therapy for hypertension and Parkinson's disease new knowledge is beginning to be brought to bear on some of the degenerative diseases of old age.) The incidence of some degenerative diseases that are painful or crippling, but usually not fatal, such as arthritis, has also increased.

Unfortunately, the great gains in increased years of life have not been equally shared by the American people. Nonwhite expectation of life at birth in 1900 was 33.0 years, 14.6 years below that of the whites. By 1965, nonwhite life expectancy had risen to 64.1 years but was still 6.9 years below that of whites.

Similarly, while the risk of death in early childhood has decreased markedly for both white and nonwhite children, the disparity between the death rates for white and nonwhite children has actually increased over the years. In 1965, the nonwhite death rate for infants under one year of age was 187 percent of the white rate, as compared to 160 percent in 1935.

Some Recent Trends

Since the mid-fifties there have been some gains in health, some losses and some areas where we are holding our own or where progress has been uncertain. For example, the incidence of such infectious diseases as diptheria, measles, polio, and whooping cough has declined since 1957. On the other hand, some diseases, including hepatitis, food-borne infections and streptococcal infections, have become more frequent. In addition, age-specific death rates for coronary heart disease among adults have continued to advance, as have death rates for cancer of the lung, cirrhosis of the liver, and chronic lung diseases such as emphysema, and chronic bronchitis. The diet and sedentary life associated with affluence, cigarette smoking, alcohol consumption and perhaps air pollution are major factors in the occurrence of these diseases. The death rate from motor vehicle accidents has also risen but less markedly.

Furthermore, the number of years which Americans can look forward to without any form of bed disability has changed little since 1958, the year when this calculation first became possible. This finding is based on a social indicator calculated for the Social Report. This indicator measures the expectation of healthy life. It reflects both those increases in the length of healthy life that are due to reductions in bed-disability or institutional confinement, and those that are due to increases in life expectancy.

As Table 2 shows, the unchanged life expectancy over the decade and the static expectation of disability days have resulted in a nearly constant expectation of healthy life. The figure in 1957-58 was 67.2 years, but this was a year of an influenza epidemic, so no upward trend can be clearly established, and if one exists at all it is very slight. The figures on expectation of healthy life remaining at age 65, shown in Table 2, also indicate only limited improvement.

Males and females show slightly different patterns. Since 1958, females gained a full year of total life expectancy at birth or 1.3 years free of bed-disability, while males improvide their situation by only 0.4 years of life expectancy or 0.6 years free of bed-disability. Expectations at age 65 show even greater sex discrepancies, with males having made no advances at all while females gained about a half year in both total and disability-free years.

The findings that expectation of healthy life is increasing so slowly does not mean that the health of the population has not improved. The measure of expectation of healthy life does not take into account differences in suffering. It is likely that the average day of bed-disability has become easier to bear in recent years because of the development of tranquilizers, pain killers and sedatives. Also, the index does not measure the progress made in relieving victims of illnesses that do not require bed disability. During July 1966–June 1967, the average American experienced 15.4 days of restricted activity, of which only 5.6 days required bed-disability.

TABLE 2.—EXPECTATION OF HEALTHY LIFE (IN YEARS), UNITED STATES, FISCAL YEARS 1958-66

Year	Expectation of life [1]	Expected bed disability and institutionalization during life	Expectancy of healthy life
AT BIRTH			
1958	69.5	2.3	67.2
1959	69.6	1.8	67.8
1960	69.9	2.0	67.9
1961	69.9	1.9	68.0
1962	70.2	2.1	68.1
1963	70.0	2.1	67.9
1964	69.9	2.0	67.9
1965	70.2	2.0	68.2
1966	70.2	2.0	68.2
AT AGE 65			
1958	14.2	1.1	13.1
1959	14.3	1.0	13.3
1960	14.5	1.1	13.4
1961	14.4	1.1	13.3
1962	14.6	1.1	13.5
1963	14.4	1.1	13.3
1964	14.3	1.1	13.2
1965	14.6	1.1	13.5
1966	14.6	1.1	13.5

[1] Disability and institutionalization figures are given in terms of the fiscal year that overlapped the calendar year listed. Expectation of life figures are for the calendar year during which the fiscal year began.

Source: Estimated from published and unpublished data obtained from the censuses of 1950 and 1960, and from the Health Interview Survey and Vital Statistics Division of the National Center for Health Statistics.

Recent reductions in infant mortality represent a hopeful sign. Though the infant mortality rate was practically unchanged from 1950 to 1965, it decreased by more than five percent in 1966 and by another five percent in 1967. While we cannot be certain about the causes of this possible trend, the sudden reduction in infant mortality may well be related to the new Federal programs for maternal and infant care and family planning.

Trends in mental health and illness

It is difficult to know with certainty whether mental illness represents an area of improvement or a growing problem. Because of still unsolved problems of psychiatric diagnosis, and because the types of behavior which are considered manifestations of mental illness change with our culture, no adequate measures of the mental health of a population have been developed. Nationwide data on the prevalence of emotional disturbance in the general population are meager.

Local surveys have been carried out in the United States to determine the prevalence of mental disorders, but their results do not lend themselves to comparison. Despite the lack of comparability among studies, each shows that sizable proportions of the population studied suffer or have suffered from a mental disorder.[1]

[1] To illustrate, three of these surveys carried out in different parts of the United

Data on trends in mental health status are limited. Only for the most serious and incapacitating forms of mental illness which may require hospital care do the data bear trend analysis.

It is noteworthy that the number of persons in state and county long-term care mental hospitals has declined since 1955, from 559 thousand to 401 thousand in 1968. These data probably reflect mainly the impact of tranquillizers and other new drugs and the wider availability of community-based care which have reduced the need for prolonged hospitalization of the mentally ill.

How much healthier could we be?

Is it realistic to hope for major gains in health and life expectancy during the next decade? In the absence of extraordinary scientific breakthroughs in the treatment of degenerative diseases, the gains in expectation of life will not begin to match those achieved during the first half of this century. Even if all deaths below age 55 were eliminated, expectation of life at birth would increase only 6.5 years.

To what extent could we improve health or extend life with presently known biomedical knowledge and technology? To obtain some insights into this question we can compare the health status of different groups in this country. Though the possibility of some genetic differences in health and life expectancy cannot be excluded, large differences in health and life expectancy would probably indicate that we had not done all that we could in applying medical skills and resources to advance health and life. Such differences would also be of interest because of what they told us about the inequalities in our society.

Another way in which we can examine the question of whether we could be significantly healthier with present technology and resources is by comparing the life expectancy of the United States with that of other developed countries. Some differences may conceivably be due to climatic or genetic factors, but large differences could surely not be explained in this way.

Differences Within the United States

The data reveal striking differences among the regions and groups in our society. There are, for instance, substantial differences in life expectancy among the geographic regions of the country. For white males, life expectancy at birth in the South is about one-half year below that in the North and West. There is a difference of about five years in life expectancy at birth between those States with the best records and those with the worst. Moreover, the infant mortality rate was twice as great in the poorest state as in the best State, and the maternal mortality rate was four times as great. Infant mortality rates are also available by county. In the worst 10 percent of the counties the infant mortality rate in 1961–65 was about 21 per 1,000 live births more than in the best 10 percent of the counties.

There is a significant difference in health status between whites and non-whites. While bed-disability is only slightly greater for Negroes, there is a major disparity between the life expectancy of Negroes and whites ages 65 and less (Table 3).

Negro infant mortality has been about four-fifths greater than that of whites. While infant mortality for whites was 20.6 per 1,000 live births, for non-whites it was 38.7 per 1,000 in 1966. Negro maternal mortality has been about *four* times as great as the white rate (in 1965, 90.2 and 22.4 maternal deaths per 100,000 live births, respectively).

TABLE 3.—AVERAGE NUMBER OF YEARS OF LIFE REMAINING AT SELECTED AGES, BY COLOR AND SEX: UNITED STATES, 1964

	Average number of years of life remaining					
	Males			Females		
Age	White	Non-white	Difference	White	Non-white	Difference
0	67.7	61.1	6.6	74.6	67.2	7.4
5	64.6	59.5	5.1	71.3	65.1	6.2
15	54.9	49.9	5.0	61.5	55.4	6.1
25	45.6	40.9	4.7	51.8	45.9	5.9
45	27.4	24.7	2.7	32.9	28.7	4.2
65	13.0	12.8	.2	16.3	15.6	.7
75	8.1	9.8	−1.7	9.6	11.1	−1.5

Negroes also have higher death rates for infectious diseases than whites, and higher death rates for certain tumors, such as cancer of the cervix. Since all of these death rates are subject to large reductions through more and better health services, the inequalities in the distribution of health services in our society are clearly an important factor accounting for these differences.

Furthermore, the available information indicates that illness causing limited activity is significantly higher for persons with low incomes, both black and white. For example, for males in the working age group 45–64, those with incomes of less than $2,000 have three and one-half times as many disability days as those in the over $7,000 income group.[2]

Moreover, several studies have shown that less than half of the low-income children with chronic conditions, including mental and emotional disorders, and hearing and vision defects, are under treatment. Yet two-thirds of these conditions could be prevented or corrected if the appropriate health services were available.

International Comparisons

At least fifteen nations have a longer life expectancy at birth than the United States. Life expectancy in the leading countries, Holland, Sweden, and Norway is about 3.5 years longer than it is in the United States. At the start of the decade at least 27 countries had lower age-adjusted death rates for heart disease among males than the United States.

Part of the explanation for our relatively low rank in life expectancy in comparison with other developed nations is our style of life and the competitive pressures in our society. More than a dozen countries have lower rates of ulcers, diabetes, cirrhosis of the liver, hypertension without heart involvement, and accidents. Our high automobile accident rate is perhaps due to the fact that we have more automobiles and use them more. The rates for diabetes and cirrhosis of the liver may be partly explained by the fact that we eat and drink more than some other peoples. The high rates of ulcers and hypertension may be part of the price we pay for our dynamic and competitive economy.

Some of the areas in which we lag behind could be affected by the amount and quality of health services available to our population. In 1964, the United States ranked fourteenth among the countries with the lowest infant mortality rates. Moreover, our relative rank with respect to infant mortality rates has progressively worsened over the years. In 1950 the United States ranked fifth; in 1955 we ranked eighth; and we fell to twelfth by 1960. While many other countries were making great progress in the reduction of infant mortality, the United States rate declined sluggishly. Also, at least five countries have better maternal mortality rates. Finally, our death rates from tuberculosis and pneumonia are far from the best.

Why Aren't We Healthier?

The United States cannot attribute the shortcomings of its health record to a lack of total expenditures for health services or to deficiencies in its supply of highly trained health manpower. The United States spends more on health services as a percentage of Gross National Product than any other country. And the proportion of GNP devoted to health care is rising rapidly. It increased from 4.6 percent in Fiscal Year 1950 to 6.5 percent in Fiscal Year 1968 or from $12.1 billion to $53.1 billion. When compared to the 13 countries with better infant mortality rates than the United States in 1964, we had the fourth highest ratio of both dentists and physicians to population, and the third highest ratio of professional nurses to population.

Nor can our poor showing compared to many other developed nations be blamed on the state of bio-medical science and technology in this country. The United States spends considerably more on bio-medical research than any other country. It is widely acknowledged that we are the leading nation in biomedical science and technology.

Genetic and environmental factors could possibly help to explain why our health is not better. Indeed, it is possible that adverse environmental factors and changes in life styles have cancelled out many of the more recent improvements in health services. The chapter on Environment shows that air pollution can be detrimental to health and this is also evident from the increase in death rates during periods when pollution is exceptionally severe. And a growing majority of Americans live in large metropolitan areas which are generally subject to concentrations of polluted air.

Perhaps more important than environmental factors, however, is the American style of life. For the vast majority of the population, health may be adversely affected by rich diet, smoking, lack of exercise, and the pressure of business and professional life. The high pressure of life may explain why the United States male life expectancy is so much lower by international comparative standards than the female life expectancy. For the underprivileged minority, bad health may reflect inadequate diet and ignorance about both proper preventive behavior and the value of early care, as well as unfavorable housing and sanitary conditions.

Of all these adverse factors, the health consequences of smoking have been perhaps best documented in recent years.[3] A wide variety of studies indicate that cigarette smoking leads to a substantial excess of deaths among those who smoke. It increases the risk of death from chronic bronchitis, pulmonary emphysema, heart disease, and lung cancer. Life expectancy for young men is reduced by an average of 8 years in "heavy" cigarette smokers, those who smoke over two packs a day, and an average of 4 years among those who smoke less than one-half pack per day.

