• American Association for Adult and Continuing Education •

DR. DREW W. ALLBRITTEN

Dr. Drew W. Allbritten was named Executive Director of the American Association for Adult and Continuing Education (AAACE) in 1991. AAACE is the nation's premier professional association in adult and continuing education; and has members from secondary and post-secondary education, business and labor, military and government, and community-based organizations. AAACE has over 60 affiliates with members from over 40 nations. Under Dr. Allbritten's leadership, AAACE advocates for federal public policy and legislation, sponsors the Annual Adult Education Conference and other national meetings, manages the adult education foundation, and according to the U.S. Department of Education publishes three of the nation's top periodicals in education and training.

Dr. Allbritten serves on several national boards (e.g., Coalition of Lifelong Learning Organizations, National Coalition on Literacy, National Coordinating Council for Technology in Education and Training) and advisory councils (e.g., ACT's Work Keys Project, IBM's Community Management Institute, USA Today's Literacy Council). He also consults on education projects (e.g., "Good Morning America" and "Hour Magazine," IBM Foundation and Texaco Inc., Wall Street Journal and Washington Post, Newsweek and U.S. News & World Report, and numerous other newspapers and magazines) and advises state and national leaders (e.g., White House Task Force on Technology and Learning, Federal Working Group on Family Self-Sufficiency, National Education Goals Panel, Virginia's Business-Education Partnerships) on a variety of public policy issues (e.g., welfare reform, AmeriCorps, workplace literacy, School-to-Work Opportunities Act, information superhighway, telecommunications deregulation, Re-employment Act, as well as adult, continuing and community education legislation and regulations).

Prior to his AAACE appointment, Dr. Allbritten served at the local, state, and national levels in educational, governmental, and association leadership positions. He served as Executive Director of the Iowa Association for Community College Trustees and Presidents. From 1981-87, Dr. Allbritten served as Executive Assistant for Intergovernmental Relations at HUD, and wrote national economic development policy for the White House. From 1979-81, Drew served in the Michigan Legislature on the Urban Affairs, Social Services, and Consumer Affairs committees. Prior to this, he served ten years as a community college administrator and three years as an inner-city math teacher. Allbritten earned his doctorate (Summa Cum Laude) from Western Michigan University, and his Specialist and Masters degrees in Personnel and Counseling, respectively.

• American Association for Adult and Continuing Education •

VISION STATEMENT

The American Association for Adult and Continuing Education (AAACE)
is dedicated to the belief that
lifelong learning contributes to human fulfillment and positive social change.
We envision a more humane world
made possible by the diverse practice of our members
in helping adults acquire the knowledge, skills, and values
needed to lead productive and satisfying lives.

MISSION STATEMENT

The mission of the American Association for Adult and Continuing Education (AAACE) is
to provide leadership for the field of adult and continuing education
by expanding opportunities for adult growth and development;
unifying adult educators;
fostering the development and dissemination of theory, research, information, and best practices;
promoting identity and standards for the profession; and
advocating relevant public policy and social change initiatives.

Mr. PORTER. Let me say, I don't think the request is unreasonable at all. I would urge you also to impact John Kasich and the Budget Committee in hopes that this subcommittee can receive a better allocation than we had to work with last year, in the next fiscal year. Of course, that will be happening very soon.

So we thank you for being here, for the most efficient testimony of the day, and you are exactly right: it is inversely proportional.

Thank you very much for being with us.

Dr. ALBRITTEN. Thank you very much.

WEDNESDAY, MARCH 6, 1996.

WITNESS

WAYNE R. MATSON Ph.D, ESA, INC.

Mr. BONILLA [presiding]. At this time we would like to welcome Wayne Matson, Ph.D., Founder, