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DAILY DIGEST

SENATE

Chamber Action:

Antipoverty: By 46 yeas to 22 nays, Senate adopted conference report on H.R. 8283, proposed Economic Opportunity Act Amendments, thus clearing bill for President's signature.

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HOUSE

Chamber Action:

Major Diseases: By a voice vote the House passed H.R. 3141, to amend the Public Health Service Act to assist in combating heart disease, cancer, stroke, and other major diseases, after adopting a committee substitute amendment that provided a new text. Prior to its adoption the committee substitute amendment was altered by adoption of amendments to—

Give the Comptroller General authority to audit books and records of recipients of grant funds; and

Include "other medical institutions engaged in post-graduate medical training" within the definition of "medical center."

This passage was subsequently vacated and S. 596, a similar bill, was passed in lieu after being amended to contain the House-passed language. Pages 24121–24144

Clean Air: By a record vote of 294 yeas to 4 nays the House passed and returned to the Senate S. 306, to amend the Clean Air Act to require standards for controlling the emission of pollutants from certain motor vehicles and to authorize a research and development program with respect to solid waste disposal, after adopting a committee substitute amendment that supplied a new text.

Rejected a recommittal motion designed to delete the provisions for solid waste disposal by a record vote of 80 yeas to 220 nays.

Adopted an amendment to require adherence to the Statement of Government Patent Policy by Federal personnel in connection with research, demonstrations, training, and other activities under section 204.

Rejected an amendment that was identical to the recommittal motion. Pages 24144–24167

HOUSE COMMITTEE MEETINGS FOR WEEK OF SEPTEMBER 27 thru OCTOBER 1, 1965

House Chamber

H.R. 3142, Medical Library Assistance Act of 1965 (2 hours of debate);

Committee Meetings

Committee on Interstate and Foreign Commerce: September 28 and 29, on H.R. 781, and similiar bills, to establish a Federal Commission on Alcoholism, 10 a.m., 2123 Rayburn House Office Building.

September 30 and October 1, Subcommittee on Public Health and Welfare, on H.R. 3036, and similar bills, to provide for humane treatment of animals used in experiment and research by recipients of grants from the U.S., and by agencies and instrumentalities of the U.S.; and H.R. 7312, and similar bills, to provide for the best care, welfare, and safeguards against suffering for certain animals used for scientific purposes without impeding necessary research, 10 a.m., 2123 Rayburn House Office Building.

HEART DISEASE, CANCER, AND STROKE AMENDMENTS OF 1965

Mr. HARRIS. Mr. Speaker, I move that the House resolve itself into the Committee of the Whole House on the State of the Union for the consideration of the bill (H.R. 3140) to amend the Public Health Service Act to assist in combating heart disease, cancer, stroke, and other major diseases.

The SPEAKER. The question is on the motion offered by the gentleman from Arkansas.

The motion was agreed to.

IN THE COMMITTEE OF THE WHOLE

Accordingly, the House resolved itself into the Committee of the Whole House on the State of the Union for the consideration of the bill (H.R. 3140) with Mr. FLOOD in the chair.

The Clerk read the title of the bill.

By unanimous consent, the first reading of the bill was dispensed with.

The CHAIRMAN. Under the rule, the gentleman from Arkansas [Mr. HARRIS] will be recognized for 1½ hours and the gentleman from Minnesota [Mr. NELSEN] will be recognized for 1½ hours.

The Chair recognizes the gentleman from Arkansas, but pending that, the Chair asks the gentleman to suspend for 1 minute. The Chair has two announcements to make and a couple of ground rules to lay down.

First, the Members are aware that last evening the majority leader advised us that since today is Friday, at the end of the day's business he would ask consent to go over until Monday noon. It has been a long, hard, hot week. All Members wish to be with their families. I do not blame you. That is an important announcement to the Members.

The second announcement is much more important to the Chair. The Chair advises the Members that this is the wedding anniversary of the gentleman from Pennsylvania and Mrs. Flood. [Applause, Members rising.]

You are very kind. I assume that out of deference to Mrs. Flood you are applauding. However, all the necessary festivities have been arranged. Need I say more?

The gentleman about to address the Committee has been a member of this committee and the House for 25 years. He has announced that he is retiring from the House. This is our loss. The gentleman has been nominated by the President and confirmed by the Senate unanimously as a Federal judge. He has been chairman of the great Committee on Interstate and Foreign Commerce for many, many years. He has presented many bills of vital import to the Nation. I am not sure of the date of his retirement, but the two bills he is about to present might possibly be his last major presentation. The greatest compliment and the tribute you can pay is to give him your rapt attention.

The Chair recognizes the gentleman from Arkansas.

Mr. HARRIS. Mr. Chairman, I yield myself such time as I may consume.

First. May I say to you, Mr. Chairman, and to my colleagues, I am grateful for the expression of esteem which has just been manifested by the distinguished chairman of this committee. I do not know what the date is going to be myself.

Second. On behalf of all of our colleagues let me congratulate the distinguished chairman of this committee and his wonderful and lovely wife on this occasion of their anniversary. We offer our felicitations to them on this important occasion and extend to them our wishes for many, many, many more happy and joyous years together.

Mr. Chairman, this is one of the last of three major legislative proposals that I shall have the honor of presenting to my colleagues in the House.

Mr. Chairman, it has been my honor and privilege to have served with our colleagues in this House over the last quarter of a century. This is no time to discuss some of the feelings I may have, but during that time it has been my honor and privilege to bring to you, along with the members of the great Committee on Interstate and Foreign Commerce, over the years many highly important legislative programs.

In my considered and humble judgment, this bill which we bring to you today is undoubtedly one of the most important of the legislative proposals it has been our privilege to submit to this House. As a matter of fact, I do not believe there is anyone in this House or anyone in the country who can object to or does object to, the objectives of this legislative proposal, H.R. 3140.

Our committee has had jurisdiction over matters of public health since 1795. The very first legislative proposal which was referred to the committee which is today the Committee on Interstate and Foreign Commerce was a public health bill to protect the health and welfare of the merchant marine of this country. Down through the years there have been many important legislative programs to improve the health of our people and to eradicate certain of the dreaded and terrible diseases which have wrought burdens and tragedies upon the people of this country.

Let me recall to you that with regard to some of these diseases that we have faced in the past, such as yellow fever and malaria, today we think there is not much to them, but many years ago there was. Many of us here can recall the tragedy that poliomyelitis brought to the people of our Nation. What we have been able to do about that disease in our

generation in the last decade is a revela- What a wonderful feeling it is for and for me, for all of us, who have just had a little part to play in improving the health and welfare of all of the people of this country. We can rightly be proud of contributing something to the relief of the suffering of humanity.

So today we have facing the people of this Nation the very dread disease of cancer. Which one of us has not seen our loved ones, our neighbors, and our friends as they have lingered and finally passed on to their reward because of this dread scourge? Which one of us has not seen those nearest to us suffering from heart disease, which brings to the minds of our people the suffering that humanity endures? Just this morning I learned that our former colleague in this House, the Honorable Clyde Ellis, a former Member from my State, who served here for many years, was stricken with a heart condition and is now in a hospital here in Washington. Which one of us has not seen those near and dear and close to us stricken down by stroke? Those are the three dread diseases that we are attacking here today. I do not believe that there will be any opposition to this effort as we present it here to you today.

Mr. Chairman, this legislation as originally introduced was highly controversial. It was highly controversial because we had persons who felt this legislation was in conflict with the fundamental philosophy of the Government. They felt the legislation was bringing into exist- what in this country we have been what fearful about over the years; namely, what has been termed "socialized medicine."

Now this legislation does not provide for a program that will now, or at any time in the future, lead to socialized medicine.

My hat is off to the medical profession. I think we owe them more than we can possibly pay them. We have a member of that profession on our committee. He has been invaluable, in my judgment, and I have appreciated the contribution that our colleague, the gentleman from Kentucky, Dr. CARTER, has made to this program as we bring it here to you today.

In this proposed legislation, Mr. Chairman, we attack the condition that represents the cause of 71 percent, or a little more, of the deaths of the people of this Nation. I believe we do it in a way that is consistent with our philosophy.

Our committee, in the final analysis, by a voice vote unanimously reported this amended bill to you for your consideration.

Under the bill, a program will be established under which applications will be made to the Surgeon General for planning grants to aid people in working out programs of cooperation between medical schools, research institutions, hospitals, and practicing physicians to help in meeting problems in the areas of these three diseases. The program set out under the legislation would support co- tive arrangements between medical schools and their affiliated teaching hospitals with research centers, local hospitals, and practicing physicians, under which patients could be provided the latest advances in diagnosis and treatment, and programs of continuing education would be made available to practicing physicians in forms more convenient than existing arrangements provide. Our report points out a number of programs already being conducted in the United States which are similar to the programs proposed under this bill.

The purpose of this legislation is to help meet the problem faced by our Nation arising out of heart diseses, stroke, and cancer. In March 1964, the President appointed a Commission under the chairmanship of Dr. Michael De Bakey, known as the Commission on Heart Disease, Cancer, and Stroke. This Commission studied the problems of these three diseases for 9 months and submitted a report in December 1964, which included a number of recommendations. Legislation was introduced to carry out some of the recommendations of the Commission, and after hearings on this legislation, our committee reported the present bill to the House.

A lot of opposition was expressed to the bill during the course of the hearings, principally by representatives of organized medicine. We amended the bill very substantially, in accordance with the recommendations by the American Medical Association, and thereby met many of the objections which were expressed to the bill.

Most of the amendments that the committee adopted are intended to strengthen local control of programs established under the bill. Under the bill as we reported it, local groups must get together and decide for themselves if they want to accelerate heart, cancer, and stroke control programs by increased cooperation between local medical schools and their teaching hospitals, clinical research facilities, community hospitals, and practicing physicians. An advisory committee will have to be appointed which will include practicing physicians, medical school officials, hospital administrators, representatives from appropriate medical societies, voluntary health agencies, public health officials, and members of the public. Many State and local public health departments now have existing heart, cancer, and stroke control programs with personnel and facilities which would be valuable assets to this program both in the prevention of disease and in the network of diagnosis, referral, and aftercare. If the National Advisory Council on Regional Medical Programs considers the proposed program sound enough to merit assistance, and recommends approval to the Surgeon General, the Surgeon General can make a planning grant to the local group to meet the expense of developing plans for establishing a local program of cooperation. The local group will then make studies and determine whether the establishment of such a program is feasible, and if they determine that it is, they will then work out a program tailored to the needs of the locality. Obviously, a program to meet the needs of a sparsely populated State such as Wyoming would differ from the plan worked out in a State such as Illinois, which in turn would differ from the type of program needed in a State such as Connecticut.

Once the local plans have been worked out, it will be necessary for these plans to be approved by the local advisory group. At this point an application can be made to the Surgeon General for funds to establish and operate the program at the local level. If the National Advisory Council recommends approval of the program, the Surgeon General can make a grant to meet the expenses of establishing and operating the program at the local level.

Primarily the program will consist of cooperative arrangements among existing institutions. For example, the program might pay part of the expenses of establishing at community hospitals in the local area directors of continuing education. The program could pay expenses of programs of continuing education involving visits by personnel from the participating medical school and its affiliated teaching hospitals to community hospitals. There are many ways in which programs of continuing education are carried on today, and under the bill these programs can be expanded and strengthened.

Under the program, new and sophisticated equipment can be procured for community hospitals, and doctors and supporting paramedical personnel can be trained in its use.

Research programs can be conducted at affiliated research institutions and the training of medical students, graduate students, and researchers can be improved through programs of cooperation between the medical schools, the research institutions, local hospitals, and practicing physicians.

There is nothing really new in the program proposed by this bill which we have reported to you. A program very similar to that set out in the bill has been carried on in Maine since 1931. It is called the Bingham Associates program, and Members will find it described on page 5 of our committee's report. A similar program is conducted in New York; a similar program is centered around Columbus, Ohio; a similar program is conducted in Wisconsin; there is a very successful and imaginative program of continuing education conducted in Minnesota; and a program similar to the one set out in the reported bill has been carried out in the State of Iowa since 1915.

Mr. Chairman, the American people are fortunate in having the best medical care in the world available to them in this country. It is an unfortunate fact, however, that the most modern advances and the best techniques in medical care are not always available to all of our citizens. The program established under this bill will help bring the latest advances in the care, treatment, as well as the prevention, of the three greatest killers in our country today—heart disease, cancer, and stroke. We think the program to be established under the reported bill will go a long way towards making more generally available to our citizens the very best in medical care.

Mr. LAIRD. Mr. Chairman, will the gentleman from Arkansas yield to me?

Mr. HARRIS. I should be glad to yield to the gentleman, knowing of his interest in the field of public health and the tremendous contribution that he has made in his position on the Subcommittee on Appropriations having to do with matters of public health.

Mr. LAIRD. I thank the gentleman. We are going to miss the gentleman from Arkansas as chairman of this committee. He has a great understanding of and has made an outstanding contribution to the health legislation that this Congress has enacted over the last 25 years. We shall miss him as a Member of this body, but our loss is the gain of the judicial branch.

I should like to ask the gentleman from Arkansas this question. After going over this bill, and the various things which are provided for the various aspects of the heart, cancer and stroke program, it seems to me the authority which is contained in this bill is merely a restatement in different words of the authority presently existing in Public Health Service statutes, particularly as regards the National Institutes of Health.

The authority which we presently have in the National Institutes of Health would allow all of these programs. I believe there is some need to put them together in one place so that they can be reviewed by the legislative committee on a regular basis, but does not the gentleman agree that there is authority to carry on at least most of the program set out in this bill?

Mr. HARRIS. No; the gentleman cannot agree to that because that is not the purpose or the objective of this legislation. Even though there are provisions in this proposed legislation for certain research in the field of medicine it in no way conflicts with the present authorizations for research which we have under the established policy of NIH.

If the gentleman would refer to the report, on page 12 he will find a discussion of the relationship of this program to existing Federal health programs. This is to implement and supplement existing programs. It would in no way conflict with or try to supersede them.

Mr. LAIRD. I am afraid the gentleman from Arkansas misunderstood my comment. I do not believe that it is in conflict with existing programs. But the authority in present law does give the right to carry on these programs in the Public Health Service. We have established several regional centers for various activities of the National Institutes of Health and also for medically oriented activities of vocational rehabilitation.

Take the De Bakey Center at Houston, Tex. This center is regional in scope, and we are supporting a good many beds at that institution. Then take the McArdle Center in Wisconsin.

Mr. HARRIS. I know what the gentleman has reference to. There are several, which the report refers to. There are a few programs that are already set up. These serve as an example of what we intend to do.

Mr. LAIRD. But the controversy over this bill, I think, has been over the fact this has brought a new program, a new authorization into existence, something that the National Institutes of Health do not already have.

Mr. HARRIS. The National Institutes of Health, I may say to the gentleman, has a setup for the purpose of research in the field of medicine and public health. One of the purposes of this legislation here is to bring about the fullest utilization of the results of research in these fields—that is to fill the gap that exists between research and application. What we do here is to try to bring about a program that will accomplish in the various sections of our country the same thing the gentleman speaks of in the New England area, in the Texas area, and the in the Wisconsin area.

Mr. LAIRD. These have been tried. The gentleman from Arkansas will certainly admit very similar programs have been tried in certain areas. They have been successful, the clinical application of research, the clinical data we have made available. We have given the opportunity through the clinical application of research in many areas of the country. It has been tried, and it has been successful.

Mr. HARRIS. We have given assistance under these programs the gentleman speaks of. They are programs, fortunately, that have had heavy endowments and contributions made to them. Therefore we have tried to bring about this kind of cooperation or cooperative arrangement among the medical schools, the clinical operations in the area, and the hospitals in the area. I would cite the gentleman to the example at Tufts Medical School in the New England area. That program goes back as far as 1931. They have had many years of this kind of an arrangement, under which the various public health group hospitals and medical centers cooperate together.

I repeat, Mr. Chairman, I do not believe that there is any conflict or overlapping whatsoever. This supplements and complements existing situations we have had in this country, to bring to as many people as possible throughout the country this cooperative effort in the field of medicine and medical care.

We have tried to overcome the objections that have been raised to this proposal. As I said a moment ago, when the bill started out it was highly controversial. But as a result of the hearings we have held on this legislation and the innumerable hours and days that we spent in executive session in our efforts to clarify certain of the misunderstandings and objections, we have in my judgment brought to you a bill that is fairly well accepted.

The American Medical Association is the organization that submitted the greatest objection. They testified at length. Their witnesses were outstanding people. The president of that great organization, Dr. Appel, testified at length and we discussed almost section by section the provisions and then obtained information as to what their fears and objections were.

In addition to that, while the president and the president-elect of the AMA were in Washington and spent an entire day with the HEW, there was a meeting that was held at the White House at which the Secretary of HEW and other members of the staff, Dr. Appel, president of the American Medical Association, the president-elect and several of their associates and their technical people participated at a conference with the President on this matter. They had a very frank discussion as to what their fears were.

The President met with this distinguished group. They wanted the bill postponed until next year.

As a result of the conference to which I have referred and other conferences, innumerable amendments were offered. I shall not take the time of the Members to go into them further, but I shall state some of the major modifications that we made.

First. A statement in the title of the new part 9 indicated that the legislation was designed to get at heart, cancer, stroke, and other major diseases. There was some feeling that the title indicated that we were going far afield, and we would not know where it stopped. So we amended the title to provide for heart, cancer, stroke, and related diseases. We limited it to those three major diseases and any related problems thereto.

Second. There were great fears that there would be a major Government medical program set up with clinics, categorical centers, administrative centers, hospitals, and so forth operated by the Government. So we decided that instead of calling these by the term "complexes," which had developed an image of that kind, we would refer to them in the bill as "programs." The bill provides for programs utilizing existing medical centers, hospitals and institutions. We provide for cooperative arrangements whereby medical schools in cooperation with clinical centers in the area and with the hospitals in the area, and other health activities, shall set up an advisory local committee. That advisory local committee will decide. It will be autonomous, and will decide this program within an area. That program will then be submitted to the national council.

We amended the recommendation for the national council, so that in addition to other people expert in the field, there shall be two practicing physicians on the council, and they will submit their recommendations to the national council. The national council will then advise with the Secretary in determining these programs. We think it is a built-in protection to accomplish the greatest good under the concept that we have developed in this country over the years, and I think that is a good arrangement.

There is a third very important item providing a built-inprotection under the bill. We did not provide for new construction. We amended the bill and left out the request for new construction. We have construction programs set up under other provisions that we have brought to the House recently and over the last few years, including the Hospital Construction Act that began back in 1945 and 1946, and others down through the years since then. We have

already provided those programs and they have worked out very well.

As I said to the Rules Committee the other day—and I stand on the statement today—there has been no bill in my experience which has become a part of our public health program, reported by the Committee on Interstate and Foreign Commerce, that has not worked out satisfactorily to all segments, including the medical profession themselves. I stand on that record and I stand on my experience in this House that the proposed program will likewise turn out to be such a satisfactory and very important program.

