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between right and wrong, and it erodes the foundation of self-government.

"Sunlight," Justice Holmes observed, "is the best disinfectant." Franklin Roosevelt, the warrior whose happy creed we commemorate today, always fought in the sunlight. We honor his memory best by pursuing his example now.

ASSISTANCE OF MALNOURISHED PREGNANT MOTHERS AND INFANT CHILDREN

Mr. CASE. Mr. President, today I again urge the Department of Agriculture to carry out its responsibilities and properly fund two programs designed to assist malnourished pregnant mothers and infant children.

In 1969 the Department of Agriculture initiated a modest program to assist malnourished adults and children after numerous citizen groups revealed the extent of hunger and malnourishment in the United States and pointed out the serious gap in assistance to infant children and pregnant women who most require this help.

The Department of Agriculture has never been enthusiastic about carrying on this effort which is, essentially, a distribution program providing surplus commodities to people in need. So the program has never been permitted to grow to meet the real need.

At the present time only 154,000 women and children benefit from these surplus commodities. And the program is being curtailed. For example, last year 16,000 women and children were dropped from the program because administrative funds were cut back. Moreover, unsuitable commodities such as fruit packed in sugar sirup have been used to replace much needed powdered milk.

Administrative costs have always been the responsibility of local groups with occasional emergency monetary assistance from the Office of Economic Opportunity. But Office of Economic Opportunity money is no longer available and the Department of Agriculture has not requested appropriations from Congress to pay local administrative costs.

So the prospect is that a small but tremendously valuable program may soon go under.

Last year Congress recognized that something had to be done to help infant children who were undernourished. Along with Senator HUBERT HUMPHREY, I sponsored a measure to create a pilot program to guide Congress in planning a national maternal and infant feeding program. The pilot program, signed into law by the President last September, was designed as a 2-year program at a cost of $20 million per year. It is intended as a cooperative program between physicians and people in the community. It was not intended to replace the older feeding program. Indeed, the new program was to test alternative approaches that might serve as a national program. Meanwhile, Congress expected the older program to continue until such a nationwide infant feeding program was available to replace it.

Sadly, the Department of Agriculture has not lived up to the mandate given to it by the Congress. Instead of continuing the older program for mothers and infants, the Department has permitted further erosion of the program—even to the point of failing in some instances—to provide crucial commodities such as powdered milk.

At the same time, for 9 months the Department has failed to spend one penny on the new pilot program. Now the Department reveals, through lower level officials, that it expects to begin the new program in about three months but that it will spend only a portion—20 percent—of the funds appropriated on the program. This is not enough to do a reasonable job—it will probably serve only to shore up such distribution centers as remain.

Hunger is still a serious problem in many urban and rural parts of the United States. There are still millions of people without a proper diet and without access to Federal, State, or local food assistance. In my own State of New Jersey which has a good record in providing food assistance to the needy, there are still 210,000 poor people who get no food assistance whatsoever. And, in our largest city, Newark, and its surrounding county, over 48,000 poor people get no food assistance.

While we may not be able to pinpoint exactly those who are hungry, we do see the results. For example, Newark has one of the highest infant death rates in the United States. And, while malnourishment is sometimes hard to recognize, over 200 children each year enter the Newark public schools malnourished. There are other effects as well. While we lack adequate statistics, we know malnourishment can cause brain damage, mental retardation, and any number of physical disabilities. It can cause learning and behavior problems that last the life of the person.

We can prevent this from taking place if we share a commitment to eradicate hunger and thereby prevent the damage to the person and to our society that hunger brings.

All of us have a responsibility to help. But now it is clear, the success of these efforts lies at the door of the Department of Agriculture.

SENATOR NELSON SPEAKS ON HEALTH PLANNING

Mr. MONDALE. Mr. President, while the quality of health care and medical research in the United States is truly remarkable, this country still faces grave problems in delivering and paying for high-quality care.

Senator GAYLORD NELSON made those comments recently in a speech before the Comprehensive Health Planning Agency of Southeastern Wisconsin where the Wisconsin Senator expressed concern that health planning efforts must be strengthened so that the quality of health care be responsive to increasing demands, and to prepare a strong foundation for a national health insurance system.

Senator NELSON is one of the most knowledgeable men in the Senate on the subject of medicine and health care. His father was a country doctor and his mother a nurse. He is a member of the Senate Health Subcommittee, and for nearly 6 years has conducted extensive hearings into the competitive practices of the prescription drug industry.

