Dear Peterson

THE SECOND REVOLUTION IN HEALTH

REMARKS BY SENATOR WALTER F. MONDALE
BEFORE THE MINNESOTA HOSPITAL ASSOCIATION
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This nation today confronts a gigantic credibility gap in domestic affairs. The Riot Commission Reports, the martyrdom of Dr. King, and the civil disorders of the past weeks all carry the same terrible message: there is a wide and growing gulf between our principles, our potential, and our practice as a nation. This country, dedicated to unity and equality for all today is moving toward separation and inequality in its institutional patterns and its treatment of people. And what is true in housing, in education, in welfare is also true in health.

~~Let me explain what I mean.~~

Present advances and those on the horizon of health research and technological development give this nation a glimpse of what could be a new golden age of better health for mankind. Breakthroughs in prevention and treatment of disease already have rid man of the need to suffer from age-old maladies like measles, polio, and other infectious diseases. And recent events like heart transplants and the DNA-discoveries put within reach an almost infinite improvement and prolongation of life.

But while health research gives us this potential, we have yet to make actual this possibility for millions of people in the United States. It is one thing to have the knowledge, and quite another to exercise individual and institutional wisdom in accordance with democratic principles so that benefits are spread equally to all men.

~~Our performance [illegible] shows us we are not wise enough to be so smart.~~

There is a tremendous gap between research developments, and our delivery of the products of this research to people through the health care delivery system. Operating on the implicit principle that health care is a privilege, not a right, this nation today sees the results of two systems of health care, one for the rich, another

for the poor, separate and unequal.

If the facts and statistics shock us, they should.

-- This nation that spends up to $75,000 for a single transplant operation, can't even provide the $135 per person it would take to get routine ambulatory health care to the more than one-third of its ~~citizens~~ people who are poor;

-- This nation that leads the world in child health research has slipped to 15th in infant mortality in 1965;

-- This nation whose advanced medical techniques save thousands of lives in Vietnam, lets ~~630,000~~ Americans die on its own highways because it does not spread that knowledge through rescue systems in the United States;

-- This nation that clamors for more and more new research techniques sits apparently unmoved as 7,000-15,000 Americans die every year for lack of kidney transplantation and dialysis techniques perfected years ago;

-- This nation whose research centers boast the systems approach to medical care today offers its people, particularly its poor, the most fragmented, least accessible, most ineffective health care delivery system perhaps in the entire western world.

~~Ladies and gentlemen,~~ All of us, Congressmen and constituents alike, must share in the collective guilt for this state of affairs. There was nothing inevitable about this gap between health research and service. Many factors helped create and perpetuate the problems, and American citizens played a role in all of them.

The legacy of history is important for what was past turned out to be prologue.

Health care in the United States traditionally has been based primarily on private enterprise. The delivery system relied primarily on individual practitioners serving patients who could pay themselves for health services. This system served us relatively well during the youthful years of medical science when physicians skills were few, and the facilities and charges minimal. But with the vast array of skills, and the fantastic cost and complexity of services, the "invisible hand" no longer worked to achieve an equitable distribution of health services. ~~Yet the myth of the laissez-faire ideal lingered on.~~

For years our research centers struggled to make do with private funds; and our service centers, like hospitals, survived primarily by piecemeal contributions from churches and charitable institutions.

Gradually the national consensus changed. Public funds began to mingle with private monies to provide medical care. To the limited work of the commissioned Public Health Service, public health department programs were added. Services for veterans and the rest were the result. Little went for health research.

But in the post-World War II years, the consensus shifted again. Public funds began to be pumped at an increasing rate into health research, without a similar infusion into the delivery of health services. We should not be surprised at the result. With multiple grant programs available to the Universities, [illegible] physicians, flocked to the research side of health. The cream of the medical school crop chose research, and whole generations of young men and women chose laboratory and specialty clinics over general medical practice. The family practice of medicine declined, and routine health care, particularly for the poor, became an economic impossibility. Hospitals, including the community hospitals of this state vied for funds to provide specialized care. The poor, driven from the physician's office by its cost, came to rely increasingly on the hospital emergency room or out-patient department for whatever crisis health care they got. And when they had a choice, as private hospitals did, even these community services often were abandoned.

With the advent of the Hill-Burton program, facilities planning became a real possibility. Hospital councils like yours began to develop to deal with the physical health needs of their citizens. Concerned with bricks and mortar you had to be. But who was to pay attention to the total health -- physical and mental -- of the entire community?

The clamor of public demands for immediate spread of sophisticated research through expensive facilities all but drowned out the small, often inarticulate voices of those who lacked even the most basic of health services.

Ladies and gentlemen, we have the potential ability to redress the imbalance between research and service. Most of our problems in the delivery of health services are man-made, and are corrigible to the human will. What is required in an accelerated second revolution in health.

Forward motion in this needed revolution will require action by the Congress. But ours is a pluralistic health system, and so it must remain. The creative leadership characteristic of Minnesota also will be needed to initiate and sustain actions by the public at large, and the private sector of medical care.

Minnesota has been at the forefront of the health research revolution since its very inception. The great hospital centers of the State, the Mayo Clinic, the University of Minnesota, and the rest, have for years trained the physicians, and provided the facilities for the tremendous volume of research to which Minnesota can lay proud claim. Names like Norman Shumway, Christian Barnard, Richard Lillihei, John Najarian, and John Anderson witness the central role of this state.

Minnesota also has had a head start on the delivery of services. As members of this Association know, this state has been among the leaders in the nation in development of better care facilities for its people. _____ of this Association has played an important part in this work.

But our record is not good enough. And the rationalizations of the past can no longer guide us in the present.

-- Too many hospitals here, and across the country, have refused to act on their community responsibilities. They have avoided home care; closed up their ambulatory care facilities; refused to cooperate with other health agencies and institutions to plan for what must be a total health care system;

-- Too many hospitals, here and across the country, have closed their doors to the poor -- black, red, and white -- or made them come in through the back door of the clinic;

-- Too many hospitals, here and across the country, have used the shibboleth of "quality" as an excuse not to hire and train new types of nonprofessional and auxiliary health workers that would make them able to expand their services;

-- Too many hospitals, here and across the country, have refused or almost refused privileges to non-white physicians or those from other countries;

-- Too many hospitals, here and across the country, have refused to hire non-whites, or have kept them in low-skilled, dead-end, low-paying jobs;

-- Too many hospitals, here and across the country, have separated rich from poor, black from white, making one the guinea pig for students, the other the recipient of real physician services;

-- Too many hospitals, here and across the country, have refused to give the consumers of services a real voice in their affairs, turning hospital boards into gilt-edged rubber stamps, rather than broadly representative forums for discussion of the total spectrum of health needs.

I am convinced that Minnesota, with its lead both in research and in service, can and must set the example for the rest of the nation by practicing the principles of unity and equality it preaches. I also am convinced that you in this room have an important role to play.

You know better than I the multiple needs in the delivery of services. More resources are needed in terms of personnel, facilities, and equipment. You know also about the need for making better use of the resources we have through restructuring of jobs, re-ordering

of facilities and equipment, and redistributing the location of health care facilities, putting routine care close to home, and back-up services and specialty care in the hospital centers. You know about the needs for planning, for unifying the system of health care for the community as a whole so that comprehensive, continuous care is available to all at every stage of life from birth to death, at home, on the job, and in the health care center.

Congress has already removed several of the barriers impeding progress in medical care. In the last three years, over thirty pieces of legislation have been enacted in the field of health. To cite a few:

-- The Medicare and Medicaid legislation removed the financial barriers to adequate care for many elderly and some of the medically indigent;

-- The Partnership for Health legislation created the basis for comprehensive health planning on the local and area-wide basis;

-- The manpower training programs of the Labor Department, the Department of Health, Education, and Welfare, and others provided some of the funds necessary for the creation of a pool of trained personnel in the health service field;

-- The Neighborhood Health Center program of the Office of Economic Opportunity and the Model Cities effort of the Department of Housing and Urban Development give us models for the kind of family-focused care based on community involvement which must begin to characterize the entire health care delivery system.

I know there are many problems in the existing legislation.

-- The administrative mechanism of Medicare and Medicaid must be debugged;

-- More flexibility must be written into the Comprehensive Health Planning legislation so that groups like yourselves can play a more meaningful role;

-- Manpower funds must be better coordinated, and cover more categories of personnel if communities are to be enabled to make a health-oriented training mesh of what now is a bureaucratic mess;

-- Rural versions of the OEO and HUD idea must be developed to equal the brilliance of the urban Neighborhood Health Center idea.

And of course, everything needs more adequate funding. For while Federal government investment in health has risen from $6 billion to $14 billion annually in the last three years, it clearly is not enough.

The President's health message sets before this nation some of the health care goals we must achieve in this session of Congress. The first four are these:

(1) Reduction in our unconscionably high rate of infant mortality and our poor record in child health, particularly in the ghettos, through expansion of existing programs in maternal and child health, children and youth programs, Medicaid and OEO efforts.

(2) The training of more doctors, nurses, and allied health workers to help meet the desperate need for health manpower through expansion and addition to present training programs.

(3) Curbing the high cost of medical care, and allocating our health resources more effectively through establishment in HEW of an incentive system to reduce costs and development of new payments systems for the Medicare, Medicaid, and Maternal and Child Health programs.

(4) Reduction in the toll of accidential deaths through development in HEW of a program of effective test rescue systems in local areas.

There are, of course, many other pieces of legislation now before the Congress in the field of health and many more to come.

Let me tell you about one I know perhaps the most about because I myself authored it, along with Fred Harris of Oklahoma, and fourteen other Senators. This bill, S.J.Resolution 145, would seek to create a Commission on Health Science and Society.

This Commission, appointed by the President, and responsible to him and to the Congress, seems to me an essential complement to the action program in health research and health service outlined by the President.

Obviously, we need the double revolution in health research and health services. We wouldn't want to stop either even if we could.

But we must not let the revolution in research continue as a game of Russian roulette. This I would submit is what it amounts to today because of the separation and inequality between our public commitment to research, and our public contemplation and planning for the delivery of its products to people. Research is triggering much more change in health care than the system is prepared to tolerate, and use effectively.

We are luckier so far in health than we were in atomic science. No monster bullet in the shape of behavior control or genetic engineering has yet penetrated our social skulls. We don't yet have the medical equivalent of the mushroom cloud. But this doesn't mean it could not happen, or that there are not grave public policy issues now which we must address. Recent advances raise grave ethical and moral issues: who shall live and who shall die; what what quantity and quality of life is worth preserving; how shall man be altered.

It seems to me that the inter-relationships between health research and the delivery of health service are incredibly complex,

and that today we know almost nothing about them. Public knowledge of the issues in health research and the delivery of services is as shockingly incomplete as was its consciousness of the full meaning of the riots until the Commission on Civil Disorders.

I do not think restriction of research is the answer. I think public inquiry, not government interference is in order. And I am convinced that the Commission is the way to begin the job of public education necessary if we are to face responsibly the decisions we must confront now and in the years to come.

The Commission on Health Science and Society would be composed of the best minds in the country representing many points of view -- health administrators like yourselves; physicians; scientists; theologians; philosophers; and government officials. At the end of a year the Commission would report to the President and the Congress its findings and recommendations about how encourage a more functional relationship between health science and society, one in which the aims and wishes of one would reflect and influence the other.

Hearings have just been completed on this Resolution in Senator Harris' subcommittee on Government Research, and it is my hope and expectation this session will see the passage of this needed legislation.

I have saved the fifth goal of the President's health message for last, because it sums up better than any listing I have seen for some time the challenge I would like to put to you today.

"In our drive toward a healthier America, Federal programs and Federal dollars have an important role to play," said the President. "But they cannot do the job alone. An even larger role belongs to State and local government, and to the private enterprise system of our nation."

The President listed some of the numerous groups that must and

can help make the difference. First on his list were medical and hospital associations, and their related institutions.

The President of this Nation was speaking to those in this room in five of the twelve points of his proposed mobilization for better health in America. To his call I would like to add some questions.

-- The President called for identification and reward for "new approaches by medical societies, group practice organizations and hospitals for delivering better health care at lower cost." How many hospitals in this state encourage and support the hospital-based group practices that are one answer to the fragmentation and inefficiency of solo-practice? Or must Minnesota wait for federal funds that may never be sufficient?

-- He called for establishment of "local systems of new incentives to recruit, train, retrain, license and effectively use nurses and medical corpsmen leaving the Armed Services, and other vital members of the health team." How many of you have placed veteran medical corpmen returning from Vietnam in your out-patient departments, and specialty services? Or must we all wait for Labor Department "New Careers" money that so far stretches only to two Minnesota communities.

-- He called for encouragement of the "opening of health centers to provide complete care in every community." How many of you have begun to work with Health Departments and Medical Societies to provide care, using a combination of public and private funds, or private funds alone? Public Health Service and OEO funds may never be sufficient to go much beyond the pilot effort in Minneapolis, but the rest of Minnesota's 519,000 poor cannot wait.

-- He called for development of "better programs for health services for the one-third of the working poor who suffer from chronic illness." How many of the hospitals, particularly in rural

Minnesota have taken the initiative with insurance firms to get coverage for their patients who may never see the day of the union health plan? Or must our rural poor of working age wait for the millenium when Medicare includes them too? -- And finally, he called for mobilization of "a new spirit of public concern and private action to meet and master our health problems." How many of us in this room know about the real health problems of our areas? Must we wait for the organization of comprehensive health planning councils with federal funds, or can't we begin to act on the principle of consumer-participation -- not only in planning for the future of our facilities and service patterns, but in formulating the policies that guide our hospitals and health facilities as well?

The President's program constitutes a checklist for concerned individuals in this room and outside. Every hospital association in this nation, not just the one in Minnesota, must undergo a fundamental reorientation in thinking if the products of health research are to be equitably distributed among the population as a whole. Every hospital association must move from state-based, bricks-and-mortar facilities orientation to planning for health as part of the total range of social services at the local level. Every hospital association must train itself to work effectively with consumer groups, including the poor it has tended to exclude, both from its planning, and from making policies about its service pattern.

This nation can no longer stand the gap between principles, potential and practice. We have a rendezvous to keep-a redezvous with our social consciences, if the spectacular revolution in health research is to be matched with an equally splendid and equally needed companion revolution in health service.

As President Johnson has said, "Good health services are the right of every citizen, not the privilege of a few." In a Special Message to the Congress, he has stated that we must aspire to "good health for every citizen, up to the limits of this country's capacity to provide it."

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Senate

INTRODUCTION OF JOINT RESOLUTION TO ESTABLISH A COMMISSION ON HEALTH SCIENCE AND SOCIETY

Mr. MONDALE. Mr. President, at this time I would like to introduce Joint Resolution 145, on behalf of myself and Senator FRED HARRIS, of Oklahoma, and Senators BAYH, BYRD, of West Virginia, CLARK, HART, INOUYE, EDWARD KENNEDY, ROBERT KENNEDY, MCGEE, MCGOVERN, NELSON, PROXMIRE, RANDOLPH, WILLIAMS of New Jersey, and YARBOROUGH as cosponsors.

Mr. President, the current advances in health science and technology are bringing men more and more power in matters of life and death.

In California, man has created a kind of life. In South Africa, New York, and California, man has taken another step on the path of prolonging life through the substitution of vital organs. And some scientists are predicting that human intervention in genetic processes will one day make it possible to choose which parent a child will resemble.

Mr. President, these developments might be said to move men closer to God. Heart transplant operations and genetic breakthroughs, have focused worldwide attention on the awesome implications of advances in medical and biological sciences.

These dramatic possibilites, and others perhaps unimagined as yet by most of us, hold great promise for the present and future of mankind. At the same time, they raise profound and complex questions of ethics, law, and public policy—what is life and what is death; who shall live and who shall die; how long shall life be preserved and how shall it be altered; who shall make which decisions; how shall society be prepared?

Questions like these are not new, Mr. President. Nor are present accomplishments isolated advances. Rather, as Barry Commoner has pointed out:

We are today witnessing the inevitable impact of the tidal wave created by scientific revolution more than half a century old. It is simply too late to declare a moratorium on the progress of science . . . The real question is not *whether* we should use our new knowledge, but *how* to use it.

Or to put it another way—are we wise enough to be so smart?

It is imperative that we recognize the scientific significance of these advances. But it is also essential that we begin to cope with their social and ethical implications in as rational and public a fashion as possible. For there are public questions as well as personal ones to be considered.

The need for a Commission on Health Science and Society becomes clear, if one examines some of these questions and their obvious relationships to theology, ethics, law, and public policy.

I. WHAT IS LIFE AND WHAT IS DEATH?

Heart transplant operations cloud the distinction between life and death, based on the heartbeat. The artificial production of a viral core that can replicate itself raises the issue of what besides the ability to reproduce distinguishes life from nonlife.

These definitions and related considerations have implications for theology, ethics, and the law.

The Eichwald report, published by the National Academy of Sciences, asserts:

Society seems to have accepted the notion that the welfare of the living is more important than the sanctity of the dead.