Style of life and environmental factors do not account fully for the shortcomings in our health status. Two other factors, the unequal distribution of our medical care, and

States during the past 30 years demonstrated the following:

(1) 60 per 1,000 of the total population of an urban area were on the active rolls of mental hospitals and a large number of other health, welfare, social, educational and correctional agencies that provided services to persons with mental disorders;

(2) at least 70 per 1,000 of the population of a rural county would have been referred to a mental health clinic had one existed in the county;

(3) at least 100 per 1,000 of the noninstitutional population, all ages, of a major urban area were found to have a serious mental disorder.

[2] In comparing low and high income groups, it should be noted that one reason why persons may have low income is that they are ill.

[3] See, for example: The Health Consequences of Smoking, 1968 Supplement, U.S. Public Health Service Publication No. 1969.

the deprivation suffered by the nation's poor and disadvantaged, contribute to these shortcomings.

Socioeconomic Deprivation and the Distribution of Medical Care

The lower a person's income is, the less often he sees a doctor. Whether we look at data on visits to physicians per year, or the interval since the last visit, or the use of a specialist's services, we see a clear, positive relationship between higher income and greater use of physicians' services. At the same time, there is more illness to be treated among low income than high income people.

The use of dentists also varies markedly with income. More than 20 percent of people in families with incomes under $3,000 have *never* visited a dentist, as compared to 7.2 percent of those in families with incomes over $10,000.

There is further evidence of the unequal distribution of medical care, and its importance for our health status, in the provision of prenatal care. Though virtually all American babies are now delivered in hospitals, the expectant mother usually seeks out prenatal care on her own initiative and at her own expense. As a result, in most major cities, one-third to one-half of the women delivered in public hospitals have had no prenatal care. This is in sharp contrast to the practice in the Netherlands, for example, where infant mortality rates are among the lowest. There, nearly all expectant mothers get prenatal care, but a substantial proportion of the babies are delivered at home rather than in hospitals.

A person's race is also related to the likelihood that he will obtain medical care, even after adjusting for differences in incomes. Negroes at every income level use medical services less than whites. The number of physician visits per year for Negroes earning $10,000 or more, for example, was 4.3 in 1964–65 as compared to 5.1 for whites with similar incomes. This suggests that cultural and educational factors may also influence the use of health services, and that fewer health services may be available and accessible to Negroes.

The place a person lives has a major effect upon his access to medical care. For example, Mississippi has less than one-half as many physicians in relation to its population as New York, and only 58 percent as high a doctor/population ratio as the national average. Rural areas tend to have fewer doctors in relation to population than metropolitan areas (about 55 percent as many), whereas inner city ghetto areas have fewer doctors than middle class neighborhoods in the same cities. In general, States with low doctor/population ratios tend to have high infant and maternal mortality rates, a relatively high incidence of infectious diseases, and a shorter than average life expectancy.

The Cost of Medical Care

The uneven distribution of medical care in this country is due in part to the fact that medical care is becoming more costly in relation to other goods and services. Medical care prices have been rising faster than other prices throughout the postwar period. From 1946 to 1967, all consumer prices increased 2.6 percent annually while medical care prices increased at an annual rate of 3.9 percent. Moreover, in recent years the rise in medical care prices has accelerated. They increased at an annual rate of 6.5 percent during 1965–67.

Hospital daily service charges have been increasing faster than other medical care prices. They rose at an annual rate of 8.3 percent from 1946 to 1967. More recently, hospital daily service charges have increased sharply. During the two-year period 1965–1967, hospital charges rose 35 percent. In contrast, physicians' charges increased at an average annual rate of 7.0 percent during the same two-year period.

The relatively rapid rise in medical care prices and increases in demand for services have resulted in an increase in the percentage of personal disposable income devoted to medical care (from 4.1% in 1950 to 5.9% in 1966). Even so, the public probably consumes fewer medical services than they would have if prices had risen less rapidly.