Senator NELSON emphasized in his address that, even though we have made great strides in the quality and availability of health care, much remains to be done. Environmental pollution and the pressures of modern society contribute to health problems. And he wisely observes that careful planning is essential in order to provide adequate health care in a sensible and economic fashion, without duplication and waste.

When Senator NELSON speaks on health care and related subjects, his observations deserve the widest possible dissemination. That is why I ask unanimous consent that his speech be printed in the RECORD.

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

ADDRESS BY SENATOR GAYLORD NELSON

The quality of health care and medical research in the United States is at the highest level ever, but at the same time, in a state of "crisis" in many respects. There are a number of prescriptions for curing these ills.

Medical technology and increased numbers of doctors have brought us to a more advanced state of health care than many realize. Nevertheless, problems continue to exist in the wealthiest nation in the world, where many people cannot get health care or cannot pay for it.

Certainly, at this stage in history, adequate health care should be available as a matter of right to everyone, young or old, rich or poor. That issue is hardly debatable any longer. The real issue now is how, or by what method or methods we provide for delivery of high quality medical care to everyone.

There is disagreement within Congress and between Congress and the administration over how this can best be done and over the Federal role in the delivery of health care, the training of health personnel, and support of biomedical research.

It is significant to note that in fiscal 1972, Americans spent $83.4 billion on health care—an average of nearly $400 per person, according to the Social Security Administration.

Health spending now represents 7.6 per cent of the gross national product. But the cost of health care is increasing more than twice as fast as the gross national product.

Health care has become the largest single consumer of manpower in the Nation. The number of professional and paraprofessional people working fulltime in health care occupations is close to 4 million. Over two and one-half million work fulltime in hospitals.

The Nation's health bill has doubled in eight years, and increased sixfold since 1950. Reasons for rising costs are higher prices and higher wages paid to health workers; population increases and greater use of services, along with the introduction of new, costly medical techniques.

It is unrealistic to expect health expenditures to decrease. The question is: What are our priorities, and what have we been getting for these health expenditures?

THE STATE OF THE NATION'S HEALTH

Overall, more Americans today are receiving better care than at any time in history, and care that compares favorably with or exceeds that of any other nation.

One in every 40 members of the consumer population is being served by the medical care system everyday. Some 85,000 people are admitted to hospitals each day: 1.3 million

are in hospitals at any given time; 5 million are in nursing homes; and 3 million are seen each day by a physician or other health care professional.

Few countries can match the ratio of physicians to population that we have in the United States—one doctor for every 675 people, or 166 doctors per 100,000 population. There are some 350,000 doctors in the nation and 748,000 practicing registered nurses. Between 1950 and 1970, the number of M.D.'s in the country increased almost 50 per cent or substantially more than the one-third population increase for the same period.

Thanks to medical science and other factors, the average life expectancy of a newborn baby has reached more than 71 years for the first time in the nation's history. An American born in 1930 lived an average of 60 years. Unprecedented numbers of Americans now are surviving into their 80's and 90's. The White House conference on aging noted in 1971 that the U.S. population 65 years and older increased in a decade from 16.6 million to 20 million persons—about 10 per cent of the nation's total population.

Despite these dramatic facts showing that more Americans survive to live longer than ever before, some unpleasant figures haunt us.

The U.S. ranks 13th in infant mortality in the world, 18th in male life expectancy and 11th in female life expectancy. In addition, statistics show that mortality rates and life expectancy are worse for nonwhite populations of the U.S. than for white.

In evaluating such statistics, however, we must be careful to note several contributing factors. In comparing the U.S. to other nations, we must remember that we are a much larger, more heterogeneous country than others with more favorable such figures. Israel, Czechoslovakia and Scotland have more doctors per population. Sweden, Denmark and the Netherlands, which have fewer doctors per population than the U.S., have much higher life expectancy rates, and lower infant mortality rates.

The United States infant mortality and life expectancy rates, however, are superior to the Soviet Union's, where there are more doctors per population (one for every 460 people).

OTHER FACTORS AFFECTING HEALTH

That brings us to ask, very seriously, to what extent are social, economic, and environmental factors responsible for the most industrialized and developed nation on earth not having the longest life expectancy or lowest infant mortality? To what extent are nonmedical factors contributing to what some may call a health crisis, and augmenting certain failings in the existing health system?

The U.S. Public Health Service, in a study on changing mortality of American males in the 1950's and 1960's emphasizes the rising importance of such causes of death as lung cancer, cirrhosis of the liver, homicide, suicide and automobile accidents. The medical system cannot be blamed for features of modern civilization that have caused much of the health problems.

Author Allan Chase, writing in his book "The Biological Imperatives—Health, Politics and Human Survival", states very rightly:

"From lung cancer and heart disease to traffic deaths and emphysema, many of the major underlying causes of premature death among adults in America are wholly or largely the products of man-made alteration of the total biological environment."

All the doctors in the world cannot keep us from overeating, overdrinking, smoking, taking harmful drugs, killing ourselves on the highways. There are many causes of sickness and death that are beyond the province of the medical men: These include all kinds of pollution, and a variety of stresses and fallouts from the industrial society.

Even if all these health hazards were corrected, people would still get sick. All the preventive health care in the world—better nutrition, dental care, hygenic education, vaccinations—will not prevent the onslaught of diseases, will not prevent the aged from becoming infirm, will not prevent accidental injuries.

To these curative ends, the health system can stand improvements. And that is where planning for delivery of care is so vitally important.

There is no question that there is still a lack of organization in the health system so that duplication, inaccessibility, and just plain lack of facilities or personnel exist in the country.

There is much that can be done, that can be planned into the system.

THE ROLE OF CONGRESS AND THE FEDERAL GOVERNMENT

For this reason, Congress and the administration are seeking ways to better define the federal role in order to improve health care delivery, and to formulate a system whereby all citizens will be able to afford whatever health services they need.

This is a big year for health in Washington. Twelve authorities in the Public Health Service Act expire June 30. They include: health services research and development; health statistics; public health training; migrant health; comprehensive health planning; medical libraries; Hill-Burton hospital construction; allied health training; regional medical programs; family planning and population research; community mental health centers; and developmental disabilities. There is a push for HMO (Health Maintenance Organization) legislation that will provide specifically defined federal support for prepaid group practices. [The Senate May 15th passed an $805 million dollar HMO bill.]

There is increasing public pressure for some kind of system of national health insurance. There are the ever-present needs for considering federal support of medical education, neighborhood health care centers, emergency medical care, vocational rehabilitation, maternal and child health services, among others.

WHAT IS CONGRESS DOING?

Congress is moving to enact a stop-gap measure, a one-year extension of the 12 expiring public health service acts, so that Congress has time to evaluate these programs prior to making a decision on whether they should be continued, changed, or terminated. Unfortunately, time is running out, and a number of programs, including Wisconsin's regional medical program, are being terminated. The stop-gap bill has passed the Senate and is pending in the House.

Congress, like the administration, is anticipating that some form of national health insurance will be enacted in the near future. But to phase out or end programs before that becomes a reality is shortsighted. It would leave a gap in delivery of services and health care personnel, with only promises of replacing them sometime in the vague future. The public and the medical schools have built expectations based on existing programs, and are now suddenly under-cut.

SPECIFIC LEGISLATION

One program the administration has not proposed cutting back is comprehensive health planning. An administration bill has been proposed that would extend the CHP authority for 3 years, but the bill also would eliminate authority under the CHP law for training of planners, and repeal earmarking for mental health services funds under the CHP law.

The administration also would de-categorize and consolidate under one section of law (314(e)) three health programs—migrant health, population research and family planning, and lead-based paint poisoning research and control activities. Congress will examine carefully several other proposals to de-categorize health programs.

Congress is concerned that comprehensive health planning has not had the clout that it needed, such as certificate-of-need authority, to enforce decisions that were made. Nor has *CHP* been adequately funded to make the local and State agencies capable of doing the kind of positive planning necessary to see that services are delivered in the most efficient way possible.

For this reason, Congress last year enacted, as part of the package of social security amendments (known as H.R. 1), a provision that prohibits medicare and medicaid reimbursement of costs related to capital improvements of health facilities unless the local or State comprehensive health planning organizations approve the capital improvements. This is the first time in Federal law that *CHP* agencies have been given such authority.

Twenty-one States have enacted different types of certificate-of-need authority, and I understand that such a law is now pending before the Wisconsin Legislature. All of these laws differ, however.

We know, for example, that Wisconsin is not alone in being over-stocked with hospital and nursing home beds in some areas, while none exist in other areas, and that duplication of facilities and services exist in some areas, while there are no facilities or doctors in others.

The Government Accounting Office (GAO) in a study requested as part of the Comprehensive Health Manpower Training Act of 1971, recently concluded that:

"While some planning agencies have been effective, others have been unsuccessful in preventing construction and expansion of unneeded facilities. The inability (the GAO states) of planning agencies to prevent unnecessary and costly expansion of facilities and services has been often attributed to the agencies or others lacking the authority to enforce planning agency decisions."

This has caused those of us examining the CHP legislation to consider whether some statutory certificate-of-need or enforcement authority should be given planning agencies . . . and to consider whether the existing planning system should be changed.

At the present time, the future form of health planning and Federal planning laws is hard to predict. There is considerable debate both in and out of Congress over various approaches to health planning: whether it should continue to be done with a combination of voluntary and governmental agencies; whether more or less governmental authority is desirable; or whether planning should be on a regional basis.

If local voluntary agencies are to be continued, much depends on building their credibility and insuring their acceptance by communities.

If the authority of planning agencies—local, State or regional—is strengthened by law, a due process appeals mechanism should be established, which provides for orderly appeals of planning decisions, either at State or Federal levels or both, and which protects planners from harassment or other suits. An orderly appeals system is a preferable solution over going to court. Planning laws should be clarified to include such an appeals procedure. The present Federal CHP law does not have an appeals system. Some State certificate-of-need laws do. In the case of the social security amendment, appeals decisions are in the hands of the HEW Secretary.

All of these questions will be thoroughly discussed before a new planning law is enacted by Congress. Your views and experiences as members of active, voluntary "B" agency boards will be valuable to Congress as we begin to formulate a new law.

The Health Subcommittees of both Houses of Congress are evaluating not only CHP legislation, but the 11 other expiring public

health service acts, and numerous other health measures. Separate but entirely new Public Health Service Act proposals are being presented to Congress for consideration. Bills in both the House and Senate would consolidate and revise health laws.

In examining the public health service act for loopholes, duplications, and needs, Congress is concerned that these health service delivery laws be responsive to increasing public demands for health care, and particularly, that the delivery system is prepared for a national health insurance system.

In this regard, Congress seems at present inclined to retain many of the programs the administration would scrap: community mental health centers: federal capitation support for health manpower training and nurse training; research training grants; and some form of Hill-Burton support, although it is foreseeable that the emphasis will be on renovation of existing facilities and on outpatient rather than inpatient facilities, based on current needs.

As for regional medical programs, Congress acknowledges that some programs have produced better than others. The Wisconsin *RMP* certainly is in the top ratings. However, it is conceivable that a change in that law may be required, to better define *RMP*'s role, particularly its relationship to *CHP*, so that efforts of these two programs are not duplicated. It is possible that certain aspects of *RMP* may be retained in law, others dropped, or that continued support of *RMP*-type demonstration projects may be incorporated under a different authority.

All of these laws are designed to improve health care delivery in anticipation of national health insurance. In order to provide adequate health care in a sensible and economic fashion, there has to be careful planning to avoid duplication, waste, and overlap of services.

As for national health insurance, there is a possibility for action in the next few years. Tax reform and trade legislation, however, have priority in the committees of both Houses that deal with health insurance legislation.

A number of major health insurance bills have been introduced this session that propose various health insurance systems, ranging from a Government-administered program, paid for out of payroll taxes and general revenues, to a catastrophic coverage bill. A plan will be introduced shortly that would, in effect, replace medicaid and provide Federal health insurance for the low-income population, much as medicare now covers those over 65.

The questions facing Congress are to what extent health insurance should be administered by the Federal Government or the private sector . . . what coverage should be required . . . whether the cost should be paid out of tax revenues or personal pocketbooks other than taxes . . . and to what extent national health insurance will require change in the system of delivery. It is conceivable that various aspects of several proposals may be combined into an insurance system.

OTHER SOLUTIONS

There are other things that can be done, also, to improve health care: more computerized record-keeping in hospitals . . . satellite clinics staffed by paraprofessionals and connected by telecommunication to doctors in medical centers . . . more efficient emergency care, utilizing existing military and civilian equipment . . . community health clinics stocked with equipment from 1,500 prepackaged health units now stored by the Civil Defense and not used . . . encouragement of ambulatory and home health care, possibly through health insurance coverage of these less-costly types of care . . . A method of controlling malpractice suits and high loss claims so that high premium costs, which are passed onto patients, can be reduced . . . sharing of services among hospitals, wherever possible.

It is clear in any event that health planning, such as you are participating in, must be strengthened, and that effective cooperation between planners, providers and consumers will be a critical factor in the success or failure of any system of delivering medical care.