Pope Pius XII has stated:

The removal of viable organs from the dead in the interests of science does not offend the mercy of the dead.

Other theologians, however, are said to think that "death" is not the necessary criterion, but that "inevitability" of death is sufficient justification for removal of organs from the living in order to prolong life for another.

II. WHO SHALL LIVE AND WHO SHALL DIE?

Over 400,000 persons died last year from coronary heart disease. Some could have been saved at least for a time by heart transplant operations. An estimated 7,700 persons died last year for lack of kidney transplant operations.

Theological and moral concerns are manifest in the decisionmaking process. The disparity between demand for transplants and supply of organs, personnel and facilities makes decisions about who shall give and who shall receive the most difficult kind of ethical and moral issue.

There is a new three-in-one "God" substitute at work in the decisionmaking processes with respect to transplant operations: the patient, the family, or next of kin, and the physician. In addition, one also must consider the role of the law and the society at large.

A. THE PHYSICIAN

Perhaps the heaviest weight of responsibility rests on the shoulders of the physician.

First, he must decide whether to attempt the operation at all. When is a heart transplant a justifiable risk?

During recent weeks the shades of opinion in the profession have ranged from caution to enthusiasm for the experiments conducted so far. But even when and if transplants become more common, the decisions will still be difficult.

The Hippocratic oath instructs the physician to do no harm. But developing medical techniques for prolonging life raises a complex question—no harm to the potential donor or no harm to the life of the potential recipient?

By the same token, religious principles may not provide complete guidance. "Thou shalt not kill" may be an ambiguous instruction.

William A. Nolen, M.D., of the Litchfield Clinic, Litchfield, Minn., wrote to me of some of the ethical problems he and other members of his profession face every day:

I have been a participant in the weekly surgical conferences at Hennepin General Hospital in Minneapolis for the last six years. Time and time again problems arise related to tissue transplantation. Under what circumstances can we in good conscience declare an individual dead? Do we use an electroencephalogram, and electrocardiogram, or simple clinical signs to determine the absence of life? How should the relatives of the potential donor be approached? When can the donor be put in a heart-lung by-pass? I could go on indefinitely. The point is that confusion reigns even in a center where kidney transplants are frequent. Policies are established but on uncertain grounds.

Rabbi Bernard S. Raskas of St. Paul, Minn., points out another dimension of the ethical dilemmas. He points out that the one surviving human heart transplant patient is alive because he has the heart of a mulatto beating in his breast.

The country of South Africa, he reminds us, practices strict segregation of the races. While the national policy of the United States demands racial equality, de facto, if not de jure segregation makes relevant the questions Rabbi Raskas raises:

Is it all right to have the heart of a Negro inside you, beating for you, giving you life, but not all right to have him live next door? . . . Is it perfectly permissible to use the kidneys of Negroes for one's welfare, but then to deny them the rights of employment, the opportunity to better their minds through education, and to reject their right for the pursuit of happiness?

I can only hope with Rabbi Raskas:

Science may have brought to the fore a divine subtlety . . . that it is for us in the wake of transplanting a new heart to also acquire a new spirit of authentic religious equality in dealing with all of God's children.

B. PATIENT AND FAMILY

The basic principle guiding choice of donors and recipients is the consent of both parties.

Basic to the ethics and law in this area is the notion that consent be informed and that it be voluntary.

Discussions have continued for years about what constitutes informed and voluntary consent. The same kinds of questions are raised again by the transplant operations, but in a more dramatic context.

How well informed and how voluntary the consent is for patient and family depends not only on what they are told, but on how they are told. Which is more important—the contribution to medical science or letting a relative die naturally? Amid personal grief and stress, the family or patient may make judgments they later regret.

C. SOCIETY AT LARGE

How much is a man's life worth?

To ask questions about finance is to see the relationship between social decisions and life and death.

An estimated cost for transplanting a kidney is $5,000, plus followup care. The cost for hearts may be much more, yet $130 per year could give adequate, routine health care to poor Americans.

A public commitment of $1 billion could buy enough kidney and community dialysis centers to serve the 25,000 or more who will need them in the next decade. Or it could buy comprehensive ambulatory health care for more than 1,250,000 poor people.

This is a question of distributive justice. Obviously we need both kinds of health care services. But with limited resources and disagreements about the extent and direction of public commitments, the priorities we establish affect both the quantity of life—who lives and dies—and the quality—just how healthy people really can be.

And not only the priorities, but also the financing mechanisms are important. Shall organs be bought and sold life blood? Or shall they be procured through some public mechanism? Who shall pay for the operations?

To ask this question is to raise the issue brought up by Dr. Joseph T. English, Acting Director of Health Affairs for the Office of Economic Opportunity. The question is whether the poor shall have access:

What is particularly unjust, it seems to me, is that so many of our research discoveries would not have been possible were it not for the fact that the poor have allowed us to perform our research experiments upon them. Doesn't it make sense that they then should be among the first to reap the benefits of this resarch—and that we have a moral obligation to see that this happens?

Should the "ability to pay" principal guide selection of recipients of heart and other organ transplants—selection of those who may have life?

And Dr. P. J. Peete, professor of surgery, Duke Medical Center, inquires:

Where should the money be spent? . . . Should we spend as much time and money for the defective, the incurable, the unproductive as for the rehabilitiated? Should we spend money for the mentally retarded when

it is needed for the highly intelligent? Do the ... have more right to life than the unfit?

...is, in turn, raises the question of how individual decisions are to be made, and by whom.

D. THE LAW

Legal issues emerge when one examines State statutes dealing with such subjects as donation of human tissues, property rights in dead bodies, and mutilation of corpses.

A distinction must be made between donation between the living, as is the case for kidney transplants, and donation from the dead to the living, as is the instance in heart transplants. The first situation presents fewer legal difficulties than the second.

If one relative donates a kidney to another living relative, the primary legal principal is "informed" and "voluntary" consent. While factors such as inadequate explanation and social pressure may be difficult to judge, they still are not as complex as are the issues raised by donation from dead to the living.

To begin with, what is "death"? As pointed out before, techniques which preserve the function of the heart when other body processes have ceased may make the present medical definition of death obsolete. Law does not provide guidance to the physician faced with the decision as to how long to maintain life ...cially through use of a machine. ...y writers have called for a redefinition of "death," perhaps based on cessation of brain function.

...irty-eight States, including Minnesota, have tissue-donation statutes, giving individuals the right to donate tissues and organs for specific purposes. Five additional States have laws limited to donation of eyes.

Some of these laws require that organs may be donated only through wills, omitting the possibility of donation through other written instruments, cards, or perhaps oral deathbed donations. Some limit the places to which organs may be donated. The Minnesota law, one of the earliest, limits donation to wills, and fails to mention donation to tissue banks, for example.

Then there is the issue of immunity for physicians. Even if a person has donated organ or tissue through a will, there is a legal question as to whether the physician could be found guilty of mutilating the corpse if the relatives wanted the body whole for burial. Statutory statement of immunity might remedy this possible conflict, but most States, including Minnesota, do not have such a pro...n.

...f an individual has not donated before death, other problems arise. Having property rights in the dead body, relatives might be asked to consent to removal of tissue or organs.

Often this right is not stated specifically in the statutes. It is not, for example, in Minnesota. But even if this right is stated, relatives may be under such strain at the time of death that they may be unwilling or emotionally ...le to make such a decision.

...n addition, time may prove a barrier. Present technology requires that many kinds of organs be removed almost immediately, within 30 to 60 minutes in some cases, for example. In this instance, unless the relative is present at bedside, consent may not be obtained in time to make the organ available for use in transplant operations.

Finally, there is the question of the role of the medical examiner. With the present gap between supply of organs and demand for operations, some have suggested enlarging the authority of the medical examiner to include the right to donate tissue or organs for medical research or transplantation as he is performing autopsies. This would require a ch...ge in laws which presently limit the a...ority of the medical examiner to determining cause of death in such cases as homicide, suicide, or in cases where an accident victim dies unattended by a physician.

The proposed Uniform Gift to Tissues Act, which recently received preliminary approval from the National Conference of Commissioners on Uniform State Law deals with many of these issues. If adopted, it would resolve many co...icts.

However, even it does not resolve all questions. Some lawyers suggest that this law or another might well deal with the issue of payment mechanisms, and that this group or others might address the question of how international tissue donation is to be handled.

The dramatic events of recent months have focused attention on the implications of the transplant operations. But the same kinds of questions arise when considering the implications of genetic research, including the DNA—deoxyribonucleic acid—discoveries.