Instead of providing for new construction, we provided for the situation in which there might be a medical school, a hospital, a diagnostic treatment center, a clinical center, and so forth, with an advisory committee approving plans. This is a local advisory committee. It might determine there was needed a modification of an existing structure, or a new wing for a medical school, as an example, in which new equipment would be necessary, for dealing with these diseases.

That kind of program is permitted and authorized. There is to be modification and extension as necessary to carry the program out, including equipment, and including personnel who would be trained and expert in these fields.

Mr. WAGGONNER. Mr. Chairman will the gentleman yield?

Mr. HARRIS. I yield to the gentleman from Louisiana, before I go to the next major point.

Mr. WAGGONNER. This was the point I wished to discuss. The gentleman has, to a great extent, answered my question.

Section 902 of the bill is the definitions section. Subparagraph (f) defines the term "construction" and reads:

> The term "construction" includes alteration, major repair (to the extent permitted by regulations), remodeling and renovation of existing buildings (including initial equipment thereof), and replacement of obsolete, built-in (as determined in accordance with regulations) equipment of existing buildings.

The term "includes alteration," in view of the explanation just given, means it really is limited to that sort of thing?

Mr. HARRIS. The gentleman is correct.

I refer the gentleman to the report. We place a lot of emphasis on planning by the local advisory committee, which will be composed of people who know what the conditions are locally and what is available and how we can better meet these problems. I believe that is a very good approach.

Mr. WAGGONNER. I thank the gentleman for yielding. That was not quite clear in my mind, and I wanted to ask the question.

If the gentleman will yield further, I express my personal regret, as a neighboring colleague from the adjoining State of Louisiana, that my good friend from Arkansas is leaving the Congress. I say only that the people of Arkansas losing a voice in Washington which I do not believe they will be able to replace.

Mr. HARRIS. I thank the gentleman very much for his generous comment. I am grateful for it.

Mr. Chairman, there were a good many other amendments. A moment ago the gentleman from Wisconsin [Mr. LAIRD] mentioned something about objections of certain people to this. I realize that what he was attempting to do is to bring out in the debate all facets of the program, to show how there might be conflicts or overlapping.

In order to make a legislative history, I believe that is a good thing. I thank the gentleman for bringing it to our attention.

One of the objections to this proposal related to how the program might interfere with the doctor-patient relationship.

That is very important. That is terribly important from the standpoint of the people who are knowledgeable in the field and have the know-how under our present programs and the approaches to these programs which we have brought to the people of this Nation. We have the finest health of any people in all the world in all history.

We do not intend—and I want to make this abundantly clear—to cause any disruption or interference in any way with the doctor-patient relationship. We not only make this sure by amendments to the original bill, but we later provide that no patient will be accepted by any of these programs unless he has been referred by a practicing physician. So we approach that problem head-on in order to make it abundantly clear that there will not be any disruption of this traditional approach to the treatment of our health problems in this country.

Mr. GROSS. Mr. Chairman, will the gentleman from Arkansas yield?

Mr. HARRIS. I will be glad to yield to the distinguished gentleman from Iowa.

Mr. GROSS. I note in the report that the Comptroller General suggested that his office be written into this bill for the purpose of checking on the expenditure of funds. Is the Comptroller General's Office specifically written into the bill as it is now before the House?

Mr. HARRIS. No. I know the subject was discussed and the gentleman from California [Mr. Moss] who is usually interested in these matters, did go into it with the committee. We decided that there was sufficient authority under the Public Health Service Act for this information to be made available to them.

Mr. GROSS. I would hope, if it is not to be found in the legislation, that the gentleman from Arkansas would have no objection to an amendment which would provide that the Comptroller General would have such authority.

Mr. HARRIS. If I recall, in the discussions we had in the committee in order to meet this problem we found that there was existing authority under the present Public Health Service law.

Mr. WAGGONNER. Mr. Chairman, will the gentleman yield?

Mr. HARRIS. I yield to the gentleman from Louisiana.

Mr. WAGGONNER. Is this not taken care of in the Public Health Service Act itself?

Mr. HARRIS. I think that is what we decided. We usually do that in new legislative programs that come out of our committee. I do recall that this matter was brought up for discusssion within the committee. If my memory serves me correctly, we decided that under a previous program which provided amendments to the Public Health Service Act, it was included and, therefore, it is so intended here, I will say to the gentleman.

Now, there are just two other matters that I want to discuss. One is a matter which, not to be sentimental at all, just recognizes the facts of life as we talked about it earlier. Heart disease, cancer, and stroke, as I have previously stated, account for 71 percent of the deaths in the United States. In the case of people under the age of 65 they account for 51 percent of the deaths. For example, in 1963, over 1.1 million Americans died of heart disease, cancer, or stroke. The economic cost to this country of these three diseases amounted to over $30 billion in 1962. This is both in direct cost of care and treatment as well as the indirect cost associated with the loss of earnings. Now, this is a tremendously important item to be kept in mind—$30 billion in 1 year.

An estimated 25 to 30 million individuals suffered from heart disease in the United States in 1963. In the case of over 700,000 of these individuals their illnesses terminated in death. The direct cost in medical care and treatment for heart disease in 1962 was $2.6 billion, and the indirect cost due to loss of income because of disability and premature death amounted to over $19 billion. These facts cannot be disputed.

Cancer is the second greatest killer by a wide margin. Among children between 1 and 14 years of age it is one of the most common causes of death. Deaths due to cancer have increased in recent years. In 1962, 278,000 Americans died of cancer. In 1963 the figure is 285,000, and in 1964 it exceeded 300,000.

Cancer caused 4 percent of the deaths in 1900, but in 1963 16 percent of the deaths were caused by cancer.

Mr. Chairman, we must have vision. We must have courage. We must face the facts now and for 10 and 20 years hence. The cost of cancer in this country now is $8 billion each year, of which $1.2 billion is the direct cost for treatment and care, and $6.8 billion represents the indirect cost due to disability and premature death.

The third leading cause of death in the United States is stroke, which is estimated to affect 2 million Americans. In 1963 over 200,000 persons died of stroke. The direct cost of care and treatment of victims of stroke amounted to over $400 million, and the indirect cost due to disability and premature deaths over $700 million.

These are the facts with which we are faced today. Our population is expanding. We have become an urbanized nation and we are going to be faced with more and more of these problems. We have got to do something today.

We have got to organize against these diseases that are attacking and will continue to attack our people.

Now, Mr. Chairman, giving you that information, we provide a beginning for cooperative arrangements under the bill.

Here is an example: There is a fine institution set up in New Orleans, La. There you have the Tulane Medical School, the LSU Medical School, you have Charity Hospital, and you have other great hospitals within the area. Nearby you have Baton Rouge. Then not too far away you have Shreveport with its wonderful institutions.

All of these can work together in an organized effort that will make available, if requested, information on these particular diseases to every community.

Mr. Chairman, as an example, in the State of Louisiana now you can propose a united effort of this kind. And what do we authorize? What is the estimated cost to undertake this terrific program? Three hundred and forty-five million dollars. That is all, for 3 years.

Mr. Chairman, you see, if we could have a measure of success you could see, even if you put it on the hard core of economics, how it would pay for itself over and over again.

But, Mr. Chairman, I would like to say to you and the Members, our committee is not only concerned, but we are determined, that these programs are going to be carried out in accordance with the traditions we have established in this country over the years in order that we might continue to bring to our people the finest medical attention of any people throughout the world or any people in history.

Mr. Chairman, in my judgment this is one of the finest programs in the history of this country. We could give examples which exist all around us. If we could do something for people who have experienced dreaded attacks of stroke, what a wonderful blessing it would be.

Mr. Chairman, we can say to our children and our children's children that this will contribute to the future health of the people of this country.

Mr. CRAMER. Mr. Chairman, will the gentleman yield for a question.

Mr. HARRIS. I should be glad to yield to the gentleman from Florida.

Mr. CRAMER. With reference to these regional medical programs, is there any benefit or are there substantial funds involved for requiring that these types of programs to be carried on, those programs that the area is desiring, be spread throughout the United States and not all concentrated in one area?

Is there anything to prevent these programs from being concentrated in one area rather than spread throughout the country?

Mr. HARRIS. If the gentleman will yield, first, we emphasize planning. We examined every area in the country and asked them to organize an established planning program, with local advisory committees, to start a program in connection with the people in the area, whether it be one State or more States.

Second. We expect that planning program to be submitted to the National Advisory Council. This National Advisory Council will be composed of people who will be responsible for seeing that this program is organized in a way that information will be disseminated as early as possible throughout the whole of the United States.

Third. We provide that that be done more or less on a regional basis. For example, if you want to establish a program in Florida it would not be anticipated that another would be established in Florida because we would expect that one to serve the general area.

Fourth. It is estimated one of the programs will cost approximately $4.5 million a year. We would start out the first year, from what we know, with approximately eight that will be established, and for the second and third years some 17 or more.

These would serve as pilot projects distributed as equitably as possible throughout the United States whereby it would encourage others, and they would be able to establish similar programs in an effort to ultimately make this available throughout the whole country.

Mr. CRAMER. I thank the gentleman. I think that fully clarifies that point.

I would like to ask one other question. I have introduced for a number of years a bill that would establish a geriatrics and gerontology research, relating to the diseases that are consistent with senior citizens and older age. Of course, heart disease, cancer, stroke, are of that nature.

Is it the gentleman's opinion as this bill is drafted and some of these institutions would determine that geriatrics and gerontology were such that were included in these diseases and studied on a regional basis, that they could qualify under the terms of this legislation?

Mr. HARRIS. Only as it would be related in some way to heart, cancer, and stroke.

Mr. CRAMER. To heart, cancer, and stroke, and related diseases; is that correct?

Mr. HARRIS. That is correct.

Mr. CRAMER. Of course, those are the diseases that are connected with growing old; therefore, if they were related to those diseases they could qualify?

Mr. HARRIS. That is true.

Mr. CRAMER. I thank the gentleman.

Mr. NELSEN. Mr. Chairman, I yield myself such time as I may use.

(Mr. NELSEN asked and was given permission to revise and extend his remarks.)

Mr. NELSEN. Mr. Chairman, first I would on the part of the minority want to extend congratulations to the gentleman from Pennsylvania now in the chair. I noticed when he came in he was so immaculately dressed, as usual, then I learned it is his wedding anniversary. I am sure that the minority would want to join with me in extending congratulations and best wishes to the gentleman.

The CHAIRMAN. I might assure the gentleman that in my house I am the minority.

Mr. NELSEN. Welcome to the ranks.

I would also like to take this opportunity as long as it has been mentioned that our chairman, the gentleman from Arkansas [Mr. OREN HARRIS] will go to other fields. Those of us on the minority, of course, want to wish him well. He has been an outstanding Member of this body and a wonderful chairman.

First, let us look briefly at the recommendation which was directly responsible for H.R. 3140 and S. 596. The committee and indeed the entire Congress, as well as the medical profession and the public-at-large, had every right to expect a lucid, well-reasoned, well-supported explanation of the programs suggested to carry out the President's order to the De Bakey Commission to "do something about it." Let us look at them. They come from the resulting 114 page summary entitled "A National Program To Conquer Heart Disease, Cancer, and Stroke."

The program had five levels of interrelated activity. First were centers of excellence—$40 million in nonmatching grants would be used by institutions at their discretion to strengthen various aspects of their academic and research programs. It was intended to "raise a number of institutions of demonstrated potential to a level of excellence comparable to the few outstanding medical centers of the Nation."

At the second level would be 30 medical complexes, costing $250 million. They are described thus:

> Specifically, the Commission recommends a major program of institutional grants to university medical schools for the creation of medical complexes which would involve participation by community hospitals and other health care facilities, by some of the regional heart, cancer, and stroke centers, and stations developed in proximity to each medical center, and by other community agencies and institutions.

Now that you know what a medical complex is, we shall go on to the next level, the regional centers. Of these there would be 25 for heart disease at $166 million, 20 for cancer at $600 million, and 15 for stroke at $85.5 million. They are described as follows:

Each of the proposed regional centers for heart disease, cancer, or stroke would provide a stable organizational framework for clinical and laboratory investigation, teaching, and patient care related to the disease under study. It would be staffed by specialists from all the clinical disciplines and the sciences basic to medicine necessary for a comprehensive attack on problems associated with the disease. These specialists would have at their disposal all necessary diagnostic, treatment, and research equipment and resources. The center would also provide bed support for the patients under investigation as part of their total care.

Now we are getting down to the local level. The Commission recommended establishment of a national network of diagnostic and treatment stations in communities across the Nation, to bring the highest medical skills within the reach of every citizen. There were to be 150 such stations altogether. One hundred and fifty stations would be for heart disease and cost $117.5 million. Cancer stations would number 200 and cost $225 million, and the 100 stroke stations would cost $77.7 million. To illustrate what would be done in such a place the report gives an example of what

might be expected of a typical heart station:

First. Immediate and emergency care for patients with acute cardiovascular emergencies.

Second. Provision of diagnostic facilities for the screening of patients with cardiovascular, including peripheral vascular, diseases to determine whether they will require the more highly technical facilities available at the larger medical centers.

Third. Outpatient services for patients with cardiovascular and peripheral vascular diseases.

Fourth. Stimulation of interest of medical students and practitioners.

Fifth. Training of physicians in the community.

Sixth. Education of the general public concerning prevention and treatment of heart disease.

And there we have the basic units of the system H.R. 3140 was meant to implement. At first I was concerned because no matter how I read the report or the bill I could not make much sense out of it.

Dr. Dempsey of HEW, under questioning, finally indicated that the Department had not bought the recommendations of the Commission after all. The legislation combined the 30 medical complexes and the 60 regional centers of the De Bakey proposals in one level called regional medical complexes and had limited them to 30. When it came to diagnostic and treatment stations the administration spokesmen were mighty unclear about what they were and how they would operate.

By this time I had begun to realize only too well why most of the practicing physicians across the country were deeply concerned about the so-called De Bakey proposals. They suspected that a whole new concept of medical care was about to be brought forth. They visualized the downgrading of the local hospital and the private doctor in favor of Government subsidized and controlled centers reaching down to the community and drawing all patients in these three categories into a huge integrated medical machine. They could not be sure about all this because no two people, doctors or otherwise, could arrive at identical conclusions about the program.

I have every reason to listen to my personal physician, Dr. Shepherd. If I had listened to him more carefully over the years I would be far better off physically than I am. He knows that no program we devise here, even a good one, will solve the basic problem of bringing health services to the smaller communities of this Nation. All the talk of the clinical approach, of advanced techniques and sophisticated devices for diagnosis and treatment are just conversation in such areas. They will not and cannot become realities for them. Their needs are more basic. They need doctors on hand.

As the hearings went along and more and more testimony accumulated it became very clear that general practitioners are not being created because the great emphasis on specialization and the categorical approach to medical problems discourages it. In fact, it began to appear that general practice is being consciously downgraded by those of the medical profession who should be most anxious to encourage it—the medical schools and the professional men of the health sciences who make up panels like the De Bakey Commission.

Dr. Shepherd and doctors like him need support. The medical schools should help the general practitioner increase his competance in every way possible. This seems to be underway. But a new generation of general practitioners must be trained and encouraged.

I have the greatest respect for the distinguished members of the President's Commission. They are gifted practitioners of the healing arts. I also have great respect for the local doctor who is ministering daily to the members of his community. His thoughts and his concerns about medical matters are also of great importance to us.

And here is where we determined to make some sense out of this legislation which was brought to us out of a blue cloud. Most practicing doctors wanted the matter deferred until some of the cloud banks could be penetrated and the daylight of examination and discussion could begin to press it into some recognizable form. It seemed that it hung over them like a shapeless genie, perhaps good, perhaps evil. All of the phrases thrown out, like rose petals at a wedding, about preserving the present patterns of patient care and medical practice did not allay those fears. I agreed that more time would be useful to allow the discussion to run its course and supported a motion to defer action until next session of the Congress. This did not prevail because the White House cannot let Congress do it work in orderly fashion these days and apparently it was ready to settle for anything containing the words heart, stroke and cancer. Despite misgivings on the part of many of its members, the committee settled down to write some legislation which could meet the objections and still make a start in the direction indicated in the original charge of the President's Commission. The result is the bill before you today, which came from the committee with full support.

The changes are many and they are not mere clarifications or exercises in semantics. They change an amorphous mass of objectives into a recognizable program which deals with units and controls thoroughly understood by those who must work with them. The bill now talks in terms of medical programs, put together by existing institutions under the eye of a local advisory board. It talks about cooperation and not coordination. The former means voluntary involvement and the latter infers an imposed plan. It talks of hospitals and not of diagnostic and treatment stations. The latter is an entity not familiar to practitioners, but we can all visualize a hospital and have a definite idea what it does, what it looks like, and who runs it.

So the De Bakey proposals were scrapped for lack of clarity and suspicion of subversion to the American system of medical care.

What did the committee substitute and what changes were made? The report on the bill accurately states:

> Numerous changes were made in the introduced bill by the committee designed generally to better define the scope of the program and to clarify the intent so as to guarantee that the legislation will accomplish its purpose without interfering with the patterns or methods of financing of patient care or professional practice or with the administration of hospitals.

This statement alone indicates the magnitude of the changes and the fact that the legislation as introduced was miles off the mark. Here are the specific changes:

First. Regional medical complexes were mentioned earlier in my statement. No one could even now define what they are or how they would operate. The committee substituted the term "regional medical program." At the same time, all authority to use funds for new construction, including replacement of existing buildings was removed. These are referred to in the report as primarily semantic changes. Do not believe it. They remove the specter of huge, new, autonomous institutions which receive their funds directly from the Government and quickly dominate every phase of medical practice and hospital practice in the fields of heart, stroke, and cancer.

Second. The original legislation allowed for expansion for other major diseases. The committee restricted the scope of this legislation to related diseases. That too is something more than a refinement. We have no idea that plans devised by the various States will be the ultimate answer in conquering the three diseases named. This is experimental. It cannot guarantee success in the war on heart disease, stroke, and cancer. It will do well if, from the many medical programs devised, we discover one or two which have real promise. There is little reason to leave room for expansion into other fields.

Third. The term "cooperative" was substituted for "coordinated" wherever the latter appeared. This helps to remove the prospect of domination of the program by one large institution. A program can be beautifully coordinated if all the power is concentrated at the head. What we are striving for here can only work if all elements participate through cooperative arrangements.

Fourth. Grants will be used for planning, conducting feasibility studies and operating pilot projects for the establishment of regional medical programs of research, training and demonstration activities.