MAINE TESTIMONY: HEALTH CARE BARRIERS TO OLDER AMERICANS

Mr. MUSKIE. Mr. President, in March, the Subcommittee on Health of the Elderly of the Special Committee on Aging began hearings on "Barriers to Health Care for Older Americans." As chairman of the subcommittee, I was very much impressed by the testimony given on national issues at our first set of hearings, March 6 and 7. We heard excellent arguments, in particular, against the administration proposals to increase the coinsurance and deductibles paid by medicare participants. All in all, the initial testimony provided an excellent foundation for additional hearings to be held in Washington, D.C., and in the field.

To continue the inquiry, the subcommittee heard from witnesses in Livermore Falls, Maine, on April 23. This field hearing was especially valuable, because it provided excellent, firsthand testimony on health care issues at the grassroots level.

First, the hearing gave us facts on the imaginative efforts being made to improve health care for the elderly in west-central Maine through Project Independence. Funded by the Administration on Aging, this project provides services to the elderly on an areawide basis. It offers transportation, outreach services, information and referral, health screening, and home care. In less than a year of operation, the project has provided 57,200 units of service for 8,000 different individuals, or 43 percent of the total population over age 65 in Androscoggin, Franklin, and Oxford Counties.

Mr. Richard Michaud, director of Community Services for the State of Maine, testified that Project Independence has a direct relationship to medical services:

> Project Independence addresses itself to reducing the three most important barriers to health care. They are: lack of information, lack of transportation, and lack of money.
>
> The objective of Project Independence is to increase the accessibility of older persons in the area to health-related services: (1) through linking older persons to available health services, and (2) through establishment and expansion of low-cost alternatives to high cost and often unnecessary services such as hospital and nursing homes.

Project Independence did not spring up overnight. Mr. Daniel V. Lowe, vice president of the project's Executive Council, explained that the groundwork was laid before the White House Conference on Aging of 1971; regional task forces in Maine had been organized before that conference and each had identified major needs. The Task Force that led to Project Independence actually began its work in 1969, and it has done its work well. At the heart of its success is what Mr. Harold Collins, now serving as coordinator for Project Independence, describes as cooperation and coordination. He explained:

> Each senior center throughout this area is linked through representatives of the Tri-County areawide Task Force. . . . In each county we have many senior centers scattered over the area. These do include large towns, small towns, and the cities. . . . To effectively reach all centers and areas, a county organization representing every center is needed. Thus, we formed a Council, a county senior citizen advisory council.

Furthermore, Project Independence does not try to do the job alone. It works closely with the Androscoggin County Home Health Services, the Tri-County Health Planning Agency, health and welfare offices, the Rural Health Associates and other programs directed through Mr. Michaud's office.

We received additional testimony from project representatives including a bus driver, a homemaker, and a physician who has given his active encouragement to the project. I will not give excerpts from their testimony here, but I urge that those elsewhere in the Nation who wish to have a model for similar action in their regions request the transcript of our hearing. I believe that they will find it rich in information and ideas that can and should be applied elsewhere.

The hearing was also valuable because it provided excellent testimony on current health issues of considerable importance to the Committee on Aging, and to the Congress.

Dr. Dean H. Fisher, Commissioner of Health and Welfare for Maine, warned, for example, that the threatened dismantlement of the Hill-Burton program can cause wasteful disruption of plans long in the making. He used the situation in Houlton, Maine, as an example:

> Two, and perhaps three, small hospitals are willing to merge. Community plans are agreed upon and complete. However, they will need $6 million for a new physical plant. Without Hill-Burton funds, or interest subsidy, they now need to borrow about $5 million in the open market. This means some $200,000 per year of interest charges, and another $250,000 per year of debt retirement. The facility might expect to provide some 30,000 patient days of care per year. This means some $15 per patient day for 20 years for interest and debt retirement alone. In the long run Titles XVIII (Medicare) and XIX (Medicaid) will be paying for half of it.

Dr. Richard Chamberlin, member of the Executive Board of the Maine Medical Association, warned against inappropriate use of scarce health care facilities, and he called for effective review of utilization patterns.

A vigorous presentation was also made by representatives of the State Council of Older Persons. Mr. Jack Libby, president, was concerned, in particular, about the costs of prescription drugs. He said:

> This buying medicine or prescription drugs is the roadblock to happiness for too many people. Their income, although adequate to keep them afloat while they are well and able to live without drugs, seems to evaporate so quickly when they start doing business with a pharmacist.

Mr. President, the testimony by Mr. Libby and all the others was especially valuable to a Senator from Maine, but I believe that it has much to offer anyone else concerned about the many health care problems facing older Americans. I