On a far distant horizon according to some scientists is the day when scientists will be able not only to predict whether a gene is likely to be present in human beings, but also to intervene directly in genetic processes. Some geneticists claim that work with frogs indicates that there is no reason why a man or woman could not turn out an exact genetic replica of himself instead of going through the process of fertilizing an egg and taking the chance on the outcome of the mating procedures.

Dr. Joshua Lederberg points out that through the technique of nuclear transplanation, children someday could be propagated who resemble one parent rather than a combination of the characteristics of the two. And it is said that the future implications of Dr. Kornberg's artificial production of a viral core may someday lead to vast improvements in the treatment of old-age diseases and malfunctions, including cancer and mental retardation.

The application of new knowledge of genetic chemistry to diagnosis of disease raises some questions. Who shall have access to these specialized diagnostic procedures? Those within reach of the highly sophisticated research centers? How quickly is this knowledge to be spread to the rest of the population?

Genetic intervention, also raises moral and ethical issues of the most profound magnitude.

Geneticists, such as Dr. Lederberg, stress that they are not going to change the bodies of any existing people. But if this is a possibility for the future, we should be thankful that we have many years to think and plan. I am happy that I do not have to think about deciding which kinds of people would represent "perfecting the race" through genetic chemistry and which would not. It is somewhat comforting to think that perhaps the people who will have to make decisions like that would not have the clear memory of Nazi Germany on their minds, as I do.

While we continue to discuss the implications of sterilization of ghetto women, of LSD, of marihuana, and of abortions for thalidomide babies, we must begin to address the questions of mass eugenics that genetic chemistry raises for us now and will raise in the future. For example, should we spend the $10 million Dr. Lederberg says it would take to translate genetic research into treatment as fast as science could proceed, or shall we spend it on nuclear weapons which have their own potentialities for genetic alteration?

III. HOW SHALL PUBLIC EDUCATION TAKE PLACE?

Several writers, including Dr. Irvine H. Page, have asked important questions about how public information should be handled on these scientific breakthroughs.

As Dr. Page puts it:

> The chief drawback to the newer procedure is that many wholly unsuccessful experiments are presented first as "miracles," a few days later as "maybe," and the following week, "the patient died but the experiment was a success."

How does this disillusionment affect the confidence of the public in the medical profession? Dr. Page maintains:

> Too early reporting leads to unhealthy competition among physicians and investigators, with too much emphasis on being "first."

The problem is how to put things in public perspective. The Washington Post carried an article recently about speech given by Dr. Donald S. Frederickson, Director of the National Heart Institute, in which he pointed out how limited is the current value of heart transplants for treatment of heart disorders. But this article was on a back page, while the transplants themselves made daily front-page headlines.

How many people now expect the heart transplants are "the answer"? How many Americans will put tremendous and uncalled-for pressure on physicians and hospital administrators because of unrealistic expectations?

Education of the public including patients, physicians, legislators, and administrators, is an absolute necessity if they are to appreciate the true meaning of scientfic discoveries, and to make the best possible choices.

As a famous surgeon and researcher, Dr. Michael DeBakey has pointed out:

> The moral, ethical, legal, and psychological implications of human cardiac transplantation will undoubtedly be much more far reaching than anticipated from present brief experience. The issues must be thoroughly analyzed, human values reconsidered, and satisfactory answers sought in the light of reason rather than in the heat of emotions. Cliches, irrelevancies, and capricious injunctions must not be allowed to thwart sane judgment.

Numerous groups and individuals and organizations are now at work on these problems. The Gottschalk report on chronic kidney disease was prepared for the use of the Bureau of the Budget. The National Institutes of Health has prepared guidelines for clinical investigators. The American Medical Association Journal has published numerous articles concerning medicine and society. In my own State, the Mayo Clinic has a committee considering some of the implications, and there are many, many more.

Taken together, these efforts represent a significant beginning. But something more is needed. The right information is not getting into the proper channels. Many issues remain undiscussed. And many American citizens, including Congress and the President, have yet to become involved and informed.

And I am not alone in this conviction.

I have written to more than 200 persons, including physicians, those engaged in public policy, and deans of schools of medicine, law, and theology and individuals all over the United States; I have discussed these matters abroad. In my letter, I asked whether there were social and ethical issues that deserved discussion. And I also asked what they thought of an idea I had to move this discussion forward—the creation of a Presidential Commission to consider these issues.

The response has been overwhelming and positive. I have used excerpts from some of these letters in the discussion so far. I intend to place all of them in the RECORD at a later date, along with an analysis.

Some receive any consideration of the social implications of medical research as an attempt to interfere with the magnificent progress in this field. I am thrilled by what modern medicine is producing and I recognize that medical research must be encouraged and protected if we are to continue to enjoy the fruits of this progress. I have joined the battle on several previous occasions to protect modern medical research and I will continue to do so in the future.

The purpose underlying the Commission's functions is not to interfere with medical research. Indeed it is to encourage it, but also to be sure that the moral and social implications of the products of such research are fully and responsibly considered and dealt with.

I agree with Dean Harold F. McNiece, of the School of Law, St. John's University, Brooklyn, N.Y.:

> We must develop ways and means of keeping the social and ethical sciences abreast . . . of the biological and chemical sciences . . . In brief, we must become more concerned with the why of scientific advance . . .

This resolution sets up a framework for discussion.

It provides for the establishment of a Commission to be composed of 15 members, appointed by the President from among representatives of medicine, law, physical and social science, theology, philosophy, ethics, health administration, and government. We would expect the best minds in the country to deal with the important issues, representing not only the academic community, but working scientists and laymen as well.

The Commission would undertake a comprehensive investigation and study of the legal, social, and ethical implica-

tions of health science research and development, including analysis and evaluation of the public and private national effort in this field, ascertaining public attitudes, and sifting out the implications for public policy implicit in these developments.

At the end of 1 year, the Commission would send to the President and the Congress a report, containing a statement of the findings of the Commission, together with recommendations for legislation and administrative action it deems advisable.

We would expect the Commission to make the widest possible use of materials already developed by governmental agencies, and private groups and individuals.

The Commission could establish contractual relationships with individuals and organizations, both public and private, to gather additional information they would need.

Since public involvement and education is of the essence, the Commission would be expected to go to the people through regional or local discussions at widely scattered points of the country.

The emphasis of the Commission would be on public policy. It would concern itself with setting goalls, suggesting programs, recommending priorities, suggesting legislation, and formulating models for the evaluation of our national health science effort within the context of the needs of society as a whole. The Commission would recommend actions to promote a closer relationship between health science and society, in order that the goals and actions of the one reflect and influence the aims and conduct of the other.

Of course, some of the questions I raised at the outset can never have final answers. Some are purely philosophical, others have clear relationships to public policy. Some questions are more urgent than others. Some are already being adequately addressed by other groups and individuals.

While the potential scope of the Commission is enormous, its initial focus would need to be narrow, if the findings and recommendations were to be useful.

The process of hearings will serve to guide the Commission in setting priorities, and I look forward eagerly to this process. I believe we will be deeply grateful tomorrow that we have raised these questions today.

I agree with the admonition of Rabbi Raskas:

> Don't rush to answer these questions so fast—

He says—

> for they imply basic decisions to be made about the human race. They raise the ultimate questions of existence.

Like the rabbi, "rather than finding these dilemmas disturbing, I welcome them with my whole heart."

For, like the rabbi, I see hope in the work a commission could do not only implications for health research, but for society as well. Perhaps it is not too far-fetched to dream as does Rabbi Raskas:

> Perhaps if mankind now sets its best brains to thinking about these things, then may it not be just possible that as a by-product we might find the solution to wars, poverty and prejudice. If we focus our entire thoughts on the highest reaches of man, may we not find that we all must cooperate so completely for man's welfare than the negating and destructive impulses in us will be effectively controlled and directed. We can do this if we set our hearts to the task . . .

The VICE PRESIDENT. The joint resolution will be received and appropriately referred.

The joint resolution (S.J. Res. 145) to provide for a study and evaluation of scientific research in medicine in the United States, introduced by Mr. MONDALE (for himself and other Senators), was received, read twice by its title, and referred to the Committee on Government Operations.

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SENATE

S. 3507—INTRODUCTION OF BILL ENTITLED "DOMESTIC FOOD ASSISTANCE ACT OF 1968"

Mr. MONDALE. Mr. President, I today introduce, for appropriate reference, the Domestic Food Assistance Act of 1968. This measure would enable us to launch a new attack on malnutrition, hunger, and starvation in this country, meeting one of the needs the Poor People's Campaign today dramatizes.