Fifth. Diagnostic and treatment stations have been eliminated. The bill now speaks of hospitals which participate in the program. This also demonstrates the basic character of the changes made in committee. Now the bill refers to the local hospital participating in a cooperative program. We can explain to anyone what a hospital is by merely mentioning its name. Any citizen has a definite idea of how a hospital operates, what it looks like, what kind of people service it, and who runs it. The fight against heart, stroke and cancer will come to the local patient through the people he knows

and trusts and through an institution with which he is thoroughly familiar.

Sixth. This legislation provides for advisory councils at both the local and national level and in each case the council must recommend a program before it can be implemented or funded. Of these two, however, the council at the local level is by far the more important. First of all, its membership is important. It must include practicing physicians, medical center officials, hospital administrators, medical society representatives, voluntary health agency personnel, as well as people from other organizations concerned with the program. But even the best council will not guarantee a sound program if that program is set up before the council is organized and has a chance to act upon it. For this reason the bill provides that the advisory council must be organized and must pass upon the local program before it may be considered by the Surgeon General. This should guarantee that the plan worked out in a State will not be lopsided, concentrating too heavily upon one area of activity or placing too much authority or responsibility with any one institution.

One might also object to the spending of $340 million in this fashion. It is difficult to justify any certain amount in detail. Grants will depend upon the nature of the programs submitted for approval. Probably they would soak up any amount made available. The Debakey proposals suggested appropriations of over $1.4 billion. S. 596 provides for authorizations of $650 million. The authorizations contained in this bill are not small, although they do not loom large when considered in conjunction with all funds available to NIH. If the program outlined in H.R. 3140 is to go forward it is the best judgment of our committee that the authorizations set forth are about right.

I am proud of the fine work done by the Committee on Interstate and Foreign Commerce. The result of its deliberations can be accepted with confidence by the House. If it is decided that action is necessary now I recommend the passage of H.R. 3140.

Mr. HARRIS. Mr. Chairman, will the gentleman yield?

Mr. NELSEN. I yield to our distinguished chairman.

Mr. HARRIS. I mentioned a moment ago that among the things I would like to call to the attention of the House is the thoroughness with which we went into this program and developed information on these matters.

One of the things that I believe is very important is the fact that in March of 1964 the President set up a Commission which had as its Chairman the distinguished Dr. De Bakey, to whom the gentleman from Minnesota referred earlier. There were 28 members of the Commission, and on the Commission there were 14 well-selected doctors from points throughout the United States. They were men who are eminent in the field.

They included such eminent doctors with lifetime experience behind them as Dr. Mayo from the Mayo Clinic. Other famous doctors and surgeons were included.

We had people who specialized in the field of heart, cancer, and stroke, some of whom came and testified in a panel with Dr. De Bakey on this program.

I thought that the gentleman ought to have the benefit of that information. The Presidential Commission conducted hearings which lasted for about 9 months. The Commission heard 165 witnesses, if I remember correctly. They developed a tremendous volume of testimony, approximating 7,500 pages.

That famous, important, and highly specialized Commission of medical experts made its report in December 1964. It made specific recommendations; it also made general recommendations. Out of the recommendations of that Commission came the bill which I introduced as the administration bill submitted by the President. There was brought to us the original recommendation that we have for our purpose and objective today.

We conducted hearings which lasted a total of 8 days in July of this year. Many of those hearings ran from morning until late afternoon; then a number of days were devoted to consideration by the committee itself in executive session.

I thought probably we should make that history abundantly clear to those who will administer the program, as well as those who are to receive the benefit of it. I thought that, with the gentleman's permission, this information ought to be brought to the attention of the House.

Mr. NELSEN. I thank the chairman. After the original bill had been considered, the chairman did an outstanding job and the bill was much improved.

Mr. ROUDEBUSH. Mr. Chairman, will the gentleman yield?

Mr. NELSEN. I yield to the gentleman from Indiana.

Mr. ROUDEBUSH. I should like to ask the gentleman a question. I refer specifically to the Veterans' Administration hospital system. In the case where a Veterans' Administration hospital system has a teaching staff, assuming the organization furnishing the teaching staff—such as a State university—is participating in the program proposed by this legislation, would this program in any way modify the entrance or eligibility requirements for entering a Veterans' Hospital?

Mr. NELSEN. I do not believe so. If the gentleman will restate his question for the chairman, perhaps the chairman can respond.

Mr. ROUDEBUSH. I ask this question for the purpose of writing legislative history. I specifically direct my remarks to the Veterans' Administration hospital system throughout the United States. Let us assume a VA Hospital has a participating program, a teaching program where a State university or some other hospital may work with them in treating patients of the type covered by this bill. Would this legislation in any way modify the eligibility or entrance requirements to enter a veterans hospital?

Mr. HARRIS. No, sir; it would not at all.

Mr. ROUDEBUSH. In other words, the VA could use this program without modifying the rules and regulations pertaining to admission to Veterans' Administration Hospitals?

Mr. HARRIS. Yes, indeed. This would not conflict.

Mr. ROUDEBUSH. Would it modify the requirements of any private institution, such as a Masonic group or an Elk group?

Mr. HARRIS. No, sir; it would not. This is purely a voluntary program of cooperative arrangements with institutions in a given area.

Mr. ROUDEBUSH. I thank the gentleman for his answer.

Mr. HARVEY of Michigan. Mr. Chairman, will the gentleman yield?

Mr. NELSEN. I yield to the gentleman from Michigan.

(Mr. HARVEY of Michigan asked and was given permission to revise and extend his remarks.)

Mr. HARVEY of Michigan. I should like to ask the gentleman a question. As one who serves on the Committee on Interstate and Foreign Commerce I have been somewhat disturbed by the attitude of the officers of the American Medical Association in opposing this particular bill at this particular time. As the gentleman knows, I sit on this committee next to Dr. TIM LEE CARTER, who is himself a practicing physician, whom I respect highly and to whom I do not hesitate to look for guidance on this bill, as I did while we were conducting hearings.

I have before me page 19 from the Journal of the American Medical Association dated September 20, 1965, volume 193, No. 12. On this particular page the Medical Association discusses the bill we have before us. It discusses in detail the 20 changes which the American Medical Association suggested to the bill and which we on the committee readily adopted. Yet in conclusion this statement is made:

> While we cannot support H.R. 3140 as amended, because we believe it still introduces an undesirable concept, the amendments agreed to by the administration and now adopted by the House Committee on Interstate and Foreign Commerce certainly make the bill much less objectionable.

My question to the gentleman is: Does he know of any other amendments that were suggested to our committee, other than these 20 we adopted, suggested by the American Medical Association to make this a better bill? I sat through the hearings and listened intently. I, as one Member, know of no other suggestions which were made. I believe we adopted all that were suggested to make this a better bill.

I ask the gentleman if he knows of any others that were not adopted?

Mr. NELSEN. In response to the question, I know of no suggestions that were made to the committee. I will yield to our chairman for a further answer. I believe a representative of the AMA did consult with some of the staff people, and perhaps with the chairman, to try to arrive at some position relative to the

objections of the AMA. I hope the chairman will enlarge on that. It is my understanding that an agreement was largely reached on most of the points.

Mr. HARRIS. Mr. Chairman, will the gentleman yield?

Mr. NELSEN. I yield to the chairman.

Mr. HARRIS. Let me say to the gentleman as chairman of the committee I am indeed grateful for the valuable contribution made both by the gentleman from Michigan [Mr. HARVEY], and the gentleman from Minnesota [Mr. NELSEN], to this program.

I am glad the gentleman has brought up this subject matter. There were other amendments, of course, that were proposed, and they were very important amendments.

The American Heart Association, if my colleague will recall, did submit a document in which they included several amendments, some of them similar to some of the amendments that the American Medical Association proposed, and which were worked out in cooperation between myself and the HEW people so as to fit within the framework of this legislative proposal. There were certain other amendments that were proposed to us during the course of the hearings. As we considered this matter within the committee itself, several members of our committee offered amendments to the bill as we went along.

So I will say to the gentleman that there were a number of proposals from various sources. While we are talking about this, in view of the fact that the gentleman from Michigan brought up this bulletin of the AMA of September 2 and a news release by the AMA, if the gentleman will permit, I would like to call the attention of the Members to the fact that you will find the entire bulletin in the committee report at the bottom of page 7 and the top of page 8. I would like to read three sentences from this report. On page 8 of the report the bulletin contains this sentence:

Many of the changes are substantial and will allay many of the fears the medical profession had about the original bill.

To me that is a very significant statement, which refers to the 20 amendments to the bill that have been recommended by the AMA committee.

Also in the news release it is stated:

Dr. Appel said he told administration officials—

Relating to the conference I referred to earlier in the debate with the President and the HEW people—

Dr. Appel said he told administration officials that passage of the original bill would have been followed by a severe adverse reaction from the medical profession.

Most medical leaders felt that the establishment of the series of medical complexes initially conceived would have had a more serious long-term effect on medical practice than the recently enacted medicare law.

I referred to that earlier in debate. We met the problem by establishing a cooperative program, or rather emphasizing that this is a cooperative program.

Finally, here is what he says:

We feel we were successful in getting a number of major changes in the bill which will help to preserve the high quality of medical care and the freedom of hospitals and physicians.

So to me there is a recognition of the fact that the committee has worked in cooperation with those whom we know we must depend upon to make this program successful so as to try to meet their own recommendations and philosophy.

Mr. HARVEY of Michigan. Mr. Chairman, will the gentleman yield further?

Mr. NELSEN. I yield to the gentleman.

Mr. HARVEY of Michigan. Let me see if I can expand on that record. On page 8 of the report quoted by the chairman, which is taken from the same journal of the AMA here, it would indicate that the committee accepted, as Dr. Appel says, 20 amendments to the bill as recommended by the AMA. Now, by my count, I have some 22 amendments that we accepted. Could the chairman or a member of the staff tell me whether 20 or 22 is the correct figure?

Mr. HARRIS. Well, I would say to the gentleman I believe the correct estimate is there were probably 40 or 50 amendments which we considered, but some of them were similar. As a result, we did merge them within the bill itself.

Mr. HARVEY of Michigan. Mr. Chairman, I thank the gentleman. I want him to know that it has been a very great pleasure to the gentleman from Michigan to serve with him as chairman of this committee, and that I intend to support this legislation wholeheartedly.

Mr. HARRIS. I thank the gentleman and again compliment the gentleman from Michigan, the gentleman from Minnesota, and all members of the committee for the tremendous amount of work they have put into this legislative program in order to bring out something that this House, in my judgment, should unanimously accept.

Mr. ROGERS of Florida. Mr. Chairman, will the gentleman yield?

Mr. NELSEN. I yield to the gentleman.

Mr. ROGERS of Florida. Mr. Chairman, I want to say, too, as the chairman has stated very clearly I think, that the committee considered this legislation as carefully as any we have ever considered, to try to take in all viewpoints. And as has just been brought out in the very recent colloquy, the practicing physicians were definitely brought into consideration.

I know that I had physicians from my own area come to talk about this. We talked about this program and I think we have allayed their concern because, when the legislation came out of the Senate, I think there was the general feeling that this was going to be a program to build tremendous new complexes all over the country. This is not true. The committee wrote this into the bill that this would not be the case. Rather we are developing cooperative programs for continuing education to bring the latest methods to our local community hospitals. That is the thrust of this program as it comes out of our committee.

Further I think the doctors were concerned that Washington was going to say where these regional programs would go, and so the committee took that into consideration and we have made the legislation provide that it will be the local groups—and we have even provided that the local practicing physicians must be a part of this local group, to make the plan before it is put into being. It cannot be done in Washington. It has got to be done in the local areas. This is a very reassuring approach in this whole field.

I think, too, the local practicing physician that has to treat the patient all over this country was afraid that his patient was going to be taken to a great complex and then he would never know what happened to him, he would never have any more contact with his patient. To prevent that from ever happening, we have written into the legislation as a safeguard, in response to the physicians themselves, that every patient who can get any benefit from this program will have to be referred by his own physician. This assures the continuing patient-physician relationship that we have always known in this country.

Furthermore, to give greater assurance we have provided, as the chairman has stated, that there must be practicing physicians on the National Advisory Committee. Safeguards have been written by the committee to assure the practicing physician as well as the Congress itself that we have in this legislation an effective program to bring the latest methods to the community hospital for the benefit of the local physician to treat his patients in the local community.

I think it is an excellent program. I think you are going to see this program have real benefit in bringing the latest treatment in heart, cancer, and stroke to the average community all over this country so that people will not necessarily have to endure the expense of going to a big medical center, of which there may be only a few throughout the country, such as the De Bakey Heart Center or other such outstanding centers.

So, Mr. Chairman, I would urge strong support of this measure, and I am very certain it is going to bring about the great benefits that we can see even today.

I thank the gentleman for yielding.

Mr. NELSEN. Mr. Chairman, I would like to emphasize the point that has been made by my friend, the gentleman from Florida [Mr. ROGERS], that early in the hearings I believe the general practitioner felt a wee bit on the outside, probably because of lack of communication. But under the terms of this bill he will be made a part of that team, and that is emphasized in the language that presently is contained in the format of procedure under this bill.

Mr. Chairman, I reserve the balance of my time.

Mr. HARRIS. Mr. Chairman, I yield 1 minute to the gentleman from New York [Mr. TENZER].

(Mr. TENZER asked and was given permission to revise and extend his remarks.)

Mr. TENZER. Mr. Chairman, I rise to support H.R. 3140 and to congratulate the distinguished chairman, the gentle-

man from Arkansas [Mr. OREN HARRIS], who has for many years distinguished himself as the guardian of the Nation's health, for helping us take another giant step in that direction.

For many years before I came to the Congress I was identified with organizations engaged in support of your chairman's dedication to a fifth freedom for all Americans—freedom from illness, disease and disability. For more than 28 years I served as a voting member of the New York City Cancer Committee of the American Cancer Society. For 35 years I have been active in the Federation of Jewish Philanthropists in New York City, a volunteer agency supporting 116 institutions, including hospitals, homes for the aged, and institutions for the disabled and chronically ill. For 16 years I have been an officer and director, and for the past 9 years, president of the National Council to Combat Blindness—Fight for Sight. I am a director of the Chronic Disease Hospital of Brooklyn, one of the largest private institutions for the chronically ill in the United States. Because of these affiliations and others, I was motivated to introduce H.R. 9318, a companion bill to H.R. 3140, and to appear before your committee in support of this legislation.

In recent days, as in the past months and years, we have experienced the passing of dedicated public servants, important personalities, a close friend or neighbor, an associate, a member of the family—a victim of one of the Nation's three most devastating killers—cancer, heart disease, and stroke. Such incidents serve as a constant remainder that our struggle against premature death is the Nation's most urgent unfinished business. These three killers take a toll of 1,300,000 of the 1,700,000 Americans who die each year from diseases of all kinds.

This Nation, the richest and most powerful Nation in the world, blessed with citizens of great skill, ingenuity and capacity—capable of launching its Mariner IV into space to travel 133 million miles to photograph the surface of the planet Mars while it continues on its predetermined course.

This Nation, engaged in a war on poverty, a program which seeks to eradicate a condition experienced by a significant segment of the world's population from the time of creation to the present day.

This Nation with its deep sense of responsibility not only to the underfed, the underclothed, the underhoused, within its own borders but which has responded with great concern to the needs of the poor beyond its boundaries and throughout the world.

Such a Nation cannot and must not accept defeat in the war against the dreaded and devastating killers—cancer, heart disease, and stroke.

Health is a basic human right. Its enemy—disease—respects no geographical boundaries. It discriminates against no one, irrespective of political belief, social or economic status, race or religion.

Every program to protect the Nation's health merits the unqualified support of every citizen. Such efforts are not Government handout programs, they represent a businesslike investment in our most important national asset, our most valuable natural resource, the people of the United States. Every program for Federal aid to medical research, for the aid of the mentally ill and mentally retarded, for the training of doctors and nurses, for the building of medical colleges, hospitals and institutions for the care of those less fortunate than ourselves, represents a compassionate recognition of our fellow men.

The history and record of medical research is one which has paid off in great dividends in lives and dollars. In the last 20 years death rates from the following causes have shown significant percentage declines as a result of research:

	Percent
Polio	100
Tuberculosis	87
Influenza	88
Appendicitis	85
Acute rheumatic fever	90
Maternal deaths	85
Whooping cough	83
Syphillis	82

While significant achievements in the field of mental health have been made, there is still much to be done. Countless men and women have been returned to their homes, their families, their businesses—their usefulness to society restored.

Medical research is responsible for a decline in the death rate during this same period, during which 2½ million lives have been spared—actually this is the number of additional people who would have died if the 1944–45 death rate had prevailed through 1964–65. Included in these 2½ million lives are more than 1 million wage earners whose combined earnings are over $6 billion annually and on which the Federal Treasury receives in income, gift, and excise taxes an estimated $1 billion a year.

The marked advance in the science and technology of medicine and its principal byproduct—the Nation's health—resulted in increasing the life span from 49 years in 1900 to 60 years in 1937, and to 70 years in 1962—yet the late President Kennedy stated that "America's health remains unfinished business" and it is so regarded by President Johnson. In 1961 in the first of three annual health messages to Congress, President Kennedy stated:

The health of the American people must ever be safeguarded; it must ever be improved. As long as people are stricken by a disease which we have the ability to prevent, as long as people are chained by a disability which can be reversed, as long as needless death takes its toll, then American health will be unfinished business. It is to the unfinished business in health—which affects every person and home and community in this land—that we must now direct our best efforts.

This recognition of the urgency and seriousness of the problem of the Nation's health has ofttimes merited the recognition from those in high places. The drive to raise the standards of health in the United States through medical research will represent the most exciting stories in the pages of our history.

Federal aid and recognition of the problems of our Nation's health is not a new concept. In 1916, the Democratic platform adopted at the convention held in St. Louis, Mo., at which Woodrow Wilson was nominated for President contained the following lines:

We favor the establishment by the Federal Government of tuberculosis sanitariums for the need of tubercular patients.

President Truman said 9 years ago:

In this battle there is no room for political or professional rivalries In a war against disease we cannot tolerate false economy—we cannot tolerate timidity—we will not tolerate indifference.

In President Johnson's historic message to Congress on January 7, 1965, "Advancing the Nation's Health" the conclusion reads as follows:

I believe we have come to a rare moment of opportunity and challenge in the evolution of our society. In the message I have presented to you—and in other messages I shall be sending—my purpose is to outline the attainable horizons of a greater society which a confident and prudent people can begin to build for the future.

Whatever we aspire to do together, our success in those enterprises—and our enjoyment of the fruits that result—will rest finally upon the health of our people. We cannot and will not overcome all the barriers—or surmont all the obstacles—in one effort, no matter how intensive. But in all the sectors I have mentioned we are already behind our capacity and our potential. Further delay will only compound our problems and deny our people the health and happiness that could be theirs.

The 88th Congress wrote a proud and significant record of accomplishments in the field of health legislation. I have every confidence that this Congress will write an even finer record that will be remembered with honor by generations of Americans to come.

On May 25, 1964, I had the privilege of appearing at the public hearing held by the State Delegation Platform Committee at the Garden City Hotel, at which time I proposed that the Democratic national platform include a statement in support of legislation designed for an all-out attack on the three biggest national killers—cancer—heart disease—and stroke—and for increased support for medical research to guarantee to every American citizen a fifth freedom—freedom from illness, disease and disability.

Accordingly, Mr. Chairman, I was pleased beyond my poor ability to express, when the President of the United States on January 7, 1965, sent to the Congress of the United States his health message, which included a specific recommendation for legislation authorizing a 5 year program for grants to develop multipurpose regional medical complexes for an all-out attack on heart disease, cancer, stroke and other major diseases.

The legislation which this distinguished committee is now considering provides for the establishment of regional medical centers—affiliated with medical schools and teaching hospitals—to ensure the most advanced diagnosis and treatment for patients, as well as accelerated research and development of training skills. Proper health care depends upon the availability and accessibility of modern, conveniently located,

well organized and supervised medical facilities and services.

This legislation authorizes appropriations of $340 million over a period of 3 years—a sum of less than $1.75 for every American man, woman and child to start this program of education, research, training, and demonstrations in the fields of heart disease, cancer, stroke, and related diseases.

Mr. Chairman, I urge my colleagues to join in support of this legislation.

Mr. HARRIS. Mr. Chairman, I yield such time as he may consume to the gentleman from Wyoming [Mr. RONCALIO].

(Mr. RONCALIO asked and was given permission to revise and extend his remarks.)

Mr. RONCALIO. I thank the distinguished chairman of the Committee on Interstate and Foreign Commerce for yielding.

Mr. Chairman, I wish to associate myself with the statement of the gentleman from Minnesota; I concur with the expressions of the gentleman from Florida [Mr. ROGERS], and I am particularly grateful to the full committee chairman for having produced in several months of deliberations what at first appeared to be the work of an entire winter, in consideration of the 20 amendments which have been added to this original bill.

Mr. Chairman, I am one of the Members of the House who also met with the physicians and citizens of my district. Throughout Wyoming I found the doctors deeply concerned with the original provisions of this bill and I now find them relieved, and several have expressed some gratitude that this bill has been so amended by the full committee. It is now much more palatable to the members of the medical profession in my State, if not admittedly acceptable to the Wyoming Medical Association. It was in the hope that these amendments would be adopted that I had originally requested that this bill be allowed to remain in committee until the 2d session of this 89th Congress.

Mr. Chairman, I do hope the President of the United States will be pleased with this bill; I hope he can appreciate the tremendous work that has gone into it and I hope he will accept it as a capstone of an unprecedented first session of a Congress whose Members now feel that we ought to adjourn and go home.

Mr. HARRIS. Mr. Chairman, I yield myself 1 minute.

Mr. Chairman, I wish to thank the gentleman from Wyoming as well as the gentleman from New York for their generous compliments and their fine statements on this legislative program.

Mr. Chairman, I believe I can say, without fear of contradiction, that the President would be very happy to have this bill as it has been reported by the committee and as we are considering it here in the Committee of the Whole House on the State of the Union today.

Mr. Chairman, I yield 1 minute to the gentleman from New York [Mr. FARBSTEIN].

(Mr. FARBSTEIN asked and was given permission to revise and extend his remarks.)

Mr. FARBSTEIN. Mr. Chairman, I want to congratulate the committee and say that I am in wholehearted support of this bill.

Mr. Chairman, in reading on page 8 of the report, I see a statement from the American Medical Association, as contained in its letter, to the effect that it says this bill introduces an undesirable concept.

Mr. Chairman, of course, I look with a jaundiced eye myself as to any position taken by the American Medical Association. So I cannot understand wherein, despite the fact so many amendments of their were accepted, the American Medical Association still expresses some doubts about this legislation. This is what I cannot understand, and I believe I shall never be able to understand the ideas, the views and the concepts of the American Medical Association.

Nevertheless, as I understand the bill, it certainly represents a great step forward.

Mr. Chairman, I wish to compliment the committee for its efforts and I support the legislation.

I am certain it will pass unanimously.

Mr. HARRIS. Mr. Chairman, I yield myself 5 minutes.

Mr. Chairman, in view of the fact there has been so much discussion over the amendments which were proposed by the American Medical Association and accepted by the committee, I might explain further that many of these amendments were also recommended by other groups and organizations, such as the American Heart Association, and other well-known organizations in this country.

I want to make it abundantly clear that even though we did work out this bill with these innumerable amendments referred to, we did not by doing so in any way adversely affect or jeopardize what was originally intended as the objectives of this legislation. I want to make it abundantly clear that in our judgment the committee improved the legislative program to accomplish what was sought. I think we should keep this in mind. We did not at any time accept any amendment that would take anything from the bill in order to accomplish what we sought to accomplish as a legislative program.

Mr. ROGERS of Florida. Mr. Chairman, will the gentleman yield?

Mr. HARRIS. I yield to the gentleman from Florida.

(Mr. ROGERS of Florida asked and was given permission to revise and extend his remarks.)

Mr. ROGERS of Florida. Mr. Chairman, I would like to back up the chairman in the statement he has just made. It is absolutely correct. I want to say also I feel that the chairman did a magnificent job in bringing this legislation to its present point before the House today because, as has been mentioned, this legislation came to us with great controversy. I do not know of anyone in the House of Representatives who has exhibited more skill in bringing about the adverse parties to a consensus of what should be done and what has been approved by our committee than our chairman, and I want to compliment him.

I am sure all of the committee will agree with me, when I say he did a magnificent job in making this piece of legislation an effective piece of legislation, in conformity with what was originally intended to help solve the problems of heart, cancer, and stroke.

Mr. HARRIS. I thank the gentleman, and I compliment him highly for the valuable contribution he has made to this program.

Mr. ROGERS of Florida. Mr. Chairman, in support of this important legislation, the Heart Disease, Cancer, and Stroke Amendments of 1965, we are called upon to consider many vital issues, but it is difficult to imagine any problem which is more deserving of our best efforts than the scourges of heart disease, cancer, and stroke. Medical experts estimate that more than 70 percent of all deaths in this country are attributable to these diseases, and in 1963 these three diseases claimed more than 1.2 million American lives. Certainly we can agree that the victims of these ailments should be assured of the benefits of the latest advances in medical science.

In recognition of the magnitude of this problem, the President appointed a Commission on Heart Disease, Cancer, and Stroke to recommend steps to reduce the incidence of these diseases through new knowledge and more complete utilization of the medical knowledge already in existence. That Commission, which included many eminent medical experts in the fields of heart disease, cancer, and stroke, issued its report last December, and the bill which we are considering today is intended to meet some of the needs cited by the Commission. The essential finding of the Commission was that many lives could be saved and much suffering could be prevented if the most advanced knowledge already in existence concerning the diagnosis and treatment of these diseases could be applied more widely. The Commission report also held out the hope that the extensive medical research activities now underway would be the basis of continued progress in the development of improved means of diagnosing and curing these dread diseases, and that the need to transmit these advances to the benefit of patients called for additional efforts by our medical institutions and personnel. The purpose of this legislation is to meet these needs in providing opportunities to make available to more patients the latest advances in the diagnosis and treatment of heart disease, cancer, and stroke. The proposed program is a natural outgrowth of the great medical research effort of this Nation which has been stimulated over the years by the actions of this Congress. This program should assist significantly in the final payoff of these research activities.

This legislation will carry out these purposes by providing support for cooperative arrangements which would link medical schools, clinical research centers, and community hospitals in regional medical programs providing for research, training, and for related demonstrations of patient care in the fields of heart disease, cancer, stroke, and related diseases

These regional programs will provide a setting for improved means of continuing education for practicing physicians in advanced diagnostic and treatment techniques. The program will make more widely available the trained teams of medical personnel and the specialized equipment to assist the practicing physician in applying these advanced techniques. Patient referrals will be facilitated in order to provide access to the specialized techniques necessary for a particular case. Interchange of personnel between community hospitals, medical schools, and other medical centers will be encouraged. These activities will provide assurances that a close relationship is established between the community hospital and its related practicing physicians and the medical schools and other medical centers where advanced diagnostic and treatment techniques are being developed and perfected through clinical research and teaching activities.

There can be little argument with the objectives of this legislation; however, our committee felt that the means of carrying out these objectives deserved the most careful consideration. We recognized the already great accomplishments of American medicine, and we wanted to be able to assure our colleagues that the legislation which we presented to you would not in any way jeopardize the medical system of this country which is already the envy of the world. We held extensive hearings on this bill and heard testimony from many leading medical experts, representatives of medical schools and practicing physicians. We heard a number of objections and fears expressed about the possible impact of this proposed program on the practice of medicine. My colleagues on the committee and I were determined to examine this bill closely and to make the necessary modifications to allay these fears and objections. I want to express to you my personal belief that the bill which we bring before you today has been carefully modified as the result of our deliberations and is a much sounder piece of legislation.

I want to specifically mention a number of the changes which the committee made in the bill. It was clear to us in our consideration of this proposal that the success of this program depended upon the active participation of practicing physicians who are the first line in our battle against disease. We wanted to emphasize in this legislation the need to involve the practicing physician. The bill already provided that a local advisory group be designated to assist in the planning and operation of a regional medical program. We added the requirement that this group must include practicing physicians and representatives from appropriate medical societies, as well as representatives of medical institutions and agencies. We also added to the bill the requirement that an application for a grant under this program must be approved by this local advisory group. We specified that the National Advisory Council established under this legislation must contain at least two practicing physicians, and we added the requirement that the National Advisory Council must approve all applications before a grant can be awarded by the Surgeon General.

The committee also amended the bill to specify that patients provided care under this program shall have been referred by a practicing physician. We added a provision which requires the Surgeon General to publish a list of facilities which provide the most advanced methods and techniques in the diagnosis and treatment of these diseases and to make such list available to licensed practitioners. We also made a number of changes in the bill which emphasize the cooperative nature of these regional medical programs.

Your committee also acted to correct some of the misunderstandings concerning the purposes and objectives of this legislation. The title of these regional programs was changed to correct the misunderstanding that this program provided for the construction of a large number of new medical facilities that would compete with existing institutions and personnel. To further clarify the emphasis of the program, we eliminated from the bill the provision authorizing the construction of new facilities. It was our belief that the initial emphasis of this program should be on the provision of assistance to existing institutions, and that the program could be implemented through the utilization of presently existing facilities or through the use of existing construction authorities.

We amended the bill to sharpen the focus of these programs on the three major diseases which were the initial basis of the justification of this proposal. We made changes which clarified the importance of training and continuing education in the effectiveness of this program. The testimony which we received emphasized the importance of these educational activities in carrying out the objectives of the bill. We also changed the bill to make sure that research activities related to these programs would involve the application of the advances of science to the problems of patient care. To further delineate the program and to emphasize the involvement of existing institutions, we eliminated the provision for diagonostic and treatment stations and specified that the regional programs would include hospitals.

Finally, in order to insure an orderly development of this program, the committee has amended the bill to provide grants for planning, feasibility studies, and pilot projects, and we have limited the authorization to 3 years and have provided specific appropriation ceilings for each of the 3 years. We believe that these amendments provide a sound basis on which to proceed with the development of the program. The experience gained from the regional medical programs planned and established in these 3 years will provide solid grounds for reevaluating the program at the end of the 3-year authorization. During these years, extensive experience should be developed in implementing this program in a number of different areas of the country. The committee intends to watch these developments very carefully.

I want to thank the representatives of the medical societies of my own district for their counsel and advice. I also want to thank representatives of the Department of Health, Education, and Welfare, especially Under Secretary Wilbur J. Cohen and Dr. Edward W. Dempsey for their assistance during the remolding of this legislation. They met with the representatives of the American Medical Association and discussed the legislation and various modifications at length. They were firm in their convictions and articulate in supporting their views on this important program. However, when those of us on the committee requested technical assistance in shaping amendments the full competence of these men and their staffs was used to make those amendments meaningful and effective.

I believe that this bill, as amended in committee, is a splendid indication of the constructive results which can be achieved when the medical profession is willing to consult and work with Government in a productive manner.

I am convinced that the bill that we are considering today is a better bill because of that cooperation. It provides for a substantial beginning in seeking to accomplish these worthy objectives, but it emphasizes the need to proceed carefully and to evaluate this major new effort in our battle against disease. It is my pleasure to urge the passage of this legislation.

Mr. CUNNINGHAM. Mr. Chairman, will the gentleman yield?

Mr. HARRIS. I yield to the gentleman from Nebraska.

Mr. CUNNINGHAM. I am sure there is not a Member of this body who does not want to do all he can in the field of heart, cancer, and stroke. Certainly I do. I know this committee, of which I am a member, worked very hard on this legislation. That was brought out in the testimony.

I would like to ask the gentleman whether or not there might be a severe shortage of research people who would be needed to carry out this program? I am wondering if it can be met adequately so that if the program is enacted into law we will have capable people in this field, and it will not take away from the other research institutions that are conducting work in this area?

Mr. HARRIS. The gentleman is correct. We did have the question of manpower raised during the course of the hearings and during our consideration of the program. We feel the authorization which we have provided will cause additional manpower to be trained to carry out these programs without interfering with the manpower needs in other fields of health, and in the medical profession, We feel that we have met that situation.

Mr. CUNNINGHAM. Would the gentleman say that it is going to be a problem to get this additional manpower; that it will take a little time?

Mr. HARRIS. It is always a problem to obtain manpower because you have to train them. That is why we provide in this legislation a training program for people who are to be trained in the medical profession and in the medical schools themselves.

In that way we think we can increase the manpower available and at the same

give valuable educational training those who are preparing themselves for this particular field.

Mr. CUNNINGHAM. I thank the gentleman.

Mr. NELSEN. Mr. Chairman, I yield the gentleman from Kansas [Mr. SKUBITZ] 2 minutes.

Mr. SKUBITZ. I would like to ask the chairman of the committee, the gentleman from Arkansas [Mr. HARRIS] a question. Did I understand the gentleman to say that there would be eight regional medical programs started in the first year under this program?

Mr. HARRIS. Mr. Chairman, will the gentleman yield?

Mr. SKUBITZ. I yield to the gentleman.

Mr. HARRIS. It is believed from the record we have made that adequate planning can be accomplished for recommendations to be made to the National Advisory Council for approximately eight of these pilot plant operations during this fiscal year. We therefore provided the authorization in the hope that that will be accomplished.

Mr. SKUBITZ. On page 10 of the committee report, it states:

> The committee has been informed that there are eight programs in the United States already in the planning stage which are well enough worked out so that it will be feasible to start these programs within the fairly near future.

Will the chairman please tell us in what States these eight programs are located?

Mr. HARRIS. I will say to the distinguished gentleman from Kansas, from the hearings and the information developed for the record, it was indicated that sufficient planning and consideration has been given to indicate the possibility of establishing such programs in the States of North Carolina, Virginia, Ohio, Vermont, Iowa, Missouri, and Wisconsin.

Mr. SKUBITZ. I thank the gentleman.

Mr. NELSEN. Mr. Chairman, I yield 5 minutes to the gentleman from Massachusetts [Mr. KEITH].

Mr. KEITH. Mr. Chairman, I rise in support of this legislation. I would like the record to indicate the part that was played by the Massachusetts Medical Society and in particular by its representative, Dr. Robert Browning, of the town of Plymouth, our Nation's first community.

When Dr. Browning first contacted me about this legislation, he was very much concerned with the fact that it authorized new construction of regional medical complexes which conceivably could be imposed upon the existing medical facilities of Greater Boston. In Boston, as most of you know, we have already a most outstanding medical profession which is already furnishing extraordinarily fine service in the field of heart, stroke, and cancer as well as in other diseases.

They were concerned that rival facilities would be established in which fees could be more modest because the facilities would be federally supported, and they could have an adverse effect upon the medical services that were already in existence.

They came down here and presented their case to me and in turn to the committee. I believe that in large measure their observations have been helpful in the committee's efforts to avoid the kind of problem that could have been created had we not amended the original proposal.

It is my recollection that the De Bakey Commission recommended the appropriation of about $1.4 million and it authorized, or would have authorized, the creation of brandnew facilities that could have been separate and distinct and, in fact, a rival to existing facilities.

The Senate cut the appropriation down to slightly more than $600 million, but still authorized the construction of new complexes.

Your committee, further examining this proposal, has eliminated new construction and has cut the amount of money down to what we believe is reasonable and adequate to do the job. Your committee recognized the need to coordinate existing programs, and have recognized particularly the role of local medical societies and other responsible local authorities in contributing to the planning, development, and operation of the facilities that would be developed around the existing medical plants.

I think perhaps one of our greatest contributions is in setting up an advisory group at the local level, which has to be in on the planning phase as well as in the operational phase. This advisory group will include practicing physicians, medical center officials, hospital administrators, representatives from appropriate medical societies, voluntary health agencies, and representatives from other organizations, institutions, and agencies concerned with activities of the kind to be carried on under the program.

There was an absence of such qualifications among those who initially studied the problem. I believe that the absence from that commission of those who had experience at the local level caused some difficulty and concern on the part of State and local medical societies. I believe that, once they become acquainted with the program which we have outlined in this legislation, they should be satisfied and pleased with the efforts of the committee.

(Mr. KEITH asked and was given permission to revise and extend his remarks.)

Mr. NELSEN. Mr. Chairman, I yield 2 minutes to the gentleman from Kansas [Mr. DOLE].

Mr. DOLE. Mr. Chairman, I take this time to pursue what my colleague from Kansas was discussing with the distinguished chairman, and that is with reference to the number of projects that may be initiated the first year. On page 10 of the report, I understand there is an indication there will be sufficient funds available for a total of eight programs the first year. Does any member of the committee have any idea or estimate as to how many programs might be in operation by the end of the third year of this bill?

Mr. HARRIS. Yes. As was previously pointed out during debate, a 3-year authorization for approximately 25 programs was made. I also state, for the gentleman's information, that these are supposed to be pilot projects in order to demonstrate throughout the country, as much as possible, what can be done, so that similar programs will be encouraged.

The administration originally requested about 32. After consideration by the committee, and after hearings, the committee felt this would accomplish the purposes sought in this program.

Mr. DOLE. I also understand there is a provision which would permit some construction in this bill. Could you explain this?

Mr. HARRIS. Yes. That is what we are trying to do. We want to make a distinction between what would be considered new construction and alterations or modifications, remodeling, and so forth.

As an example, an existing facility might need a new wing. Under this authorization the new wing, or whatever the addition might be, for the support of this kind of program—training, demonstrations, and so forth—could be a part of the construction program.

The gentleman from Texas [Mr. PICKLE] has suggested an expansion of the definition of "construction" which would permit, as an example, a hospital which wished to add two complete new floors to the existing facility to add these floors with aid under this legislation. As I see it, that would come in the category of new construction.

If the facility is a medical school, construction could be proceeded with under the program we provided recently for construction and expansion of medical schools. If it is a research center it would come under the construction program we recently provided for research facilities. If it were a hospital, it would come under the Hill-Burton program, as we refer to it. I appreciate the fact that my name recently has been tagged on to that, for whatever that may mean to the program. Construction could be obtained under that program to take care of the kind of expansion, for a new construction program, as proposed.

The CHAIRMAN. The time of the gentleman from Kansas has expired.

Mr. HARRIS. Mr. Chairman, I yield the gentleman 2 additional minutes, so that we may thrash this out.

What we are trying to do is to assure the medical profession and those involved in these programs throughout the country that we do not have any intention of going into a complete new complex idea, of which they were fearful. We would limit it to expansion and alteration and modification and so forth to meet the needs of the program.

Mr. PICKLE. Mr. Chairman, will the gentleman yield?

Mr. DOLE. I yield to the gentleman from Texas.

Mr. PICKLE. With reference to the expansion situation the gentleman from Arkansas mentioned, the situation I had in mind is not new construction in the general sense. As a member of the com-

ittee, I agree that on committee we greed not to get into that field. I believe we should not.

The situation I make reference to is one in which there is a research facility being built now which is in the field of research for cancer alone. I do not envision or make reference to a situation in which there is new hospital construction. Under the term "construction," under both the Hill-Burton Act and the Public Health Service Act, I recognize that generally speaking "expansion" would be covered.

I am hopeful there might be an interpretation of the word "expansion" that the situation I mentioned might be included.

Mr. HARRIS. Mr. Chairman, if the gentleman will yield, I would say in that regard, in order to make the legislative history, if that does not come within the purview of the Research Facilities Act, which we recently extended, and in no way interferes with or attempts to duplicate that program, but comes within the purview of this regional concept cooperative arrangement, then the addition would come under the concept of alteration and modification, for this purpose.

Mr. NELSEN. Mr. Chairman, I yield 5 minutes or as much time as he may desire to the gentleman from Iowa [Mr. GROSS].

(Mr. GROSS asked and was given permission to revise and extend his remarks.)

Mr. GROSS. Mr. Chairman, as one who lost both parents by the ravages of cancer, I certainly have a great interest in the subject of cancer, its origin, its cure, and so on and so forth. I am not necessarily opposed to this bill, but I wish the report had contained some figures as to the amounts of money presently being expended through various programs in projects and research with respect to cancer and heart afflictions. I regret that the report gives no evidence of the hundreds of millions of dollars presently being expended for this purpose. Was this information developed in your hearings on this pending bill?

Mr. HARRIS. Mr. Chairman, will the gentleman yield?

Mr. GROSS. Yes. I am glad to yield.

Mr. HARRIS. This question was brought up during the course of the hearings, and I believe that the gentleman from Nebraska raised the question within the committee. We do have an estimate that I would say is as nearly correct as is possible. I think you will find that in the hearings on pages 52, 53, and 54. I think that will give the gentleman some idea about the extent of the program on the part of the Federal Government in this field. Now, insofar as the total amount of funds being expended in this country is concerned, when you take into account the philanthropic organizational programs, the National Cancer Institute, and the various regional, private, and local programs that are giving a lot of study and spending a lot of money for this particular dreaded killer, I think it would be impossible to say just how much the people of the United States are giving to this problem at this time. However, it is a terrific amount, which shows just how hard we are trying to meet the problem in order to do something about it.

Mr. GROSS. Of course, there is such a thing as overfunding programs. I want them to have all of the money that can properly be used for this purpose, but here we are expending another $340 million over a period of 3 years. This is no small amount of money, and there is no indication that this will be the extent of the expenditure. I would have no quarrel with this if I could believe that we were not, through this new program, today initiating duplicating research and other studies that are already being carried on. I am sure the Committee on Appropriations with respect to the Department of Health, Education, and Welfare has been more than liberal in the granting of funds for this and other purposes. This is my deep concern with this matter here today.

Mr. HARRIS. Mr. Chairman, will the gentleman yield further?

Mr. GROSS. Yes. I am glad to yield.

Mr. HARRIS. I want to thank the gentleman for bringing this important point to the attention of the House.

For about 17 years we have been appropriating large sums of money for research. A great deal has been accomplished thereby. We have had many breakthroughs. This program is to meet a gap that exists in order that the results of this research effort will be made available to the people throughout the country.

The gentleman is very familiar with the program in his own State. The gentleman may take pride in the fact that in Iowa they started one of these very programs away back in 1915.

The CHAIRMAN. The time of the gentleman from Iowa [Mr. GROSS] has expired.

Mr. HARRIS. Mr. Chairman, I yield the gentleman 5 additional minutes.

Mr. GROSS. I thank the gentleman.

Mr. HARRIS. Away back in 1915 you started the nucleus of a program in the State of Iowa that has developed over these 50 years into the kind of a cooperative arrangement that we hope will be made applicable to other areas of this great country of ours.

I could name many people, as I am sure the gentleman could—in fact, one of our most beloved and distinguished colleagues had the benefit of this great institution in Iowa and, thank God, he is still with us even today. But I know and I know other Members know that from these 50 years of effort in the gentleman's own State there are many thousands of people in this country who have received the benefits of this program, of which I know the gentleman is proud, that has come from his own people.

Mr. GROSS. I am well aware of the program in Iowa and of the work that has been done. Of course, it was done without this program. That is not to say that I do not believe that program based upon the achievements in Iowa and elsewhere would not be good for the rest of the country. I am not saying that at all. But I do not want to see duplication where duplication can be avoided. Your own report recognizes that there can be duplication. This I do not want to see because we desperately need to conserve the financial resources of this country.

Mr. DINGELL. Mr. Chairman, will the gentleman yield?

Mr. GROSS. I yield.

Mr. DINGELL. Mr. Chairman, I want to commend the gentleman from Iowa for raising this question. I want to assure him that this is one of the questions that very much concerned me during the consideration of this legislation in the committee. But I would like to say, as has the chairman of the committee, that we went through this very carefully to assure the membership of the committee that this will not duplicate existing programs—that is attested to by the fact that the bill came out with the strong support of the membership of the committee, which was well satisfied that this will not represent duplication of existing programs.

I should like to point to programs like Hill-Burton. There is abundant need for more hospital construction than we are able to fund under Hill-Burton.

With regard to the research programs I thoroughly agree with the gentleman. These are well funded both in the public and the private sector. I would point out to my good friend that it is not the intention of the committee that we shall duplicate research or that this will actually be a research program. It is not going to be. It is going to be a program to disseminate information, to assist the members of the medical profession to obtain the fruits of research most readily available to them, to have the new devices readily available to them, to have the new methods and the new machines and the new laboratory facilities available to them on a regional basis for the treatment and care of their patients.

For example, the gentleman mentioned the misfortune that his family had with cancer. I have had in my family a similar misfortune.

I would point out that this will make available facilities for new devices and new methods for identifying cancer at an early date so we can stave it off, new devices for the treatment of heart, stroke and similar conditions that afflict human beings, so that these will be readily available to members of the medical profession.

Mr. Chairman, I would point out to the gentleman that the AMA had grave reservations about this legislation earlier but, by and large, we have accepted the comments and recommendations of the AMA and have adopted amendments suggested by them to assure that we will not intrude into the practice of medicine and will not engage in unwholesome and unwise legislating in this field.

I share the concern of the gentleman from Iowa.

Mr. GROSS. I thank the gentleman for his comment.

It is my hope—and unfortunately we are losing the chairman of this committee, Mr. HARRIS, at the end of the year and I regret seeing him go—it is my hope that whoever succeeds him will watch closely the expenditure of these funds

in order that there be no duplication in funding for this program.

The CHAIRMAN. The time of the gentleman from Iowa has again expired.

Mr. NELSEN. Mr. Chairman, I yield the gentleman 2 additional minutes.

Mr. HARVEY of Indiana. Mr. Chairman, will the gentleman yield?

Mr. GROSS. I yield to the gentleman from Indiana.

Mr. HARVEY of Indiana. Mr. Chairman, I am interested to know what will be the application of the provisions of this act, assuming it is enacted, and what the impact will be upon an institution like the great Mayo Clinic, for example. I know that Dr. Charles Mayo is on the Advisory Commission. But I still wonder, because a great many people from my community, when they are confronted with a real health hazard or problem, the first thing about which they think is going to Mayo's.

I just wonder what will be the impact upon a great institution of this kind if this legislation is enacted.

Mr. GROSS. I would say to the gentleman from Indiana, if he is addressing the question to me, that I am unable to answer it.

I would like to inquire, very briefly, of the chairman of the committee concerning President Johnson's Commission on Heard Disease, Cancer, and Stroke.

Am I correctly informed that individual members of this Commission hold contracts, Government contracts, for research?

Mr. HARRIS. Mr. Chairman, if the gentleman will yield, there are some who have their own clinics associated with the existing programs. There are some associated with existing institutions, which institutions have some contracts for certain research projects; yes.

Mr. GROSS. Well, now, does the gentleman think that this is proper? Does the gentleman not believe that under these circumstances there can exist a substantial conflict of interest, when members of a Government commission, recommending a $340 million program of this kind, themselves hold contracts, research contracts, involving perhaps $1 million or more each? This has the elements of lucrative self-perpetuation.

Does the gentleman think that this is a healthy situation?

Mr. HARRIS. Well, in the first place, if the gentleman will permit——

Mr. GROSS. Yes, of course.

Mr. HARRIS. I do not believe the President would have appointed either one of these eminent gentlemen in this field had there been any inclination or indication that there was any conflict of interest.

I do not think there is any conflict of interest involved whatsoever because this is an entirely different program, and neither of these gentlemen have anything to do with any existing projects on research at any particular location of either one of these so-called regional programs.

Mr. GROSS. I can only add that I do not think it is proper that members of a Federal commission, charged with the formulation of a program involving the expenditure of millions of dollars, should themselves hold Federal contracts of any kind. Certainly they should hold no contracts related in any way to the subject matter of this bill and the fields it is designed to cover.

Mr. NELSEN. Mr. Chairman, I yield myself 1 minute.

Mr. Chairman, in answer to the question asked by the gentleman relative to whether or not this would affect, for example, the Mayo Clinic, the answer, I think, is emphatically "No." It would not in any way damage the operation at Rochester. Actually, they would become a part of the plan for further development to extend to the country some of the research and clinical application research that they are presently employed in there.

Mr. HARVEY of Indiana. I thank the gentleman for his response.

Mr. HARRIS. Mr. Chairman, I yield such time as he may desire to the gentleman from Pennsylvania [Mr. RHODES].

Mr. RHODES of Pennsylvania. Mr. Chairman, I support this meritorious legislation and wish to commend the distinguished gentleman from Arkansas [Mr. HARRIS] and his committee for bringing H.R. 3140 to the House floor.

As a former member of the Committee on Interstate and Foreign Commerce and a member of the Health and Safety Subcommittee, I had the opportunity to participate in the study of the problem which this legislation seeks to meet.

I recall the testimony a few years ago by health specialists who told our subcommittee that many thousands of people die each year of cancer in this country who could live many more years if we could make use of the information and know-how we already have and if necessary facilities to help these people were available.

This is also true of heart disease which annually kills thousands of citizens whose lives could be lengthened.

According to public health specialists, thousands are being crippled for life every year by strokes who need not be crippled if we could apply present know-how and provide needed facilities to meet the problem.

Many citizens are receiving benefits of our medical research programs, but many still go to early graves and suffer crippling strokes.

This legislation for community health centers, facilities and personnel will bridge the gap between research and application of our know-how.

It is a good investment in the health of our citizens and a valuable contribution in seeking the cause and cure of crippling and killing diseases.

The bill deserves unanimous support of the Congress.

(Mr. RHODES of Pennsylvania asked and was given permission to revise and extend his remarks.)

Mr. HARRIS. Mr. Chairman, I yield such time as he may desire to the gentleman from Georgia [Mr. MACKAY].

Mr. MACKAY. Mr. Chairman, I take great pleasure in joining my distinguished colleagues in recommending for passage H.R. 3140, as amended by the House Committee on Interstate and Foreign Commerce.

I am particularly pleased with the substantial changes in the introduced bill which have been made by the committee to define the scope of the program more precisely and to clarify its intent. These amendments guarantee that the legislation will accomplish its purposes without interfering with present patterns of patient care and professional practice. Our medical care is among the best in the world. Our physicians have made tremendous contributions to the well-being of our citizens. It would indeed be foolish for the Congress to attempt to impose on our medical scientists or practitioners any program which, in any way, would attempt to restrict or direct from Washington their activities to promote the health of Americans, young and old.

The local nature of the program authorized under the proposed legislation is clearly stressed. Its primary thrust is to facilitate arrangements among existing institutions. No large Federal facilities, staffed by Federal employees, will be constructed throughout the country according to a master plan developed in Washington. Instead, local community hospitals and practicing physicians will be linked, at their request, with medical schools and affiliated teaching hospitals. These cooperative arrangements will enable the family doctor to put within reach of each of his patients the latest advances in diagnosing and treating disease.

The committee has taken great care to spell out ways by which local control of the programs conducted under the proposed bill is assured. Their concern is most evident in the designation of advisory groups on the local level which must approve any grant application before it can be acted upon by the National Advisory Council and the Surgeon General. The bill states that these local advisory groups must include practicing physicians, medical center officials, hospital administrators, representatives from appropriate medical societies, voluntary health agencies and other organizations concerned with the program.

It is intended that there will be careful planning before a program is approved in any area. The planning, the conduct of feasibility studies, and the operation of pilot projects will all be carried out by local participating institutions and professional organizations. It is anticipated that projects to be undertaken will be quite varied, depending upon the region of the country and the nature of existing facilities. Even when a regional medical program has been funded under this legislation, planning will continue in the area which it serves. In this manner, those closest to a program will be able to modify or expand arrangements in order to meet changing problems in local communities.

The bill further specifies that patients provided care under the regional medical programs must be referred by a practicing physician. I am told that this is a customary arrangement at research institutions such as the Clinical Center at the National Institutes of Health. Thus, in the words of the committee report:

Except in the case of those patients who, after referral to a facility, receive care incident to research, training, or demonstra-

ns, the legislation will have no effect one or the other upon the patterns, or methods of financing, of patient care.

It is my understanding, Mr. Chairman, that there are already in existence a number of programs similar to those proposed under this bill. My distinguished colleagues from Maine and other New England States could tell us of the Bingham Associates program begun in 1931. Others could describe imaginative cooperative medical research, education, and service programs in such States as New York, Wisconsin, and Iowa.

In every instance the development of these cooperative programs has enhanced the quality and quantity of medical care available to all patients in the communities within reach. Such development has not interfered with the practice of medicine in these localities other than to attract physicians to them. For alert, forward-looking practitioners cannot help but be drawn by the opportunities such programs provide for continuing education, specialized training, and supportive services.

Mr. Chairman, I am convinced that this bill, as amended, is designed to strengthen the Nation's health resources, to make the best use of the resources we now have, and to assist the doctor in the care of his patient. I urge its adoption.

(Mr. MACKAY asked and was given permission to revise and extend his remarks.)

(Mr. HARRIS asked and was given permission to revise and extend his remarks made previously during general debate.)

Mr. HARRIS. Mr. Chairman, I ask unanimous consent that all Members who desire to do so may extend their remarks at this point in the RECORD on the pending legislation.

The CHAIRMAN. Is there objection to the request of the gentleman from Arkansas?

There was no objection.

Mr. DINGELL. Mr. Chairman, I am pleased to speak in behalf of H.R. 3140, a bill to amend the Public Health Service Act to assist in combating heart disease, cancer, stroke, and related diseases through a program of grants. The principal purpose of the bill is to provide for the establishment of locally administered programs of cooperation between medical schools, clinical research institutions, and hospitals. It is hoped that through these programs research may be advanced, personnel trained, and the latest advances brought to the care of patients suffering from these disorders.

The bill is of great importance, because of the appalling toll exacted by these diseases from the people of the United States in death, disability, and economic burden. Heart disease, cancer, and stroke are overwhelmingly the leading causes of death today. In 1963, these diseases accounted for 71 percent of all deaths in the Nation. Compared with them, all the other hazards of man—infectious diseases, accidents, congenital, and nutritional disorders—fade into insignificance.

Heart disease and stroke accounted for 904,747 recorded deaths in 1963. In addition to their dominance as a cause of death, these diseases are the cause of extremely widespread illness and disability. Studies conducted by the National Health Survey of the U.S. Public Health Service in 1960–62 indicate that an estimated 14.6 million adults suffered from definite heart disease, and nearly as many were suspected cases. Over 2 million Americans are currently disabled because of stroke and there are over 400,000 new cases each year.

The economic cost to the Nation of any disease may be measured in terms of its direct costs in diagnosis, treatment, and rehabilitation, and the indirect costs associated with loss of earnings due to disability and premature death. Heart disease, with its enormous death toll and still greater prevalence as a chronic disabling condition, imposes a multibillion dollar burden on the economy, each year. Direct expenditures for hospital and nursing home care, physicians' services, drugs, and other medical services for persons with heart disease amounted to $2.6 billion in 1962. To this must be added the immense economic burden of lost output. In 1962, 540,000 man-years, or the equivalent of $2.5 billion, were lost during that year through disability from heart disease. Calculations of losses resulting from premature deaths reach really astronomic proportions, amounting, when added to direct costs and output losses, to 4 percent of GNP.

Cancer is the cause of 16 percent of all deaths in the United States, amounting to about 300,000 in 1964, and the rate is rising. About 830,000 people in the Nation are under treatment for cancer, and on the basis of current trends, it can be assumed that about 48 million people now living will become cancer sufferers. While the rise of cancer as a health menace can be charged in large part to the changing age composition of our population, substantial percentages of cancer deaths are in the younger age groups. In 1963, 45 percent were in age groups under 65, and 9 percent were in age groups under 45. Cancer is a leading cause of death in children between 1 and 14 years.

The economic toll from cancer also runs into billions annually. Direct costs of diagnosis, treatment, and care were estimated at $1.2 billion in 1962. The estimate for lost output was 221,000 man-years, or $1 billion. Summing direct costs and losses of output through disability, we get an estimate of $8 billion, or 1.4 percent of GNP for 1962.

More sudden and dramatic than cancer, and usually more sudden than heart disease, stroke looms as the third great health menace of our generation. Its death toll is not far behind that of cancer, and more than double that of accidents, the fourth-ranking cause. The proportion of disabled persons in relation to the total stricken is high in the case of stroke, as 8 out of 10 stroke victims survive the acute initial phase of the disease.

Direct costs of stroke are estimated on the same bases as above at $440 million annually. Output losses resulting from disability and premature death are estimated at $700 million for 1962.

Statistics are useful tools for reviewing the problem of heart disease, cancer, and stroke in terms of deaths, disability, and financial loss. They are of course quite useless for measuring the suffering and the human loss. There are no measures for these.

Fully as great a problem as the simple fact of the existence of these three health menaces is the problem of applying what knowledge we have to them. Several hundred thousand unnecessary deaths occur each year from heart disease, cancer, and stroke. Even the well-publicized advances are not reaching all of our people. Until a few years ago, victims of certain congenital heart defects were doomed to die in infancy; now they are growing up toward productive adulthood. Until recently, 9 out of 10 persons who developed the disease known as aneurysm were dead within 5 years; now 7 out of 10 who receive the benefit of new surgical advances are alive and well at the end of 5 years. Until development of the smear test, cancer of the cervix could rarely be diagnosed until too late for successful treatment. Now there is almost 100 percent survival and cure for those who receive early diagnosis and treatment. But tragically, babies still die of congenital defects; patients still die of aneurysms; 14,000 women still die each year of uterine cancer. Of the more than 2 million Americans currently disabled because of stroke, a large majority could be helped through intensive modern rehabilitative care. Many of these people have not been reached by scientific medicine.

As a nation we can look with pride on our health resources, and particularly on the rapid increase in the rate of their development in the past 20 years. But it has not been enough. Thanks in large measure to the Hill-Burton program, more than 7,000 hospitals and other centers for medical service, providing more than 300,000 beds, have been built since World War II. But there are serious bed shortages in many suburban areas; many older hospitals have deteriorated physically; and many beds in general hospitals are being occupied by patients with long-term illness who could be better and more economically served in facilities specially designed to meet their needs. Thanks to the Health Professions Educational Assistance Act, substantial financial assistance can now begin to be brought to bear on the construction of new medical schools and the expansion of existing schools. There is thus the prospect that our physician output can be increased from the present figure of about 7,700 per year to about 9,000 per year by 1975. But this will fall far short of meeting the need arising from population growth.

Faced both with shortages and some maldistribution of our health resources, we are struck with the obvious and overriding need for coordination of effort. H.R. 3140 seeks to aid in achieving precisely this. It is an imaginative response to an immense national challenge. We can well afford this program and the people will enthusiastically support in-

creased expenditures intended to save lives today and produce more lifesaving knowledge for tomorrow.

Mr. BURLESON. Mr. Chairman, this bill proposes to establish a massive Federal arrangement of medical centers to deal with the problems of heart disease, cancer, stroke and other related diseases.

All of us agree with the stated objective of this proposed legislation. All of us are against heart disease, all of us are against stroke, all of us are against cancer. If I thought that this bill actually would make any headway, however slight, against these serious health problems, I would be the first to support it.

This bill will not prevent heart attacks. It will not prevent strokes. It will not prevent cancer. In fact, it is by no means beyond the realm of possibility that the program proposed in this bill, if adopted, would make it even more difficult for many Americans to get a doctor quickly when they are stricken by a serious ailment.

There are fundamental reasons why this bill is bad legislation, why it should be rejected by the House of Representatives and sent back to the Committee on Interstate and Foreign Committee for more study and evaluation.

I shall confine myself to comment on one aspect of H.R. 3140 which is in itself full and sufficient reason to vote "no" on this proposal.

I refer to the fact that this proposal, if adopted and fully implemented, would sweep a large group of American physicians into these regional centers and leave the rest of the Nation with few doctors.

The creation of regional medical centers will discourage physicians from locating in suburban or rural areas.

The Subcommittee on Manpower of the President's Commission recognized the need for a wide distribution of general practitioners. The enactment of H.R. 3140, in the face of this need, would have the effect of stimulating heavy emphasis toward the medical centers and away from local practice.

The rural areas of this Nation, in which there already is widespread need for the upgrading of medical care, would suffer the most. This legislation, with its heavy emphasis on concentration of the best doctors in these medical centers, would undoubtedly make it even more difficult to persuade young physicians to settle in the small towns and smaller cities across the land.

In fact, the whole program would stimulate the decline of the family doctor. He would become a second-class citizen in the medical world. He would be consulted only for colds and flu, or to lance a carbuncle, or to remove a fishhook. For anything more complicated, his patients would head for the nearest big medical center.

Those concerned with physician placement, with the programs of obtaining physicians to practice in smaller communities, tell me that many communities already have lost their physicians because they called him only in emergencies, going to physicians in large metropolitan areas the remainder of the time.

The doctor does not want to be a second-class citizen in his profession any more than the rest of us. When a young man completing his medical education looks around for a place to begin his practice, do you think he will move to a community in which his practice will be largely the treating of trivial ailments?

Do you think he will be interested in spending long hours stitching up the cuts and salving the bruises of the children in his community, only to have his patients leave him when they become really sick?

The American doctor is a highly trained scientist. He spends many years learning how to do all that medical science can do for victims of heart disease, stroke, cancer and all of the other ailments that beset mankind. He reads the professional journals, he attends medical conventions, he confers with his colleagues—all so that he can bring the best possible care to his patients. If the opportunity to apply these years of research and study and learning is restricted or largely denied him, his natural inclination will be to go where the opportunity is broader.

And the sad thing about a situation like this is that the chances are very good that the patient will not be much, if any, better off by going hundreds of miles away to a regional medical center. The men and women in that center would not be able to prevent heart disease, they would not be able to cure a stroke victim, they would not be able to cure most cancers.

If H.R. 3140 should become law, it would be only a few years until most rural areas, many small towns, many suburbs would be almost without any doctors at all. The bright young men would head for the new Federal center, and in some parts of the country these would be far, far away.

We need more doctors in the country and in the small towns, not less. We need to encourage young physicians to practice in the small towns and in the country, not discourage them. We need to keep physicians close to their patients, not send them far away.

Mr. Chairman, I urge that you join with me in voting that H.R. 3140 be returned to the Committee on Interstate and Foreign Commerce in order that sufficient time to study and evaluate this important subject can be made.

Mr. HELSTOSKI. Mr. Chairman, I rise in support of H.R. 3140, legislation to encourage and assist in the establishment of regional centers for research, training and demonstration of patient care primarily in the fields of heart disease, cancer, and stroke.

My support of this legislation has been previously indicated through the introduction of my bill (H.R. 9536), dealing with this subject.

This is a matter which painfully touches our lives. Nearly 15 million people suffer from heart disease which, together with strokes, is the cause of more than half the deaths in this country each year.

In 1962, deaths from arteriosclerosis, including heart attacks and strokes and hypertension totaled nearly 889,000, or 51 percent of all the deaths reported in that year. Over 215,000 or 24.2 percent of these deaths were in the working group, that is in the 25 to 64 age group. Over 672,000 deaths were in the over 65 years of age group, and only 1,510 deaths occurred in the age groups under 25.

What does this loss in the working age group mean to our national economy? If these 215,000 people who died between the ages of 25 and 64 had been able to live an extra, healthy year, they could have earned over $1 billion in that year alone. The Federal Government could have gained in that 1 year approximately $190 million in income tax revenue on these earnings.

What are the needs in the fight of combating heart disease?

First. More funds for research training, community health services and education in this field are urgently needed both in the United States and worldwide.

Second. A simple method for early detection and diagnosis of this disease must be found, as well as better methods of treatment cures and methods of prevention.

Third. It is essential that the technical language presently in use in the field of heart disease be simplified and the terminology made uniform and understandable to the lay public.

The No. 2 killer of our people is cancer. There were 277,110 Americans who died of cancer in 1962, or about 1 out of every 6 deaths. It is estimated that 48 million people now alive in this country will eventually have cancer unless preventative measures are found. Unless new treatments and cures are found, one person in every six will die from cancer.

What is the economic loss from cancer? Each year cancer costs the national economy nearly 50,000 man-years of productivity. Cancer also costs American business and industry the loss of valuable executives at the peak of their efficiency and trained workers at the height of their productivity. The dollar loss is inestimable.

Again, if these Americans had been alive and able to work an extra year, they could have earned over $368 million and paid taxes to the Federal Government on this income totaling over $54.5 million.

Each of us has seen or experienced the anguish these diseases cause. The stark fact is that much of this pain is needless. A man's suffering, his family's sorrow, the Nation's loss of talent and productive capacity—all are to a great extent avoidable. In a great measure, we already possess the knowledge to help the victims of these diseases; our failure is in its application.

The report of the President's Commission on Heart Disease and Stroke and Cancer speaks of "our new intolerance," intolerance that a human being die when he need not, or that his life be circumscribed because knowledge and skills that could preserve its fullness are simply not available to him. H.R. 3140 grows out of this intolerance. It proposes that the Federal Government encourage and assist in the establishment of regionally coordinated arrangements among medical schools, research institutions, and

hospitals for research and training and demonstration of patient care in these three diseases. I believe that such regional centers will work to close the present gap between research and treatment and so to dramatically reduce disability and loss of life.

We already have considerable experience indicating that the best medical care is provided where research and education are an integral part of medical care. For this reason, the Veterans' Administration affiliated its hospitals with medical schools and involved them with other medical resources in the communities. The National Institutes of Health operate 10 clinical research centers which admits patients who will contribute to a specific study. And there are active programs designed to integrate medical schools with community hospitals and other medical care resources in New England, New York, Michigan, Ohio, and Kansas, to name only a few. From all of these—but especially from the voluntary programs involving medical schools with their communities—we can draw encourgement and valuable experience in the planning and administration of the complex arrangements envisioned in this bill.

We are also greatly aided toward our goal by the quality of the research institutions in this country and their striking contributions to health and longer life. As a result of their efforts, infants born with congenital heart defects can grow to adulthood, cancer of the cervix can be detected early enough for successful treatment, other cancer can be treated by radiation and chemotherapy, and hypertension related to heart disease can be relieved with drugs. These and other techniques discovered through research can be extended to thousands of people through the regional centers proposed; the research efforts, in turn, will gain impetus and be nourished by their close contact with diagnosis and treatment procedures. I expect this will be particularly true of research on strokes, which has been neglected in the past.

One of the difficulties in implementing the provisions proposed by the bill will be the critical shortage of doctors and other health personnel. Roughly 3 to 4 million people are engaged in the health services, but this will not be sufficient for a large-scale attack on heart disease, cancer, and stroke. In fact, success in the attack is predicated on an expansion of all phases of medical manpower.

The shortage of doctors is most critical. The Health Professions Educational Assistance Act, which Congress dealt with in 1963 and 1964 and for which we considered and passed amendments on September 1, is an important beginning to what must become a concerted national effort to recruit and train young people for the medical profession. We must keep this factor in mind as we debate the present bill.

But with this reservation aside, we can accomplish what we set out to do with a system of regional centers: to cultivate communication between research and clinical specialists, to place diagnostic and treatment facilities within reasonable distance of all citizens. The needs of different applicants, predicably, vary greatly. There are a number of medical centers in the country that are in many ways already functioning as regional complexes that we propose. There are other areas, particularly where there are no medical schools, where the initial steps will be difficult and costly—and it is these areas which most need assistance. The $50 million proposed by this bill for 1966 will be directed mainly for planning and development costs; as specific plans are formed, we will get more precise guidelines with which to estimate the extent of our financial commitment in future years. I look forward to following this development with keen interest.

In total, Mr. Chairman, what we propose to do with this bill is, as President Johnson's Commission said, "to develop new patterns of partnership" between public and private resources for health—patterns demanded by accelerating developments in research, medical care, medical education, and public expectations—patterns which I expect to be most fruitful for the health and long life of the people of the United States.

Mr. FOGARTY. Mr. Chairman, last March I introduced in the House a measure (H.R. 5999) designed to benefit the health of the American people. It was intended to provide a solid basis for the great aim of the President's Commission on Heart Disease, Cancer, and Stroke: to match medical research potential with public health achievement by making the advances of medical science more readily available to our people.

At that time I reminded all of you that heart disease, cancer, and stroke together accounted for 7 out of every 10 deaths in the United States each year. I reminded you that this toll could be sharply reduced—if only the medical profession and medical institutions could make available to their patients the latest advances in the diagnosis and treatment of these diseases.

A lot has happened since March to the various proposals—introduced into the Senate by Senator HILL and into the House by myself and the gentleman from Arkansas [Mr. HARRIS]—to implement a program for regional centers to combat these three killer diseases. On June 28 the Senate passed the measure and earlier this month the House Interstate Commerce Committee—after extensive hearings—reported out H.R. 3140, the Heart Disease, Cancer, and Stroke Amendments of 1965. It is this measure that I wish to rise to support, today.

It is a tribute to the remarkable understanding and dedication to matters of health by the chairman of the House of Interstate Commerce Committee—that a measure that was at one time considered controversial has now gained such acceptance that it may fairly be said that a consensus has been reached regarding it.

This measure now enjoys the support of such voluntary agencies as the American Heart Association and the American Cancer Society. It also enjoys the support of such respected professional organizations as the American Hospital Association and the Association of American Medical Colleges. It enjoys the support of numerous deans and officers of medical schools.

In addition, it now enjoys the qualified support of the American Medical Association. In a news release from the AMA on September 2 that organization reported that an AMA advisory committee had met with President Johnson to discuss this measure. AMA President James Appel said he was gratified that as a result of these meetings some 20 amendments to the bill were accepted by the administration and that—and I quote:

> Many of the changes are substantial and will allay many of the fears the medical profession had about the original bill.

The AMA president was also quoted as saying:

> We feel that we were successful in getting a number of major changes in the bill which will help preserve the high quality of medical care and the freedom of hospitals and physicians.

Now, the amendment we are considering is a complete substitute for the original bills and incorporates numerous changes intended to define the scope of the program and to guarantee that the legislation will accomplish its stated purpose without in any way interfering with the patterns or the methods of financing of patient care or professional practice or with the administration of hospitals.

I will not embark upon a section-by-section analysis of this bill—into which so much thoughtful compromise has gone. I will instead point out the significant elements of the bill that have emerged from compromises agreeable to both proponents and critics of the original measure.

One of the changes is in the title of the bill. We will hear no more of "regional medical complexes," but rather, of "regional medical programs." This is an important change. It is intended to make it unmistakably clear that it is not intended to amount a new construction program but rather to rely on existing facilities. Thus we emphasize the local nature of this program, its limited scope, and a firm base which includes local hospitals and local medical facilities. The construction authorized under this bill will be alternation, major repair or renovation of existing buildings or replacement of obsolete built-in equipment. No new construction will be permitted from any funds provided by this bill.

Another change undergone by the regional medical program has been to provide language so that this program will be concerned with heart disease, cancer, stroke and "related diseases," instead of—as in the original wording—"other diseases." My medical friends assure me that this in no way impairs the intent of this bill, but that the present wording is essential as a practical consideration. They cite heart disease as an example. A program of research, training, and demonstrations relating to heart disease, which did not include work on diabetes—when there is an apparent relationship between diabetes with its complicating arteriosclerosis and heart disease—would be incomplete. This seems eminently sound and above critcism.

A major limiting change made in the original measure was its reduction in size and scope from 5 years to 3 and from what some called an open-end authorization to $340 million authorization.

The emphasis in the bill is now upon pilot projects and feasibility studies—in short, upon planning and exploration of mechanics. Section 903 of this bill authorizes grants to assist in the planning of regional medical programs. It is the intent of the bill's sponsors to take full advantage of the extensive planning and organization that have already been carried out in some areas of this country. Nor is this planning to be a one-time thing. After regional medical programs have been funded and some experience has accumulated, the Surgean General is required to submit a full report on or before June 30, 1967. In the light of that report this House will consider extension or expansion of the present tentative effort.

Certainly one of the major reasons for the acceptability of the present bill by members of the medical profession is the new and clear-cut emphasis it gives to the participation of community physicians and health organizations. Borrowing from the experience of the great clinical center at the National Institutes of Health, all patients who will be treated under this program must be referred by practicing physicians. Thus, except in the case of patients who are referred by their physicians to a facility to receive care incident to research, training or demonstration, this bill will have no effect on the patterns or the methods of financing of patient care.

Related to this is a significant change in the composition of the National Advisory Council which enlarges physician participation. Of the 12 Council members 1 must be an authority in heart disease; 1 in cancer; 1 in stroke—and at least 2 other members must be physicians. The Surgeon General may not make a grant for any program except upon the recommendation of this Council.

The establishment of a National Advisory Council on regional medical programs is based upon the successful experience of the NIH with this reviewing mechanism for grants—an experience that extends over the past 25 years and more. I am confident that no wiser course of action could have been taken by the committee, chaired by my able colleague, the gentleman from Arkansas [Mr. HARRIS]. I am equally confident that one of the best assurances of the success of this program is to draw upon the excellent record of the NIH in its program administration and to concur in the Senate recommendation in this matter. There is no doubt in anyone's mind but that the NIH shall and will administer this program as ably as it has administered its many other pioneering research and health programs.

The Members of this House are considering today a bill which modifies the administration proposal as the result of constructive criticism by many diverse groups. It is one of the most carefully reworked measures I have encountered in the course of my years in Congress. I believe that this measure is no longer controversial but acceptable to all reasonable men. I urge its passage by this House, today.

Mr. FULTON of Tennessee. Mr. Chairman, in this century, the marvels of scientific research augmented by man's dreams, aspirations and desire for knowledge of the unknown, have led us into worlds heretofore undreamed.

In this century, man has learned the secret of propelled flight, has charted vast parched deserts of the world, mapped the dense jungles and carved cities where less than a century ago only wilderness abounded.

Today men not only go down to the sea in ships, they go beneath the sea in modern scientific vessels to plot the unknown depths and, through research, seek to unlock their hidden treasures which may well be required to sustain life on land in the decades to come.

Research and discovery are essential for the preservation of man.

In the field of medical research, man's accomplishments over recent decades are truly scientific miracles. In that time we have conquered such killers as tuberculosis, scarlet fever, diphtheria, and that cruel child crippler, polio. The list is even longer and the diseases conquered equally as impressive.

These achievements have not been total, however, nor will they ever be as long as man remains mortal.

But as man seeks spiritual perfection, he will continue to seek remedies for those infirmities which weaken the body. And this is proper. For why should man, created in the image of God, not seek to prolong his productive years, safeguard the security of his family, and contribute to the welfare of his community?

Obviously the individual is powerless to conduct this search in his own behalf. Great knowledge and personal dedication on the part of thousands of highly skilled men and women combined with vast, complex and expensive research centers and facilities are required.

These facilities, large and small, and these dedicated professional persons exist in this country. They stand ready and most ably prepared to launch a concerted attack against the most prolific killers of our time, heart disease, cancer, and strokes.

We are today being asked to join in this battle. The legislation before us would combine the assistance of the Federal Government with facilities of nonprofit private institutions to encourage and assist in the establishment of regional cooperative arrangements among medical schools, research institutions, and hospitals for research and training and for related demonstrations of patient care in the fields of heart disease, cancer, stroke and related diseases.

This legislation is no bold step forward. It is not a crash program. Nor can it be considered, in any sense, an all-out attack against these maladies. It is, however, a commonsense and rational first step toward the goal of cure and prevention.