Fortunately, the proportion of the direct medical expenditures that are paid by private health insurance or public programs have been rising, and this has greatly reduced individual financial burden from 1950 to 1966, the proportion of personal health care expenditure met by "third party" payments (government, private health insurance and philanthropy) rose from 35 percent of the total to 50 percent. Still, there are millions under 65 without private health insurance who do not qualify for aid under Medicaid, and who are accordingly left to their own resources when illness strikes. Moreover, it is estimated that Medicare covers only about 35 percent of the total medical care expenses for those age 65 and older. Thus, despite the fact that public outlays for personal health services have risen from $7.9 billion in fiscal year 1966 to $15.7 billion in fiscal year 1968, the medically indigent and those persons over age 65 must still pay for a substantial share of their own medical expenses.

Though low income families spend a higher percentage of their income for medical care than more affluent families, they spend less in absolute terms. This shows up most notably where preventive, as opposed to curative or ameliorative, care is concerned. During 1963–64, for instance, 54 percent of those persons under 17 years of age with family incomes in excess of $10,000 had at least one general physical examination, but only 16 percent of those persons under 17 years of age with family incomes of less than $2,000 had such a routine checkup. Generally, poor people fall farther behind high income people in their expenditures for physicians' and dentists' services, which are partly for preventive purposes, than for hospital care, which is largely designed to cure or ameliorate existing health problems.

In addition to the direct costs of medical care, there are the costs of the earned income foregone when a person is sick or obtaining medical care. For the family with the medical problem, as for the economy as a whole, these costs are considerable. In 1963, an estimated 3.8 million man-years were lost through illness, and 2.9 million of these would have been economically productive.

One estimate has placed the value of the labor lost for that year at $15.9 billion. Such an estimate can only be illustrative, for we cannot know what labor would be worth in a society without any health problems. But it does illustrate the point that the indirect costs of health problems are considerable, and that the burden of expenditures for medical care often falls on people whose incomes have been diminished because they could not work.

The System of Providing Health Care

Given the unmet health needs of our population and the rapidly increasing cost of medical care, the nation can certainly not afford to waste its health resources. Yet our system of providing and financing medical care fosters inefficiency and waste.

First, our methods of paying for health care provide incentives to use too little preventive care, and relatively too much curative and ameliorative care. Both private and public insurance generally cover hospital and surgical care, but they rarely reimburse patients for physical checkups and other forms of preventive care. There is considerable evidence that, as a consequence, our prevailing forms of health insurance have some effect on the decisions of patients, and the advice of physicians to patients, to use surgical services. A number of studies indicate that surgical rates for such "elective" procedures as tonsillectomies, hysterectomies, and appendectomies are considerably higher for persons with hospital insurance.

Even those who have no insurance are induced to take relatively to much curative and ameliorative care and relatively too little preventive care. The Chinese in ancient times used to pay their doctors when the patient was well, but not when he was sick. This system of payment gives a doctor a strong incentive to provide preventive care, but our system does not. Health professionals are usually paid in accordance with the amount of care rendered, and therefore they have little financial incentive (but considerable ethical incentives) to avoid providing unnecessary care.

Second, prevailing insurance plans generally give the patient incentives to use the highest cost component of the health care system—the hopsital—when less costly outpatient facilities or services might be equally satisfactory. The United States has more short-term hospital beds in relation to population than all but a few countries; and there is a good deal of evidence that hospitals are overused in this country. For example, a detailed study of the Kaiser Health Plan in California, which is a comprehensive prepaid health care plan providing a full range of health care services, showed that the age-adjusted utilization rates for Kaiser hospitals were more than 30 percent below the California average. Thus, the Kaiser Plan held its rise in hospital expenditures to 15 percent during 1950–65, as compared to a 50 percent increase for the country as a whole.

Third, the reimbursement of hospitals on the basis of costs provides no rewards for efficient operation. The Medicare and Medicaid hospital reimbursement formulas, based on "reasonable cost," and the formulas of most private insurance plans, make it easy for hospitals to "pass on" cost increases to third parties. At present, there are generally no reimbursement systems which make the level of income of hospitals depend upon the ability to operate effectively and thereby control costs.