Mr. President, what welfare mothers, rural farmers, Senate subcommittee hearings, and the report by the Citizens' Board of Inquiry all have told us can no longer be ignored: Hunger stalks this country. Malnutrition shames this Nation.

Mr. President, many are the paradoxes in this country. But to me none is more appalling, or less forgivable, than the paradox of hungry poor in this land of plenty.

This Nation of voluntary dieters has thousands condemned to forced fasting every day;

This Nation of food fads has thousands sick for lack of protein and vitamins they cannot afford;

This Nation that spends billions to keep food off the market has perhaps 10 million people whom the choice is beans and biscuits, or no food at all.

And part of the paradox is that we do not even know the true dimensions of the problem. For this Nation that knows much about the nutritional status of the underdeveloped countries has never done a complete study of itself.

Nevertheless, the information now available is more than sufficient to show us the nature, if not the scope of the hunger problem in this country.

Like poverty itself, hunger is a pervasive phenomenon. The look of hunger can be seen; the cry of hunger can be heard in every State in the United States. In the rural South, in the Appalachian North, on Indian reservations, in migrant camps, in urban ghettos live men, women, and children for whom each day represents a new horror, and to whom the malnutrition, disease, and death associated with Asia and Africa are a daily threat in America.

> The baby is suffering from chronic malnutrition compounded by acute dehydration—

Said Dr. Christian M. Hansen, Jr., U.S.P.H.S. doctor servicing at the OEO-funded Tufts Delta Health Center in Mound Bayou, Miss., of a baby he examined. What is more, this month-old child was but one of hundreds of Negro children found already by the health center grotesque in shape, permanently stunted, and damaged in growth, due to lack of adequate food. This child was receiving only one-fifth the milk he should have had. And according to the pastor of the Catholic church of the area:

> There is widespread malnutrition, especially among the children.

The findings at the Tufts center in the last few months simply confirm and reinforce the findings reported by the board of physicians that visited Mississippi and reported to the Senate Subcommittee on Employment, Manpower, and Poverty last summer. The findings are always the same:

Infant mortality rates much higher for Negro children than for white. For Negroes in the northern half of Bolivar County, the rate is three times that of whites. The cause: acute, persistent malnutrition.

Severe anemias. Thirty cases of iron deficiency anemia had already been found by March, just the beginning of the numbers of children suffering from a condition that leads to chronic fatigue and possibly brain damage.

Widespread malnutrition, especially among the children, with attendant long-term and immediate damage to the brain, to muscles, bones, skin, and to general growth and development.

Prevalence of bacteria and parasitic disease: 1,800 of 6,000 Headstart children in one survey were carrying worms in their intestinal tracts.

And this is but a sampling of the population, and a small number of the problems.

The Citizens' Board of Inquiry Into Hunger and Malnutrition in the United States heard the litany of "Hunger, U.S.A.," the litany of physical, social, and psychological damage caused millions in the United States by lack of food, or inadequate nutrition. They heard of anemic children in Massachusetts, in South Carolina, in Kentucky, in Alabama; of anemic and protein and vitamin-deficient pregnant women in Texas, Kentucky, Louisiana, Alabama, and Tennessee; of retarded growth—low heights and weights—in urban and rural areas; of the most severe protein deficiency diseases on Indian reservations in Arizona and South Carolina, and among migrant children in Florida; of parasitic diseases associated with malnutrition in South Carolina, Florida, Mississippi, Alabama, and on Indian reservations; of nutritional problems among the aged in New York State; of pervasive and persistent malnutrition among migratory farmworkers, Indians, and the urban poor of Boston, Baltimore, Cleveland, and New York City.

The study of the committee exhausted the scant literature of the field. It confirmed the fears and updated the information of those who read the results of the closest approximation to a national study of nutritional status listed by the National Library of Medicine, "The Cooperative Nutritional Status Studies," conducted in the early 1950's by USDA and PHS in four regions of the United States. Even in the period from 1947 to 1952, the western region sample of 69 children, 1,134 adolescents, 41 adults, and 664 older adults showed significant percentages having less than two-thirds the recommended National Research Council dietary standards. Even averaging rich and poor, one-third and more of the teenaged boys and girls were low in calcium, thiamine, and ascorbic acid. And when one group of the poor, Spanish-American boys of New Mexico, were studied, the list expanded to include deficiency in calories and vitamin A as well. Again, even averaging in rich and poor, as the study did, 9 to 17 percent of adults, and 14 to 25 percent of children, consumed less than two-thirds the calories recommended, and after age 50 the percentage of men, more than 20 percent underweight, shot up appreciably.

And these findings were corroborated by the studies in other regions. In the northeast region, a study of 854 males and 950 females in New York, Maine, Rhode Island, West Virginia, New Jersey, and Massachusetts found diets low in vitamin C, calcium, vitamin A, and riboflavin. In the north central region, 1,188 schoolchildren were studied. One-half to two-third were eating poor breakfasts, and many got insufficient milk, meat, and eggs. Again, these were overall averages which probably masked much greater problems in the poor segments of the populations of States studied.

We must wait for more current data for the studies to be released this summer by the Public Health Service, and the USDA.

Hunger means different things to different people. To the desperate mother, it is children who "go to bed hungry and get up hungry and do not ever know nothing else in between."

To the horrified physician, it is "evidence of vitamin and mineral deficiencies; unattended bone diseases, secondary to poor food intake, prevalence of bacteria and parasitic disease; and chronic anemias."

To the concerned psychiatrist, it is the urban and rural problem of "the sick, chronically malnourished child:" who "literally grows up to be tired, fearful, anxious, and suspicious," and who takes this with him as he moves from rural into urban poverty.

To every citizen, it is the national disgrace of people living out the "no win" cycle of poverty, hunger, illness, and dependency; the cycle of people sick because they are hungry, skipping medicine to buy food; the specter of millions of Americans too sick and hungry to get the education and the jobs they need to trade dependency for dignity.

Mr. President, as the report by the citizens board of inquiry points out:

> *Hunger kills:* Malnutrition causes lowering of resistance to infection and consequently is a prime cause of infant mortality;
>
> *Hunger maims:* There is increasing evidence that lack of protein in the diet of youngsters can cause severe and irreversible brain damage; . . . and that it can cause disabilities resulting from inadequate growth;
>
> *Hunger sickens:* . . . Diseases such as blindness, rickets, scurvy, and pellagra . . . result from deficiencies of a particular nutrient;
>
> *Hunger affects us all:* The cost of . . . chronic hunger and undernutrition takes many forms; educational, psychological, and social . . . hunger contributes directly to the schisms which threaten our society today.

Mr. President, hunger is a national disgrace. But it is also a curable condition. For among all the complex causes of poverty, hunger is among the easiest to correct.

Just as the citizens' commission helped us see the hunger problem, so too they help us perceive its solution.

The hunger problem is not new to this Nation. For years, Federal food and welfare programs have worked to provide needed sustenance to thousands of needy Americans. But while our past record must be acknowledged, present problems must also be addressed. While the food stamp and commodity distribution programs have helped many, they have failed to do the total job.

In 1967, food programs reached only about 18 percent of the poor. As the citizens' inquiry points out:

> We cannot assume that any of the remaining poor . . . are getting enough food.

The reasons are many;

Food stamps cost too much.

Food distributed through the commodity distribution program is insufficient, and too small a variety of foods is available;

There are not enough consumer services associated with the programs; women who need to know most about food purchase and preparation often know the least; and

There is inadequate communication between those who are recipients of food and those who administer the programs, and the system lacks either consultation

or appeals mechanisms.

Mr. President, the bill I introduce today would remedy these defects. It would remove this blight from our countryside. While this legislation preserves and continues the best feature of the Food Stamp Act of 1964, it is intended to be, and is, a complete legislative overhaul of the Food Stamp Act and other domestic feeding legislation. Its purpose is to assure that no person in this land of riches and plenty need starve or suffer malnutrition because of insufficient income.

Its main provisions are—

Free food stamps to those under the poverty level or whose income prevents them from attaining a fully adequate and nutritious diet;

Establishment of a task force on hunger, composed of commercial enterprises in the food and grocery business to bring the power and imagination of the private sector to bear on the hunger problem, following the pattern of the urban coalition;

Provision for new food stamp programs and direct food distribution programs to exist side by side;

Provision for nonprofit and charitable agencies, any capable agency of Federal, State, or local government, in addition to commercial enterprises, to run programs to feed eligible households;

Requirement that nutrition counseling and home economic services be provided food recipients;

Eligibility upon applicant affidavit, with no onerous redtape;

Changes in emphasis of standards from normal food expenditures to enough food for an adequate and nutritious diet;

Requirement and authorization for distribution by Federal Government of all commodities, whether or not in surplus, to supplement the food stamp program;

Involvement and self-help by the poor, through formation of cooperatives of low-income consumers, local advisory committees, and a National Food Assistance Commission.