This is not an expensive program. We are not asking billions for years to come. The administration's original request for $1.2 billion over 6 years was not unreasonable. Yet this bill asks only $340 million over 3 years. A modest sum by any standard for such important work, and surely the cure and prevention of these diseases is as important to mankind as the first spaceship on the moon or a dozen or more communications satellites for which we are spending thousands of millions of dollars.

This is not to be a Government dominated or controlled program. The House committee has made every effort and spared no counsel in its determination to assure that the program control remains in competent local hands. Indeed, the cornerstone of this program is cooperation, not coordination.

Mr. Chairman, I would be less than candid if I were to say that this bill is as comprehensive as I would wish. It is my feeling that with more funds and a broader program, the efforts directed at the goals which we seek might be accelerated.

Nonetheless, this is a reasonable and worthy first step. The committee has done a commendable job in its efforts to reach a consensus among the bill's supporters and adversaries.

Gentlemen, the hour has come for us now to demonstrate to the Nation that the Congress is as interested in medicine as in missiles, or in life research as in lunar rockets. We have a great opportunity on this occasion to assist in making more secure not only our generation but generations for years to come. Let us not fail them.

Mr. CORMAN. Mr. Chairman, I rise in support of H.R. 3140 as reported by the Committee on Interstate and Foreign Commerce, and urge its adoption. The Heart Disease, Cancer, and Stroke Amendments of 1965 comprise a program which is intended to make the benefits of medical research more widely available to our citizens. The purpose of this legislation is to launch a major assault on our Nation's three greatest killers—heart disease, cancer, and stroke—which today exact such a staggering toll in human life and suffering.

In order to combat heart disease, cancer, and stroke, we have before us a program of grants to foster cooperation among the medical institutions and practitioners in the regions of our Nation. These regional medical programs are to be established locally to best utilize the capabilities and resources of a region in meeting its own needs and goals related to heart disease, cancer and stroke.

This program will serve a twofold purpose. It will provide for grants for cooperative arrangements among key medical resources, including medical centers, research institutions, hospitals, and other health agencies, for the conduct of research and training, and for demonstrations of patient care in the fields of heart disease, cancer, and stroke. These cooperative arrangements then are to be the means to afford physicians the more abundant opportunity to make available to their patients the latest advances in the diagnosis and treatment of these three major killers and cripplers.

According to testimony received by the committee, the projects to be carried out under these regional medical programs will be quite varied, since the regions of

the country are so varied in problems and resources. As you well know, the problems of congested urban areas are very different from those of a sparsely settled rural area, and the means to the solution of those problems must be very different too. This program is founded on the concept of local initiative so vital to our Federal system of government.

The regional medical program can provide for the referral of patients to specialized medical centers, continuing education, and advanced training for physicians, new equipment and interchange of medical personnel among institutions, all of which are recognized needs in the modern age of medicine. These are all vital factors in the application of research discoveries to the care of sick patients which can be made possible throughout the country by the enactment of this legislation.

Under this plan we hope to see to it that the best diagnosis and treatment is available to all of our citizens. Millions of tax dollars have gone to support medical reserach over the years, and these dollars have produced fantastic new advances in the diagnosis, treatment, and prevention of disease.

We are now riding the crest of a scientific and technological revolution that has recorded an amazing list of achievements. Biomedical research has all but erased yesterday's dread diseases and has harnessed the crippling infections of childhood, thereby prolonging and shaping the very character of our lives. It is time this wealth was shared by all of our people.

We look forward to these new training opportunities for the medical profession, to the new and more intensive research into the mysteries of disease, but most of all we look forward to the brighter future the provisions of this bill will provide to victims and potential victims of heart disease, cancer, and stroke.

Mr. Chairman, I urge passage of this legislation as amended by the Committee on Interstate and Foreign Commerce.

Mr. VAN DEERLIN. Mr. Chairman, as we come to final consideration of H.R. 3140, I hope that the American people will understand and appreciate the full significance of the important legislation embodied in this measure.

The United States has become the outstanding Nation of the world in the advancement of medical science, and in the abundance and quality of medical services available to our people. The Public Health Service, one of the oldest agencies of the Federal establishment, has made a distinguished record in the control of disease, particularly in cooperation with the State health departments. Since the mid-1930's we have seen the development, with the willing support of Congress, of the National Institutes of Health as the greatest medical research organization in the world today.

We have reached a stage, however, where something must be done to see that the benefits of this huge medical research effort are made available as quickly and as thoroughly as possible to the people in every part of this land. We are all familiar, I am sure, with the great medical centers in our metropolitan areas and larger cities. These hospitals, with their fine staffs of well-trained and experienced doctors and nurses, are making the finest and most advanced equipment, facilities, and medical care available to those within their reach. But there are many parts of the country which do not have these fine, modern establishments. They have good hospitals and good doctors, but their facilities are limited and they cannot operate with the degree of sophistication that has been developed in the larger institutions.

The bill that we are about to act upon can correct this imbalance by making possible the establishment of regional cooperative arrangements, to use the language of the bill, "among medical schools, research institutions, and hospitals for research and training, and for related demonstrations of patient care in the fields of heart disease, cancer, stroke, and related diseases."

It has been pointed out, Mr. Chairman, that this language—altering substantially the original wording of the bill—was inserted with fullest participation and approval of legal counsel for the American Medical Association.

In a meeting last weekend with top officers of the county medical society in my home community of San Diego, Calif., I ascertained that many previously held objections to the bill have now been met. It would be incorrect to say that these physicians are yet enthusiastic for it—but they feel that our committee has come more than halfway toward the resolution of conflicting viewpoints.

One remaining doubt, I was advised, concerns the direct pipeline that will exist between participants in the regional programs and officials at the National Institutes of Health, here in Washington. It is felt that without fuller contacts between and among adjoining areas, there is danger that overlapping functions could result in a waste of both time and money.

I have taken up this question with officials at HEW. They lead me to hope that section 907 of the bill, providing a system of disseminating information by the Surgeon General, may offset the fears voiced by my constituent doctors. It seems to me this is a phase of the upcoming operation that we should watch very closely.

I want to emphasize that what this bill stands for is the welfare of every citizen irrespective of his age, his race, his religion, his geographical location, or his politics. This is not a measure designed to benefit any selected group or any particular State or district. Heart disease is blind to a person's color or national origin. Cancer strikes the young, the middle-aged and the old, wherever they may be. Stroke, resulting in paralysis or death, can occur not only in the elderly, but in young mothers and young wage-earning fathers as well.

In a democracy such as ours we govern ourselves through political procedures which involve the most intensive party rivalry. Only so long as this rivalry exists and is encouraged will our society remain secure and our freedom assured. We want no dictatorship or one-party rule in the United States. Yet, as firmly established as this system is in spirit and in practice, there are two situations in which it gives way under the pressure of overriding concern: one, an external threat to national security; the other, the health and welfare of our people.

Yes, there are times to forget politics, and one of those times is now, when we are considering a measure so important to the fulfillment of our responsibility to see that every American shall have the benefits of what is being accomplished, with Federal support, toward the advancement of medical science and the improvement of medical practice and patient care.

Again, to quote the bill before us, its purposes include these:

> To afford to the medical profession and the medical institutions of the Nation, through such cooperative arrangements, the opportunity of making available to their patients the latest advances in the diagnosis and treatment of these diseases.
>
> By these means, to improve generally the health manpower and facilities available to the Nation, and to accomplish these ends without interfering with the patterns, or the methods of financing, of patient care or professional practice, or with the administration of hospitals, and in cooperation with practicing physicians, medical center officials, hospital administrators, and representatives from appropriate voluntary health agencies.

This is a splendid charge and a great challenge. Mr. Chairman, I wish to second the proposals enumerated in H.R. 3140 as amended and reported by the Committee on Interstate and Foreign Commerce, and I urge upon my distinguished colleagues of the House their approval of it.

Mr. DONOHUE. Mr. Chairman, I most earnestly urge this House to speedily and overwhelmingly approve this measure now before us, H.R. 3140, the Heart Disease, Cancer, and Stroke Amendments of 1965.

In connection with our consideration of this vitally important bill I think it is very pertinent to note that the President's Commission on Heart Disease, Cancer, and Stroke pointed out in their report, of December 1964, that over 70 percent of all deaths occurring in the United States each year result from these three dread diseases. It was further emphasized in that report that the effect upon our economy, due to premature disability and death caused by these three diseases, is close to $30 billion in losses each year.

The authoritative statistics clearly reveal these three diseases are the major cripplers and killers within our society. Beyond and above their adverse economic impact they cause untold and immeasurable human hardship, anguish, and suffering.

However, the history of medical science definitely indicates that they, like other dreaded diseases in the past, can be subjected to control and cure by organized scientific attack; that is the basic reason for this bill.

The principal purpose of the measure is to provide for the establishment of programs of cooperation between medical schools, clinical research institutions, and hospitals by means of which the latest advances in the care of patients suffering from heart disease, stroke, can-

cer, and related diseases may be afforded through locally administered programs of research, training, and continuing education and related demonstrations of patient care.

I think it is of major interest and moment to us, and the committee chairman and members surely merit our admiration and gratitude on this point, to note that the committee has included provisions in the bill designed to guarantee that it will accomplish its purposes without unwarranted and unwise interference with the patterns, or the methods of financing, of patient care or professional medical practice or with the administration of hospitals.

Mr. Chariman, I submit that the objectives of this bill are undoubtedly in the best itnerests of the American people; the manner provided for the realization of these objectives is prudent; the appropriations involved are, indeed, quite reasonable, and in view of the increasingly adverse effect these particular diseases is having on our society the legislation is most timely. Therefore, I again urge my colleagues to overwhelmingly approve this measure without further delay.

Mr. KASTENMEIER. Mr. Chairman, even though I am in support of the bill H.R. 3140 to assist in combating heart disease, cancer, stroke, and related diseases, I am concerned about one aspect of it. What a number of people fear, including myself, is that the increased tendency to categorize medicine along the lines of particular diseases will be destructive of efforts in many cases to provide a broad medical education. Whereas we still expect to train and educate young doctors to fight diseases and illness of many types, the creation of institutes of specialization will surely inhibit and curtail this type of education. Nowhere have I seen a critical, yet understanding, view of this better expressed than in the following paragraph from a letter from a member of the University of Wisconsin Medical School faculty:

As a member of a medical school faculty, I am intensely aware of the impact of mental retardation programs and categorical programs for heart disease, cancer and stroke on medical education and practice. These programs always cause me to pause and consider the implications for medical education in the United States and the development of our medical educational system. Categorical programs tend to isolate and specialize medicine. It is unrealistic to think that the passage of these various bills will not affect medicine through incfeased specialization, and make it increasingly difficult to produce broad programs. For example, these programs at the University of Wisconsin could create a situation whereby the medical school would be composed largely of institutes. Even though this would further medical research in categorical disease areas, it would work to the detriment of educational effort. The pediatrician must necessarily have knowledge about many areas. He cannot simply be a cardiologist, a neurologist, or a mental retardation expert. In order to see these categorical problems in their proper setting, he must also see children with other disease processes and understand the broad problems of child development, growth and disease. Thus, categorical programs threaten us some, but this threat is not insurmountable if we can turn it into a unifying and strengthening force rather than a divisive force for our various disciplines. For example, to have categorical disease research and care and teaching institutes widely separated over the University of Wisconsin would be lethal to the concept of medical education. To have them all participate as a unifying measure in one physical setting would be less divisive and would actually be an aid to our future growth and development. Therefore, it is really our problem to put these programs to good use in the future, if any of the money should come our way, but I think that our Representatives in Congress should be aware of this aspect of the problem. Whereas most of us in academic medicine are for welfare legislation, we are concerned about the impact this will have on medical education.

It is perhaps somewhat reassuring that the bill has been changed in committee from including "other major diseases" to "and related diseases"—related referring to heart diseases, cancer, and stroke. This wuold at least prevent overspecialization in too many other areas than those specifically mentioned. Yet, Mr. Chairman, I think it is well that we be aware of the effect on medical education that wholly well-meaning congressional action can entail with respect to the type of medical education which I am sure we all agree we would like to preserve and maintain throughout this great country.

The CHAIRMAN. If there are no further requests for time, the Clerk will read the substitute amendment as an original bill for the purpose of amendment.

The Clerk read as follows:

H.R. 3140

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Heart Disease, Cancer, and Stroke Amendments of 1965".

SEC. 2. The Public Health Service Act (42 U.S.C. ch. 6A) is amended by adding at the end thereof the following new title:

"TITLE IX—EDUCATION, RESEARCH, TRAINING, AND DEMONSTRATIONS IN THE FIELDS OF HEART DISEASE, CANCER, STROKE, AND RELATED DISEASES

"Purposes

"SEC. 900. The purposes of this title are—

"(a) Through grants, to encourage and assist in the establishment of regional cooperative arrangements among medical schools, research institutions, and hospitals for research and training (including continuing education) and for related demonstrations of patient care in the fields of heart disease, cancer, stroke, and related diseases;

"(b) To afford to the medical profession and the medical institutions of the Nation, through such cooperative arrangements, the opportunity of making available to their patients the latest advances in the diagnosis and treatment of these diseases; and

"(c) By these means, to improve generally the health manpower and facilities available to the Nation, and to accomplish these ends without interfering with the patterns, or the methods of financing, of patient care or professional practice, or with the administration of hospitals, and in cooperation with practicing physicians, medical center officials, hospital administrators, and represenatives from appropriate voluntary health agencies.

"Authorization of appropriations

"SEC. 901. (a) There are authorized to be appropriated $50,000,000 for the fiscal year ending June 30, 1966, $90,000,000 for the fiscal year ending June 30, 1967, and $200,000,000 for the fiscal year ending June 30, 1968, for grants to assist public or nonprofit private universities, medical schools, research institutions, and other public or nonprofit private institutions and agencies in planning, in conducting feasibility studies, and in operating pilot projects for the establishment, of regional medical programs of research, training, and demonstration activities for carrying out the purposes of this title. Sums appropriated under this section for any fiscal year shall remain available for making such grants until the end of the fiscal year following the fiscal year for which the appropriation is made.

"(b) A grant under this title shall be for part or all of the cost of the planning or other activities with respect to which the application is made, except that any such grant with respect to construction of, or provision of built-in (as determined in accordance with regulations) equipment for, any facility may not exceed 90 per centum of the cost of such construction or equipment.

"(c) Funds appropriated pursuant to this title shall not be available to pay the cost of hospital, medical, or other care of patients except to the extent it is, as determined in accordance with regulations, incident to those research, training, or demonstration activities which are encompassed by the purposes of this title. No patient shall be furnished hospital, medical, or other care at any facility incident to research, training, or demonstration activities carried out with funds appropriated pursuant to this title, unless he has been referred to such facility by a practicing physician.

"Definitions

"SEC. 902. For the purposes of this title—

"(a) The term 'regional medical program' means a cooperative arrangement among a group of public or nonprofit private institutions or agencies engaged in research training, diagnosis, and treatment relating to heart disease, cancer, or stroke, and, at the option of the applicant, related disease or diseases; but only if such group—

"(1) is situated within a geographic area, composed of any part or parts of any one or more States, which the Surgeon General determines, in accordance with regulations, to be appropriate for carrying out the purposes of this title;

"(2) consists of one or more medical centers, one or more clinical research centers, and one or more hospitals; and

"(3) has in effect cooperative arrangements among its component units which the Surgeon General finds will be adequate for effectively carrying out the purposes of this title.

"(b) The term 'medical center' means a medical school and one or more hospitals affiliated therewith for teaching, research, and demonstration purposes.

"(c) The term 'clinical research center' means an institution (or part of an institution) the primary function of which is research, training of specialists, and demonstrations and which, in connection therewith, provides specialized, high-quality diagnostic and treatment services for inpatients and outpatients.

"(d) The term 'hospital' means a hospital as defined in section 625(c) or other health facility in which local capability for diagnosis and treatment is supported and augmented by the program established under this title.

"(e) The term 'nonprofit' as applied to any institution or agency means an institution or agency which is owned and operated by one or more nonprofit corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

"(f) The term 'construction' includes alteration, major repair (to the extent per-

mitted by regulations), remodeling and renovation of existing buildings (including initial equipment thereof), and replacement of obsolete, built-in (as determined in accordance with regulations) equipment of existing buildings.

"Grants for planning

"SEC. 903. (a) The Surgeon General, upon the recommendation of the National Advisory Council or Regional Medical Programs established by section 905 (hereafter in this title referred to as the 'Council'), is authorized to make grants to public or nonprofit private universities, medical schools, research institutions, and other public or nonprofit private agencies and institutions to assist them in planning the development of regional medical programs.

"(b) Grants under this section may be made only upon application therefor approved by the Surgeon General. Any such application may be approved only if it contains or is supported by—

"(1) reasonable assurances that Federal funds paid pursuant to any such grant will be used only for the purposes for which paid and in accordance with the applicable provisions of this title and the regulations thereunder;

"(2) reasonable assurances that the applicant will provide for such fiscal control and fund accounting procedures as are required by the Surgeon General to assure proper disbursement of and accounting for such Federal funds;

"(3) reasonable assurances that the applicant will make such reports, in such form and containing such information as the Surgeon General may from time to time reasonably require, and will keep such records and afford such access thereto as the Surgeon General may find necessary to assure the correctness and verification of such reports; and

"(4) a satisfactory showing that the applicant has designated an advisory group, to advise the applicant (and (the institutions and agencies participating in the resulting regional medical program) in formulating and carrying out the plan for the establishment and operation of such regional medical program, which advisory group includes practicing physicians, medical center officials, hospital administrators, representatives from appropriate medical societies, voluntary health agencies, and representatives of other organizations, institutions, and agencies concerned with activities of the kind to be carried on under the program and members of the public familiar with the need for the services provided under the program.

"Grants for establishment and operation of regional medical programs

"SEC. 904. (a) The Surgeon General, upon the recommendation of the Council, is authorized to make grants to public or nonprofit private universities, medical schools, research institutions, and other public or nonprofit private agencies and institutions to assist in establishment and operation of regional medical programs, including construction and equipment of facilities in connection therewith.

"(b) Grants under this section may be made only upon application therefor approved by the Surgeon General. Any such application may be approved only if it is recommended by the advisory group described in section 903(b)(4) and contains or is supported by reasonable assurances that—

"(1) Federal funds paid pursuant to any such grant (A) will be used only for the purposes for which paid and in accordance with the applicable provisions of this title and the regulations thereunder, and (B) will not supplant funds that are otherwise available for establishment or operation of the regional medical program with respect to which the grant is made;

"(2) the applicant will provide for such fiscal control and fund accounting procedures as are required by the Surgeon General to assure proper disbursement of and accounting for such Federal funds;

"(3) the applicant will make such reports, in such form and containing such information as the Surgeon General may from time to time reasonably require, and will keep such records and afford such access thereto as the Surgeon General may find necessary to assure the correctness and verification of such reports; and

"(4) any laborer or mechanic employed by any contractor or subcontractor in the performance of work on any construction aided by payments pursuant to any grant under this section will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Davis-Bacon Act, as amended (40 U.S.C. 276a—276a–5; and the Secretary of Labor shall have, with respect to the labor standards specified in this paragraph, the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. 133z–15) and section 2 of the Act of June 13, 1934, as amended (40 U.S.C. 276c).