Further, our system of independent hospitals and practitioners discourages *coordination* among the various elements responsible for providing medical care. This in turn leads to gaps in the type of care offered, a wasteful duplication of facilities and equipment, and considerable difficulty for many individuals in finding points of entry into our medical care system. However, there are some examples which show that a greater degree of coordination of health services is possible. In some areas of the country regional planning bodies have been effective in assuring that unneeded facilities are not constructed. Further, some group practice plans provide convenient access to care, the appropriate utilization of the skills of different medical specialists, and comprehensive care. Moreover, the experimental federally supported neighborhood health care centers for the poor may demonstrate that greater use of para-medical personnel outside of the hospital setting can work effectively in this country. Our present almost exclusive reliance on the physician for care outside the hospital is in sharp contrast to the extensive use of such personnel as visiting nurses and midwives in many foreign countries.

And finally, a factor that *may* help account for the high cost of medical care is the basically "small scale" of the health industry. Hospitals in the United States are generally small in comparison to those of Europe and, unlike foreign hospitals and United States commercial plants, are usually independently managed. The most striking example of small-scale production is, of course, the individual physician, especially the general practitioner. Although group practice is increasing, it is still unusual for moderate size groups of physicians to practice together and

utilize common laboratory facilities and ancillary staff.

The policy challenge

We have seen that the first half of the twentieth century saw extraordinary advances in health and life expectancy, but that the rate of advance has been slower in the fifties and sixties. In large part this slower rate of advance has been due to the fact that many of the most serious health problems of infants, children, and young adults had been solved by mid-century; and to the fact that it has not been possible to make many significant scientific breakthroughs in the treatment and prevention of degenerative diseases associated with the process of aging.

Nonetheless, the considerably longer life expectancy in some other countries, and the differences in health status among the different groups in our own country suggest that we could have better health and longer life, even without any new breakthroughs in medical science. There can be little doubt that appropriate public policy decisions can help to alleviate some of the factors adversely affecting the health status of our population. Public policy can aim to redress the imbalance in health resources, prevent and control harmful environmental factors, and even influence our thinking about those personal habits and forms of behavior which may prove detrimental to our health.

We have made some progress in the provision of health care for the young, in better preventive care, and in providing broader access to mental health facilities. The neighborhood health care centers of the Office of Economic Opportunity, and the community mental health centers supported through the National Institute of Mental Health are examples of new public policy actions in these areas.

However, much remains to be done. Many old but still unresolved public policy questions must be reexamined. The preceding discussion of the health status of our nation suggests that these are *among* the most important issues which must be resolved:

How much of our resources should be devoted to medical research for tomorrow and how much to provide services now?

Can the nation provide health services in a manner which will not discourage preventive care, and which will insure that *all persons* have access to health services which are reasonably comprehensive?

How much of the nation's health resources should be used to serve the elderly as opposed to young children and those in the prime of life?

Can we find new ways to meet the challenge to the health status of the population posed by sharp increases in medical care costs?

How can public policy redirect or control harmful practices which damage our environment, and alter personal habits and styles of life harmful to health, while still allowing organizations and individuals a satisfactory degree of freedom?

At present, we have no answers or only partial answers to these questions and many similar but subsidiary questions. America, in short, needs not only more effort, but also more debate and thought, if it is to realize the full potential for better health and longer life inherent in its advanced level of scientific and economic development.

OPPORTUNITIES INDUSTRIALIZATION CENTERS

Mr. BOGGS. Mr. President, in the city of Philadelphia, in my own city of Wilmington, Del., and in 73 other cities across the country there is operating a program which has trained 20,000 of America's poor for work and found permanent jobs for them.

That program is the Opportunities Industrialization Centers, founded by the Reverend Leon H. Sullivan, a Philadelphia minister who put the resources of his congregation to work.

In addition to the successful training programs, Dr. Sullivan's efforts have led to creation of an entrepreneurial program that now embraces a shopping center, a garment factory, and the aerospace industry.

The OIC has done, and is continuing to do, these things with minimal help from the public sector.

From his congregational base he has expanded to obtain help from private industry and from private philanthropy. The Federal Government now contributes to the support of 25 of the 75 OIC projects; and, as far as is known, Delaware is the only State to offer financial support.

Dr. Sullivan says that increased Government support would be beneficial to his program; but, unlike many similar projects, he emphasizes it will continue, with or without the support. He says:

I'm going to continue doing what I'm doing, even if the government doesn't give me a penny. My train is on the track. The government can get on board if it wants to. If it doesn't the train is pulling out anyhow.

Mr. President, the February 17 edition of the U.S. News & World Report contains an interesting interview with Dr. Sullivan. I ask unanimous consent that it be printed in the RECORD.