While this bill no doubt will be referred to the Senate Agriculture Committee, I intend to work closely with other members of the Senate to insure that this bill or some closely parallel version receives active consideration in hearings beginning May 23 in the Senate Labor and Public Welfare Committee. Senator McGOVERN and I are sponsors with many other colleagues of a resolution to establish a select committee to explore thoroughly our reaction to this most grave problem. Whatever course of action is taken by the Senate and whatever bills are considered, I intend to urge the strongest and most comprehensive approach possible. It is much too serious and much too urgent a problem to be treated otherwise.

This bill does not establish a monetary standard for the amount of food stamps, since this will necessarily vary according to circumstances, but relies on the standards of a "fully adequate and nutritious diet." While this is true, however, it is difficult to see how it could go below $90 a month for a family of four or the equivalent, which the USDA determines is a minimum needed to assure a nutritious diet.

I ask unanimous consent that a summary entitled "Hunger, U.S.A.," be printed in the RECORD.

The PRESIDING OFFICER. The bill will be received and appropriately referred; and, without objection, the summary will be printed in the RECORD.

The bill (S. 3507) to repeal the Food Stamp Act of 1964 and enact in lieu thereof the Domestic Food Assistance Act of 1968, introduced by Mr. MONDALE (for himself and other Senators), was received, read twice by its title, and referred to the Committee on Agriculture and Forestry.

The summary, presented by Mr. MONDALE, is as follows:

HUNGER, U.S.A.—A SUMMARY

INTRODUCTION

In issuing this report, we find ourselves somewhat startled by our own findings, for we too had been lulled into the comforting belief that at least the extremes of privation had been eliminated in the process of becoming the world's wealthiest nation. Even the most concerned, aware, and informed of us were not prepared to take issue with the presumption stated by Michael Harrington on the opening page of his classic, *The Other America:* "to be sure, the other America is not impoverished in the same sense as those poor nations where millions cling to hunger as a defense against starvation. This country has escaped such extremes." But starting from this premise, we found ourselves compelled to conclude that America has not escaped such extremes. For it became increasingly difficult, and eventualy impossible, to reconcile our preconceptions with statements we heard everywhere we went:

That substantial numbers of new-born, who survive the hazards of birth and live through the first month, die between the second month and their second birthday from causes which can be traced directly and primarily to malnutrition.

That protein deprivation between the ages of six months and a year and one-half causes permanent and irreversible brain damage to some young infants.

That nutritional anemia, stemming primarily from protein deficiency and iron deficiency, was commonly found in percentages ranging from 30 to 70 percent among children from poverty backgrounds.

That teachers report children who come to school without br fast, who are too hungry to learn, and in such pain that they must be taken home or sent to the school nurse.

That mother after mother in region after region reported that the cupboard was bare, sometimes at the beginning and throughout the month, sometimes only the last week of the month.

That doctors personally testified to seeing case after case of premature death, infant deaths, and vulnerability to secondary infection, all of which were attributable to or indicative of malnutrition.

That in some communities people band together to share the little food they have, living from hand to mouth.

That aged living alone, subsist on liquid foods that provide inadequate sustenance.

We also found ourselves surrounded by myths which were all too easy to believe because they are so comforting. We number among these:

Myth: The really poor and needy have access to adequate surplus commodities and food stamps if they are in danger of starving.

Fact: Only 5.4 million of the more than 29 million poor participate in these two government food programs, and the majority of those participating are not the poorest of the poor.

Myth: Progress is being made as a result of massive federal efforts in which multimillion dollar food programs take care of more people now than ever before.

Fact: Participation in government food programs has dropped 1.4 million in the last six years. Malnutrition among the poor has risen sharply over the past decade.

Myth: Hunger and starvation must be restricted to terrible places of need, such as Mississippi, which will not institute programs to take adequate care of its people.

Fact: Mississippi makes more extensive use of the two federal food programs than any state in the United States.

In addition to the hearings, the site visits, the personal interviews, the anecdotal stories, we learned from government officials, statistics, studies, and reports, that where, by accident or otherwise, someone looked for malnutrition, he found it—to an extent and degree of severity previously unsuspected.

To the best of our knowledge, we have collected the studies and information compiled by all who have gone before us and have supplemented it with the best evidence that our own direct efforts could uncover. At best, we can make an educated guess as to the order of magnitude of the problem. But the chief contribution we can make does not rest with engaging in a numbers game.

It lies elsewhere—with the reversal of presumption. Prior to our efforts, the presumption was against hunger, against malnutrition; now the presumption has shifted. The burden of proof has shifted. It rests with those who would deny the following words of one of our members, "there is sufficient evidence to indict" on the following charges:

1. Hunger and malnutrition exist in this country, affecting millions of our fellow Americans and increasing in severity and extent from year to year.

2. Hunger and malnutrition take their toll in this country in the form of infant deaths, organic brain damage, retarded growth and learning rates, increased vulnerability to disease, withdrawal, apathy, alienation, frustration and violence.

3. There is a shocking absence of knowledge in this country about the extent and severity of malnutrition—a lack of information and action which stands in marked contrast to our recorded knowledge in other countries.

4. Federal efforts aimed at securing adequate nutrition for the needy have failed to reach a significant portion of the poor and to help those it did reach in any substantial and satisfactory degree.

5. The failure of federal efforts to feed the poor cannot be divorced from our nation's agricultural policy, the congressional committees that dictate that policy and the Department of Agriculture that implements it; for hunger and malnutrition in a country of abundance must be seen as consequences of a political and economic system that spends billions to remove food from the market, to limit productions, to retire land from production, to guarantee and sustain profits for the producer.

Perhaps more surprising and shocking is the extent to which it now rests within our power substantially to alleviate hunger and malnutrition. While new programs are needed, and new legislation is desired and urged, there are now reserves of power, of money, of discretionary authority and of technical know-how which could make substantial inroads on the worst of the conditions we have uncovered—and this could be commenced not next year or next month—but today.

CHAPTER I. THE MISSISSIPPI STORY: A CASE HISTORY IN BUREAUCRATIC NON-RESPONSE

This chapter sets forth the events which triggered national awareness of the existence of hunger and malnutrition in Mississippi, the Congressional and administrative concern generated by these disclosures. It documents the ineffectiveness of the so-called massive federal efforts substantially to alleviate the problem to date.

CHAPTER II. DOCUMENTING THE EXTENT OF HUNGER AND MALNUTRITION IN THE UNITED STATES

Scope of the problem

The Board found concrete evidence of chronic hunger and malnutrition in every part of the United States, as a result either of field trips or hearings or upon a review of all available studies evaluating the nutritional status of the poor.

These conditions are not confined to Mississippi. In America, the number of victims of chronic hunger and malnutrition appears to reach well into the millions—and the situation is worsening.

Those conditions, directly documented or corroborated by the Board include:

A high incidence of anemia among poor infants and children—urban and rural—white and non-white. Among the young, anemia can have serious and lasting medical and emotional effects.

Evidence of retarded growth (abnormally low in heights and weights) attributable to malnutrition in both urban and rural poverty areas.

Conditions of severe protein deficiency, which in early childhood, may cause permament brain damage.

A prevalence of nutritional deficiencies and anemia among pregnant women in poverty.

A high incidence of parasitic diseases associated with malnutrition on field visits to South Carolina, Florida, Mississippi, Alabama and Indian reservations.

Order of magnitude and probable pattern of distribution

The Board recognizes that no definitive estimate can now be made regarding the number of people suffering from hunger and malnutrition in the United States. Nonetheless, the Board presents evidence which supports its tentative estimate:

"It is possible to assert, with a high degree of probability that we face a problem which, conservatively estimated, affects 10 million Americans and in all likelihood a substantially higher number."

Moreover, it is possible to identify those areas where the incidence of hunger and malnutrition is likely to be extremely high. Where income is low, where postneonatal (one month to one year) mortality rates are high, and where participation in welfare and food assistance programs is low or nonexistent, the Board suggests that hunger and malnutrition are prevalent. On this basis, the Board has identified 256 hunger counties requiring immediate and emergency attention.