"National Advisory Council on Regional Medical Programs

"SEC. 905. (a) The Surgeon General, with the approval of the Secretary, may appoint, without regard to the civil service laws, a National Advisory Council on Regional Medical Programs. The Council shall consist of the Surgeon General, who shall be the chairman, and twelve members, not otherwise in the regular full-time employ of the United States, who are leaders in the fields of the fundamental sciences, the medical sciences, or public affairs. At least two of the appointed members shall be practicing physicians, one shall be outstanding in the study, diagnosis, or treatment of heart disease, one shall be outstanding in the study, diagnosis, or treatment of cancer, and one shall be outstanding in the study, diagnosis, or treatment of stroke.

"(b) Each appointed member of the Council shall hold office for a term of four years, except that any member appointed to fill a vacancy prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and except that the terms of office of the members first taking office shall expire, as designated by the Surgeon General at the time of appointment, four at the end of the first year, four at the end of the second year, and four at the end of the third year after the date of appointment. An appointed member shall not be eligible to serve continuously for more than two terms.

"(c) Appointed members of the Council, while attending meetings or conferences thereof or otherwise serving on business of the Council, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding $100 per day, including travel-time, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5 of the Administrative Expenses Act of 1946 (5 U.S.C. 73b–2) for persons in the Government service employed intermittently.

"(d) The Council shall advise and assist the Surgeon General in the preparation of regulations for, and as to policy matters arising with respect to, the administration of this title. The Council shall consider all applications for grants under this title and shall make recommendations to the Surgeon General with respect to approval of applications for and the amounts of grants under this title.

"Regulations

"SEC. 906. The Surgeon General, after consultation with the Council, shall prescribe general regulations covering the terms and conditions for approving applications for grants under this title and the coordination of programs assisted under this title with programs for training, research, and demonstrations relating to the same diseases assisted or authorized under other titles of this Act or other Acts of Congress.

"Information on special treatment and training centers

"SEC. 907. The Surgeon General shall establish, and maintain on a current basis, a list or lists of facilities in the United States equipped and staffed to provide the most advanced specialty training in such facilities, nosis and treatment of heart disease, cancer, or stroke, together with such related information, including the availability of advanced speciality training in such facilities, as he deems useful, and shall make such list or lists and related information readily available to licensed practitioners and other persons requiring such information. To the end of making such list or lists and other information most useful, the Surgeon General shall from time to time consult with interested national professional organizations.

"Report

"SEC. 908. On or before June 30, 1967, the Surgeon General, after consultation with the Council, shall submit to the Secretary for transmission to the President and then to the Congress, a report of the activities under this title together with (1) a statement of the relationship between Federal financing and financing from other sources of the activities undertaken pursuant to this title, (2) an appraisal of the activities assisted under this title in the light of their effectiveness in carrying out the purposes of this title, and (3) recommendations with respect to extension or modification of this title in the light thereof."

AMENDMENT OFFERED BY MR. GROSS

Mr. GROSS. Mr. Chairman, I offer an amendment.

The Clerk read as follows:

Amendment offered by Mr. GROSS: Page 23, line 6, strike out the quotation marks, and immediately after line 6 insert the following:

"Records and audit

"SEC. 909. (a) Each recipient of a grant under this title shall keep such records as the Surgeon General may prescribe, including records which fully disclose the amount and disposition by such recipient of the proceeds of such grant, the total cost of the project or undertaking in connection with which such grant is made or used, and the amount of that portion of the cost of the project or undertaking supplied by other sources, and such other records as will facilitate an effective audit.

"(b) The Secretary of Health, Education, and Welfare and the Comptroller General of the United States, or any of their duly authorized representatives, shall have access for the purpose of audit and examination to any books, documents, papers, and records of the recipient of any grant under this title which are pertinent to any such grant."

The CHAIRMAN. The gentleman from Iowa [Mr. GROSS] is recognized in support of his amendment.

(Mr. GROSS asked and was given permission to revise and extend his remarks.)

Mr. GROSS. Mr. Chairman, I would hope that the distinguished chairman of the committee would accept this amendment which is basically section 11 of Public Law 88–206 which is to follow as the next order of business this afternoon. This would give to the Comptroller General authority to audit the books and records of this program. The money to be expended in this program will be widely distributed over the country and I cer-

tainly think it is very much in order to give the Comptroller General full power to scrutinize what is being done. Again, Mr. Chairman, I urge the gentleman from Arkansas to accept the amendment.

Mr. HARRIS. Mr. Chairman, will the gentleman yield?

Mr. GROSS. I am glad to yield to the gentleman.

Mr. HARRIS. First, let me thank the gentleman for providing me in advance with a copy of the amendment he has just proposed. I have had an opportunity to look it over and I observe that it is identical to section 11 of the Clean Air Act which was approved by our committee and adopted by the House and the Congress, and is a part of the present law. I believe a similar amendment is included in some of the other public health acts. I do know that only a few days ago the committee included a similar amendment to the Library Act that we have reported out.

Mr. GROSS. As well as the national parks and concessionaires bill.

Mr. HARRIS. Yes, that is true, and on various other legislative proposals. I compliment the gentleman for offering the amendment.

As I indicated earlier, the distinguished gentleman from California [Mr. Moss], a member of the committee, usually sees to it that these proposals are included. I am not in a position to speak for other members of the committee except that I have had occasion to talk briefly to some members here at the table, but personally I am prepared to accept the amendment and I shall be glad on my own account to accept the gentleman's amendment. I think it is a good amendment.

Mr. GROSS. I thank the gentleman.

The CHAIRMAN. Does the gentleman accept the amendment?

Mr. HARRIS. As I say, Mr. Chairman, on my own I accept the gentleman's amendment.

The CHAIRMAN. Without objection, the amendment is agreed to.

There was no objection.

AMENDMENT OFFERED BY MR. WHITE OF TEXAS

Mr. WHITE of Texas. Mr. Chairman, I offer an amendment.

The Clerk read as follows:

Amendment offered by Mr. WHITE of Texas: On page 15, line 11, after "medical school" insert the following: "or other medical institution involved in postgraduate medical training".

Mr. WHITE of Texas. Mr. Chairman, the amendment I am proposing is the same as that adopted by the Senate committee. Its purpose is to make possible the establishment of a regional medical complex in an area where no medical school is located, provided there is some other medical institution involved in postgraduate medical training.

I believe my home city of El Paso, Tex., is an excellent example of such a location. It is the largest city in a radius of more than 400 miles. Together with its sister city of Juarez, Mexico, it forms a metropolitan community with a population of more than 600,000. While it has no medical school, it is the site of a major U.S. Army Hospital which also serves for treatment of veterans, of the only school of nursing within a 300-mile radius, and of a medical community consisting of outstanding doctors and hospital facilities. Because of its border location, El Paso has special opportunities for research and for cooperation with outstanding medical advances in the Republic of Mexico. With proper organization and preparation, El Paso could meet every criterion mentioned in this bill, except for the presence of a medical school.

I believe the same situation exists in many other important metropolitan areas. Dr. Murray M. Copeland in his statement to the Senate Committee on Labor and Public Welfare said:

We believe the committee should recognize that specialized institutions, referred to in this bill as Categorical Research Centers, now in existence, are performing much of the program which is envisioned in this bill, and in the cancer field have been the source of much of the strength of the present progress against cancer. We recommend, therefore, in the language of the bill it be made clear that they can furnish essential planning and administrative leadership in regional complexes, and that they are furnishing and should continue to furnish, the type of teaching and training of manpower which is particularly necessary for the successful functioning of the proposed complexes.

And note especially these words of Dr. Copeland:

There do exist areas in which such manpower can best be planned for through teaching institutions not directly affiliated with medical schools.

The Senate saw fit to amend its bill in keeping with the suggestion of Dr. Copeland. I respectfully ask that the House broaden the results of the proposed health program by adopting this amendment.

Mr. HARRIS. Mr. Chairman, will the gentleman yield?

Mr. WHITE of Texas. I yield.

Mr. HARRIS. The gentleman will observe that on page 15 of the committee bill, in section 902(b), the definition of a medical center is a "medical school and one or more hospitals affiliated therewith for teaching, research, and demonstration purposes."

The gentleman's amendment would add the words "or other medical institution involved in post graduate medical training." That is the precise language that is included in the Senate-passed bill.

Mr. WHITE of Texas. That is correct.

Mr. HARRIS. As I analyze the language, in my judgment, the amendment would be complementary to the terms included in the definition of "other institutions affiliated therewith," though we do use the term "hospitals affiliated therewith for teaching," and so forth. I can see no conflict and, so far as I am personally concerned, having discussed it briefly with other Members who are here, I have no objection to the amendment.

The CHAIRMAN. The question is on the amendment to the committee amendment offered by the gentleman from Texas [Mr. WHITE].

The amendment to the committee amendment was agreed to.

(By unanimous consent, Mr. ALBERT was granted permission to address the House for 5 minutes and to speak out of order.)

JOINT STATEMENT BY PRESIDENT OF THE UNITED STATES AND PRESIDENT OF PANAMA ON AREAS OF AGREEMENT REACHED IN CURRENT TREATY NEGOTIATIONS

Mr. ALBERT. Mr. Chairman, I take this time only to advise the House that President Johnson and President Robles, of Panama, have just issued a joint announcement in which they outlined areas of agreement that have been reached in the current treaty negotiations concerning the Panama Canal. Once again the United States has proclaimed to the world that we intend to abide by our commitments with full respect for the rights of others. The commitment I refer to is the bold yet prudent statement delivered by President Johnson on December 18, 1964, in which he proposed that the United States should press forward with Panama and other interested governments in plans and preparations for a sea level canal in this area and that the United States should negotiate with Panama an entirely new treaty to govern the operation of the existing Panama Canal during the remainder of its life.

In my judgment, these bold proposals recognized the forward thinking of our country without in any way belittling the magnificent achievement of those Americans who built the Panama Canal and those who have taken part so efficiently in the operation of the canal as a service to world commerce for the past half century.

The joint statement just issued indicated that the United States and Panama have reached a significant phase in what is manifestly an orderly negotiating process in this very complex matter. It is clear that both countries are making every effort to understand and meet the needs of both the present and the future with full recognition of the rights as well as the responsibilities of each country.

With the abrogation of the 1903 treaty and the recognition of Panama's sovereignty over the area of the present Canal Zone, the United States has shown its complete awareness of the "winds of change" prevailing throughout the world. At the same time, participation by both countries in the administration of the canal demonstrates graphically the mutual sense of responsibility and cooperation prevalent in the negotiations.

We are delighted to note the genuine concern of both countries for the welfare of the present employees of the canal organization and to see the affirmation that arrangements will be made to insure that their rights and interests are safeguarded.

I strongly endorse this joint statement as eloquent proof of the friendship and good will existing between our two countries and I am confident that the negotiations will proceed in this same harmonious atmosphere to the mutual benefit of Panama, the United States, and world commerce.

The joint statement follows:

JOINT STATEMENT OF THE PRESIDENT OF THE UNITED STATES OF AMERICA AND THE PRESIDENT OF THE REPUBLIC OF PANAMA, SEPTEMBER 24, 1965

The President of the United States of America and the President of the Republic of Panama announced today that areas of agreement have been reached in the current treaty negotiations along the following lines:

In order to meet their present and future needs the two countries are negotiating separately a new and modern treaty to replace the 1903 treaty and its amendments, a base rights and status of forces agreement and a treaty under which there might be constructed across Panama a new sea level canal.

The two countries recognize that the primary interest of both countries lies in insuring that arrangements are provided for effective operation and defense of the existing Panama Canal and any new canal which may be constructed in Panama in the future.

With respect to the status of the negotiations on a new treaty to replace the 1903 treaty and its amendments, general areas of agreement have been reached. The details of these areas of agreements are the subject of current negotiations.

The purpose is to insure that Panama will share with the United States responsibility in the administration, management, and operation of the canal as may be provided in the treaty. Panama will also share with the United States in the direct and indirect benefits from the existence of the canal on its territory.

The areas of agreement reached are the following:

1. The 1903 treaty will be abrogated.

2. The new treaty will effectively recognize Panama's sovereignty over the area of the present Canal Zone.

3. The new treaty will terminate after a specified number of years or on the date of the opening of the sea level canal whichever occurs first.

4. A primary objective of the new treaty will be to provide for an appropriate political, economic, and social integration of the area used in the canal operation with the rest of the Republic of Panama. Both countries recognize there is need for an orderly transition to avoid abrupt and possibly harmful dislocations. We also recognize that certain changes should be made over a period of time. The new canal administration will be empowered to make such changes in accordance with guidelines in the new treaty.

5. Both countries recognize the important responsibility they have to be fair and helpful to the employees of all national ties who are serving so efficiently and well in the operation of the canal. Appropriate arrangements will be made to insure that the rights and interests of these employees are safeguarded.

The new treaties will provide for the defense of the existing canal and any sea level canal which may be constructed in Panama. U.S. forces and military facilities will be maintained under a base rights and status of forces agreement.

With respect to the sea level canal, the United States will make studies and site surveys of possible routes in Panama. Negotiations are continuing with respect to the methods and conditions of financing, constructing, and operating a sea level canal, in the light of the importance of such a canal to the Republic of Panama, to the United States of America, to world commerce and to the progress of mankind.

The United States and Panama will seek the necessary solutions to the economic problems which would be caused by the construction of a sea level canal.

The present canal and any new canal which may be constructed in the future shall be open at all times to the vessels of all nations on a nondiscriminatory basis. The tolls would be reasonable in the light of the contribution of the Republic of Panama and the United States of America and of the interest of world commerce.

(Mr. ALBERT asked and was given permission to revise and extend his remarks.)

The CHAIRMAN. The Clerk will read.

The Clerk read as follows:

SEC. 3. (a) Section 1 of the Public Health Service Act is amended to read as follows:

"SECTION 1. Titles I to IX, inclusive, of this Act may be cited as the 'Public Health Service Act'."

(b) The Act of July 1, 1944 (58 Stat. 682), as amended, is further amended by renumbering title IX (as in effect prior to the enactment of this Act) as title X, and by renumbering sections 901 through 914 (as in effect prior to the enactment of this Act), and references thereto, as sections 1001 through 1014, respectively.

Mr. KEE. Mr. Chairman, it is a real privilege today to have this opportunity to enthusiastically support H.R. 3140, a bill to amend the Public Health Service Act to assist in combating heart disase, cancer, stroke, and other major diseases.

In this connection, for more than two decades, the Federal Government has made generous contributions to the twin purposes of public health and medical research with gratifying results. In this sense, the program before the House for consideration today, is an enlargement and development of the programs now in effect.

Perhaps the most striking feature of this proposed enlarged program is that a massive campaign will be waged against the three great killers of modern times—cancer, heart disease, and stroke. These three enemies of the human race will cause 7 out of every 10 deaths in the United States in 1965. These three killers are the successors to the old plague diseases which took heavy toll in former centuries, but which have been very nearly extinguished by the advance of modern science. But while poliomyelitis, smallpox, yellow fever, and malaria had been common in the past, medical experts estimate that 48 million citizens—that is approximately one-fourth of our present population now living—will become cancer victims during their lifetime. The elimination of this killer, through the joint efforts of the medical profession and the Government, could be the greatest boon ever conferred upon the American people. This health plan would establish regional health centers to make available the latest means of combating heart disease, stroke, and cancer. These regional centers are not designed to work independently but are designed to assist medical schools and to assist teaching hospitals and local medical centers in doing the job that must be done.

Another important feature of this extremely essential proposed legislation is the provision designed to help the medical profession meet the growing needs of trained personnel. Ten years, hence, the Nation will need 50,000 more doctors than today. Already there is an acute shortage of dentists and 10 years hence the country will need 100 percent more dentists than we have today. Obviously, privately owned and operated medical and dental schools cannot bear the great expense needed for this expansion.

Mr. Chairman, no man can deny the fact that the future of our Nation—the future in our children—will be dependent upon the expanded joint efforts proposed in H.R. 3140 in order to provide the best possible care for the three great killers of modern times. By approving this measure today, we will take a tremendous step forward in providing more effective measures that will insure a healthy America of tomorrow.

Therefore, Mr. Chairman, from the bottom of my heart, I believe that Chairman HARRIS and the members of the Committee on Interstate and Foreign Commerce of the U.S. House of Representatives are to be highly commended for the effective program presented today.

In conclusion, Mr. Chairman, it is my deep hope that the Members of the House will unanimously approve H.R. 3140 and, by such action, each of us will leave the Chamber today with the conviction in our hearts that we have made a substantial contribution that will benefit not only the younger generations of America, but those yet to come.

The CHAIRMAN. The question is on the committee amendment as a substitute for the bill.

The committee amendment was agreed to.

The CHAIRMAN. Under the rule, the Committee rises.

Accordingly, the Committee rose; and the Speaker having resumed the chair, Mr. FLOOD, Chairman of the Committee of the Whole House on the State of the Union, reported that that Committee, having had under consideration the bill (H.R. 3140) to amend the Public Health Service Act to assist in combating heart disease, cancer, stroke, and other major diseases, pursuant to House Resolution 586, he reported the bill back to the House with an amendment adopted by the Committee of the Whole.

The SPEAKER. Under the rule, the previous question is ordered. The question is on the amendment.

The amendment was agreed to.

The SPEAKER. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time and was read the third time.

The SPEAKER. The question is on the passage of the bill.

The bill was passed.

The title was amended so as to read: "A bill to amend the Public Health Service Act to assist in combating heart disease, cancer, stroke, and related diseases."

A motion to reconsider was laid on the table.

The SPEAKER. Pursuant to the provisions of House Resolution 586, the Committee on Interstate and Foreign

Commerce is discharged from the further consideration of the bill S. 596.

The Clerk read the title of the Senate bill.

MOTION OFFERED BY MR. HARRIS

Mr. HARRIS. Mr. Speaker, I offer a motion.

The Clerk read as follows:

Motion offered by Mr. HARRIS: Strike out all after the enacting clause of S. 596 and insert in lieu thereof the provisions of H.R. 3140 as passed.

The motion was agreed to.

The Senate bill as amended was ordered to be read a third time, was read the third time, and passed.

The title was amended so as to read: "A bill to amend the Public Health Service Act to assist in combating heart disease, cancer, stroke, and related diseases."

A motion to reconsider was laid on the table.

A similar House bill was laid on the table.