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

[From the U.S. News & World Report, Feb. 17, 1969]

BLACK CAPITALISM AT WORK: WHAT'S HAPPENING IN PHILADELPHIA—AN EXCLUSIVE INTERVIEW

(NOTE.—President Nixon is pushing this idea for easing the nation's racial conflict: Give Negroes a bigger stake in America by promoting black ownership of business firms—with help from U.S. private enterprise. Does this approach offer real hope? What are the results in places where it is being tried? One man who has made a widely acclaimed success of "black capitalism" is the Rev. Leon H. Sullivan of Philadelphia. In this interview with staff members of "U.S. News & World Report," Dr. Sullivan describes what "black capitalism" really is—and how Negroes can work together to build a better future for themselves.)

Q. Dr. Sullivan, what is needed to solve America's racial conflict in the long run?

A. Many things are needed to bring that about. There must be full justice and opportunity for the Negro to show what he can do. He must be given the education he needs to compete in our complex society.

Ultimately, I think, the black man will require a fair share of ownership in the American economy. And that will come in large part through his own efforts. Thus he will gain self-respect through self-help.

A man is not free until he owns something and has self-pride. This is not to say that riots and disruption may not be productive of gains in their own peculiar way. Many of my people are locked up in the box of deep prejudice and segregation and ignorance, and they can't get out. The only way they can let you know they are there is just to pound on the box and even knock down the sides.

In the long run, however, the only way that the streets of America are going to be cooled is by people in those streets believing in the country—giving something to it in their work, and getting in proportion to what they give.

Q. Does that mean "black capitalism" is the answer?

A. You can't have "black capitalism" and white capitalism" in an effective economy, any more than you can have a "black America" and "white America" in an effective society.

No, I see the African American becoming a part of *American* capitalism—in fact, joining the free-enterprise system worldwide.

For all the years that my brothers and sisters—and my poor ancestors—have been a part of America, we have been outside the door of free enterprise, outside the door of capitalism. What I want to see is my black brothers walking through the door of free enterprise, not as "black capitalists" but as black men who can join the whole free-enterprise system and share its benefits.

Separatism in any form offers no future. What a lot of people are talking about, really, when they talk about "black capitalism" is a separate economy, and that would be no different from the way things are in the Republic of South Africa. I see the future of black Americans being fulfilled when America is Americanized for all people.

PROVING NEGRO ABILITY

Q. In economic terms, how is that going to be accomplished?

A. I think in Philadelphia we're showing how it can be done. We're showing how black people, with very few resources except will and energy, can train themselves for jobs and pool their capital to create jobs for more people by going into business for themselves.

The ordinary Negro is proving that he can become a successful businessman, just as the white man or a person of any other race can become a good businessman. We have a job-training program that is being copied all over the country and even abroad. We have an investment program. We have business firms and industries making more jobs for more people—both black and white, I might add.

Q. How was this done?

A. Well, I am a minister, and everything I do flows from that fact. It sounds strange—how can a man be a minister and still get involved in business and job-training?

My church has 5,000 members, and the first thing I did was to create the "selective buying" movement in 1958, which some people called a boycott. We simply told merchants: "Either you employ people on the basis of their ability, not the color of their skin, or we will not buy from you."

With the support of 400 ministers in Philadelphia and a half million people, we opened thousands of jobs to black men and women, and the movement has been borrowed and improved upon in other cities.

Q. So your first step was to find job opportunities for Negroes in white-owned enterprises?

A. That is right. Now, when these opportunities opened up, I began to find it difficult to find black men and women to fill the jobs in business and industry. These jobs were a new world to us. Our world has been more of a "servicing" world that required little education and few skills.

So in 1964 I created the Opportunities Industrialization Center, with the help of many people—mostly ministers. OIC was the first massive program in manpower training to "reach the unreached" in this country. It was dedicated in an old jailhouse that I had secured from the city for $1 a year in rent.

To get it started, I raised $100,000 from the black community, an anonymous donor gave me $50,000, and my church gave me a $40,000 loan. I mortgaged my house to round out the rest of what was needed to get OIC started.

"HAND-UPS," NOT HANDOUTS

Q. Did the Federal Government offer any help?

A. I had no federal money because I always initiate a program without Government money. Once someone starts giving you