CHAPTER III. THE DIFFICULTY OF DOCUMENTING HUNGER AND MALNUTRITION IN THE UNITED STATES

The Board of Inquiry was startled by the absence of knowledge, research, experimentation, affirmative action—and even concern

about the existence of hunger and malnutrition in the Untied States. In seeking to learn why so little information was available, the Board turned to those sectors of society which seemed to possess the responsibility for documenting the nutritional status of the American people: the health professions, public health authorities, private charitable organizations, and the private food sector. The Board concludes that each of these sectors have failed to fulfill its responsibility, has allowed hunger to go, not merely unchecked, but also unidentified. As a result, the Board recognizes that—

"If this report is marred by any single element, it is the anomaly of asserting that a phenomenon exists, and that it is widespread, without being able to ascertain its exact magnitude or severity because no one ever believed it existed."

The health professions

The board presents evidence that—

The extent of recorded medical knowledge about dietary intake and malnutrition among the poor in the United States consists of about 30 studies, which—with a few exceptions—have been limited in scope and limited in methodology to the most easily determined manifestations of malnutrition.

Medical schools do not train students to recognize malnutrition.

Most hospitals do not keep systematic records or perform tests necessary to ascertain the presence of malnutrition.

The lack of data is used as the basis for inability to move quickly toward solutions, and some professionals have turned lack of data into confirmation that malnutrition does not constitute a serious or pervasive problem.

Public officials

Among public officials, where the responsibility is clearcut, the Board found a shocking lack of information or action:

The Public Health Service has no knowledge of the extent of malnutrition in the United States, although it concedes that a serious problem exists.

The Department of Agriculture has conducted extensive studies to learn how much money is spent on food, and which foods are most popular among Americans at large. At the same time, its knowledge of nutrient deficiencies of the poor is scant, superficial, and unsatisfactory.

Other federal agencies have not added, significantly, to the collective knowledge of the federal government about hunger and malnutrition.

Dieticians and nutrition experts, public and private, on the state as well as the federal level, have not become familiar with the dietary and nutritional needs of the poor.

Private charitable organizations

In a survey of over 100 charitable organizations across the nation, the Board of Inquiry learned that in contrast to the extensive overseas feeding programs of organizations such as CARE, the immediate and severe problems of hunger in the United States have been addressed by the private sector in only a limited fashion.

The private food sector

The Board of Inquiry asked 75 food manufacturing companies: (a) what steps were being taken to determine the number of people now being excluded from the domestic food market because of low income and (b) what remedial efforts they were engaged in. Of 35 companies responding, the Board learned that there has been little activity in the private sector in determining the food needs of the poor.

This inactivity on the domestic front contrasts markedly with the situation abroad. A major contribution of the private sector is helping needy populations in poor and developing countries has been the development of new and fortified foods, which by themselves, provide many of the nutrients for a nutritionally adequate diet.

When certain barriers to acceptance of these foods are recognized, when taste, appearance, ease of preparation, adequate delivery systems are considered, and finally when an appeal is made to the nutritional advantages of a food rather than its special utility to the poor, the likelihood of acceptance is significantly increased. With these qualifications, the Board of Inquiry makes recognition of the valuable role that fortified foods can play in alleviating hunger and malnutrition in the United States.

CHAPTER IV. ANALYSIS OF FEDERAL FOOD AND WELFARE PROGRAMS

The Board has examined in depth the three chief programs designed to alleviate hunger and malnutrition: The Commodity Distribution Program; the Food Stamp Program; the Welfare Program. And it has taken a brief look at consumer education efforts and the school lunch program an consumer education programs as ancillary programs to combat hunger and malnutrition.

We are forced to conclude that these programs do not do the job.

These programs clearly have failed—but responsibility for this failure cannot be laid merely to lack of money or staff. Much of the responsibility for the failure of these programs rests with the mode of administration adopted, the discretionary decisions made, and the failure to use the full statutory power available to fulfill the purpose of these programs.

Commodity distribution program

Under this program, the Department distributes surplus commodities to needy families. These foods are called basic commodities and are provided in the form of cornmeal, corn grits, flour, non-fat dry milk, peanut butter, rice and rolled wheat. These are the foods that the commodity recipient can count on receiving each month—albeit with some variations in amount and variety.

The government, however, has available special additional money to buy and distribute free any other kind of food—orange juice, turkeys, beef, vegetables. It has the power to distribute such foods to the hungry.

This "Section 32" money (Section 32, P.L. 320, 74th Congress) designed to keep the farmer's prices high and to provide food for those in need, is not part of the President's budget. The Congress does not have to appropriate it. It comes directly and automatically to the Secretary. Last year, it added up to $700 million. Of that $700 million, some $500 million was either returned to the Treasury or carried forward into the 1968 fiscal year. Less than $150 million was used in connection with commodity or food distribution programs.

The Board of Inquiry found that 300 of the poorest counties in the United States have no food assistance of any kind. Local officials in many of these poor counties have refused to apply for federal food assistance, because of unwillingness to extend help to Negroes, who constitute the overwhelming majority of the poor in counties without food assistance.

The Department of Agriculture has the power to start food assistance programs where need is evident. Yet, until April 1968, the Department consistently declined to exercise its power to institute commodity distribution programs where local officials had refused to apply.

In counties where commodities are distributed, they seldom reach even a majority of the poor population. Some people are declared ineligible because their income is too high, although substantially below the poverty line. Some people are discouraged from participating because the distribution depots where they must go to obtain commodities are too far away, and the commodities received are difficult to transport.

The commodity distribution program does not supply enough food for the month. Food runs out, people go days without food. Moreover, the variety of foods distributed is not adequate to meet minimum nutritional requirements, despite the recognized fact that most of the three million participants must look to the commodity distribution program for their total food supply.

As the Board points out, the USDA does not meet its own standards for minimum nutrition:

"Each month the USDA distributes to a family of four commodities with a total retail value of slightly over $20. The USDA has determined, however, that a family of four should spend over $90 per month—on a variety of foods—in order to obtain a nutritious diet.

"Each month the USDA distributes less than 100 pounds of food to a family of four, a total of 23.38 pounds of food per person. The USDA recommends however, that to obtain an adequate diet, a family of four should have 308 pounds of a variety of nutritious foods. This figure excludes milk and eggs.

"The USDA recommends 50 pounds of meat, poultry or fish per month for a family of four. It distributes less than eight pounds to a family of four on commodities.

"The USDA suggests 176 pounds of fruits and vegetables. The family on commodities receives less than five pounds a month."

The Board of Inquiry concludes that the commodity distribution program is a failure. While they do not feel that changes will make the program successful in the long run, they make proposals for administrative reform which, within the framework of existing legislative authority, would benefit the hungry and malnourished substantially. (See page 56).

Food stamp program

The food stamp program, in theory, was to correct the deficiencies of the commodity program. It was to let the poor choose their own foods. The bonus coupons they bought with their normal food dollars would multiply their food purchasing power at local stores. Eligible families would buy the food stamps at rates set by the Secretary of Agriculture. The law requires that such prices be set at a rate equivalent to the "normal expenditure" for food. The Secretary decided to set stamp prices by determining average expenditures for families of different size and income.

Averaging the food expenditures of the poverty population proved administratively expedient to the USDA, but became a nightmare for the hungry. Families who had literally no income were averaged in with lowest income families and expected to pay rates based on averages with money that did not exist. In areas where the commodity distribution program was being scrapped in favor of food stamps, the no-income family found itself whipsawed between a program that had distributed food free and a new program that assumed that the family had paid for its food. When the switchover occurred, participation dropped radically. For once, America became aware of its hungry.

This awareness led to piecemeal efforts at improvement. These efforts in turn uncovered other inadequacies in the planning and administration of the food stamp program. The lowering of the minimum food stamp charges pointed up the inequity of the prices at "higher" income levels. Every time the income of a family of four rises by 10 dollars, six of those dollars must go toward food stamps. The schedule of charges set up by the USDA suffers from certain internal inconsistencies and operates to discourage participation.

Consider the following:

Assumption: That all families with a given number of members and a given income normally spend the same amount of money on food. This is the assumption underlying the use of surveys to determine what are "normal expenditures."

Fact: The USDA concedes that a primary problem in poor families is that there is no plan for spending money, hence, there is no "normal" amount of money spent each month on food. Bills, fixed expenses, and poor consumer practices devour income the day it dribbles in, so that there can be no amount specifically allocated for food expenditures. No steady dollar-and-cents pattern to the expenditures of poor people has yet been established.

Assumption: A family in poverty normally pays a constant amount of money for food from month to month. This justifies the requirement that participants spend a fixed sum on stamps each month or be ineligible for further assistance.

Fact: Food expenditures may double—or be cut in half—from month to month depending upon emergencies, pressing bills—and on income which may vary from month to month or season to season.

Assumption: That as a family's income increases, the percent of income spent on food increases. Food stamp prices are set so that, at the lowest levels a sharp rise in stamp prices accompanies a modest rise in income. This assumption appears to be coupled with the further assumption that the lowest income families spend for food first and pay their bills last.

Fact: At low levels of family income, food expenditures give way to fixed expenses. Items like rent, utilities, and overdue bills come first. What is left is what is spent for food. And this pattern does not change as income increases (until one is substantially above the poverty line).

The requirement that the poor lay out the cash for stamps all in one lump sum—and that they purchase the minimum amount or none at all—has worked considerable hardship. And once a person chooses to participate, he must continue to do so at the same level every month or he will be disqualified and required to apply all over again for eligibility.

A further inadequacy of the program is its unwillingness to provide even its participants with an adequate diet. By the Department of Agriculture's own standards, the money value of stamps falls consistently and deliberately below the amount necessary to secure a minimally adequate diet. Nutritional studies indicate that those participating in food stamps in fact are only slightly better off nutritionally than non-participants.

The county option system which has thwarted use of the commodity distribution program in many counties has been at least as great an obstacle to instituting the food stamp plan. The Secretary of Agriculture denies that he has the power to distribute food stamps in counties which refuse to apply. Yet section 14(a) of the Food Stamp Act expressly gives him that power.

After presenting this and other evidence, the Board of Inquiry concludes that the food stamp program has failed to fulfill its promise, and proposes a number of steps for administrative reform. (See pages 66–67.)

School lunch program

Despite its potential for directly alleviating hunger and malnutrition among the children of the poor, the school lunch pro-

gram has to date proved unsuccessful. At most, one-third of poverty stricken children attending public schools participate. Although Congress expressly provided in the National School Lunch Act that poor children shall be served without cost or at a reduced cost, a majority of poor children are forced to pay the full price for school lunch or go without. The school lunch program in fact, operates for the benefit of the middle class.

Consumer education programs

Education in the advantages of budget, planning, bargain shopping and food selection has been held out as a solution of the malnutrition problem.

If education is the answer, the Board finds that little of it exists. In addition, limited evidence would appear to indicate that the poor use their food dollar well and that they need greater purchasing power, more than education on how to use that purchasing power.

Much of the need for education, budgeting knowledge, sophistication and skills stems from policies and procedures which make programs complex and directly decrease their utility to the poor. The call for education sometimes masks a shifting of responsibility for the defects of a program from the administrators, who have made the program complex, to the poor, who cannot cope wtih that complexity and red tape.

The role of public assistance programs in feeding the poor

The ability to eat adequately in the final analysis depends upon money. The poor do not have enough money to buy the food they need, despite the myth of massive federal handouts. Three out of every four Americans who live below the poverty level receive no help from federal public assistance programs whatsoever.

Some of those who do not receive federal assistance receive "general assistance" from the state and local government. But "general assistance" is miniscule in scale—amounting to less than six percent of federal expenditures under public assistance programs.

Most states administering federal welfare monies do not pay the minimal amount necessary for subsistence as estimated either by their own standards or by the federal government's standards. Actual payments consistently fall below the level to which families are entitled by law.

Consequently, the Board of Inquiry finds those who do participate in federal public assistance programs do not get enough money to secure a nutritionally adequate diet. In fact, welfare recipients who receive the highest level of payment in the nation have been found to suffer from inadequate diet.

Thus to live on welfare is to be virtually certain of inadequate nutrition. But three-fourths of the poor do not even get welfare. There are four distinct causes for this lack of participation.

1. The categories of federal assistance are a limitation on eligibility.

2. The state exercises its power to restrict participation in federal public assistance programs. The states can simply decline to participate in federal programs, or they can restrict the number of participants by imposing additional eligibility requirements.

3. The mode of administration on the state and local level restricts participation.

4. The Department of Health, Education and Welfare consistently declines to re-examine state plans for conformity to federal law, court decisions and affirmative constitutional requirements.

At the same time the interests that dominate agricultural policy have not supported efforts to feed the hungry. The Board of Inquiry concludes:

1. The composition of the agricultural committees of Congress—which pass upon major food assistance legislation—dictates that inevitably the needs of the poor and hungry will be subordinated to the interests of large agricultural producers.

2. The relationship between these agricultural committees and the Department of Agriculture—which administers all major food assistance legislation—dictates that inevitably the Department's priorities will place the interests of agricultural producers first, the needs of the poor and hungry second.

CHAPTER V. AGRICULTURAL POLICY

Responsibility for the design, enactment and administration of food assistance programs—both domestic and international—has traditionally been vested in those groups and individuals in government concerned with protection of the producers of food. Such a policy converts programs to feed the poor into disposal systems to relieve market gluts and protect profits.

The central focus of agricultural policy has shifted over the years from the small producer, the family farmer, to the large producer, the commercial and corporate farmer.

In 1967 alone, for example, nine large landowners received a total of over $14 million from one or a combination of farm programs designed, as the Department of Agriculture puts it, "to encourage, promote and strengthen the family farm".

Judged by the allocation of payments to farmers in 1967, this purpose has not been achieved. Some 42.7 percent of farmers—the classically small family farmers—with gross income of less than $2,500 received 4.5 percent of total farm payments from the government while the top 10 percent of farmers—the large, diversified, and in many cases corporate landowners—each with more than $20,000 gross income received 54.5 percent of total farm payments.

The large scale producer, as a result, is well protected.

CHAPTER VI. RECOMMENDATIONS

The Board of Inquiry has made recommendations which call for both immediate action to alleviate the present emergency conditions and for long range programs to eradicate hunger and malnutrition in the United States.

Immediate relief

We call upon the President to—

Declare that a national emergency exists;

Institute emergency food programs within these 256 hunger counties, at migrant farm camps, and, after consultation with tribal councils, on selected Indian reservations; all this to be done as the first earnest effort of a national resolve to dispel hunger;

Use all available statutory authority and funds including that under Section 32, P.L. 320 74th Congress customs receipts; under emergency food and medical appropriations (receipts) for the Office of Economic Opportunity, and under the 1967 Social Security Amendments providing for federal participation to needy families with children in order to assure completely adequate food programs in these counties;

Ask Congress for immediate enactment of such other powers and appropriations as he needs;

Use also in these places the authority and funds provided under the federal food programs, to the extent that doing so will not take funds away from other areas;

Report to the people by September 1968 the numbers of needy people reached in these counties, the numbers yet unreached (if there be any) and the nutritional adequacy of the diets provided for all these programs;

Report, at the same time, plans for longer range programs.

Lang-range recommendations

The basic federal food program should b the *free* Food Stamp Program.

Eligibility for food stamps should be keyed to income, dependents, and medical expenses. The formula should bear some negative relationship to the same factors as the federal income tax.

At levels set by law, persons should become eligible for varying quantities of stamps without further investigation.

An eligible person should receive more or fewer stamps depending on need. Since the criterion is need, there would be no reason that the recipient pay anything for the stamps to which he or she is entitled.

We believe that school lunches should be available to every child enrolled in public, private, or parochial schools up to and including the 12th grade, as well as in kindergarten, Headstart or other pre-school centers, nursery schools, and day care centers. The lunches would have to conform to federal nutritional standards.

If it be required that families who can afford to pay for lunches do so, then we suggest consideration of a system of non-transferable lunch stamps which would be the only currency acceptable for federally supplied lunches, which would go to food stamp recipients along with their other stamps and which could be purchased by other parents at the issuing office.

School lunches could appropriately be used for prudent experiments with the palatability and nutritional effectiveness of so-called fortified foods.

Either the Department of Health, Educ tion, and Welfare or the Office of Econom Opportunity should be directed and funded to employ and train a large number of fo stamp recipients (perhaps at a ratio of trainee to every 50 recipients) as nutriti and health care extension workers among the poor.

Until such time as the President is able to report to the country that no households (or only an insignificant number) have diets that fall below the Department of Agriculture's criterion of "good" and that federal assistance is no longer a factor in keeping them at that level, custom receipts under Section 32 should be made available as required to supplement other appropriations for the food needs of the poor.

Medical, graduate, and nursing schools should give much more attention to the diagnosis and treatment of malnutrition, and to an understanding of its causes and effects.

Finally, we do hope and urge that private organizations concerned with human welfare will address themselves to this most elemental of all of humanity's problems and that each will find within its purposes and resources its own distinctive contribution; and that all these organizations will, as part of their contribution, continuously monitor and evaluate governmental programs. To this end, and as a first step, we shall ourselves distribute our principal findings and o recommendations to groups representative the nation's poor.

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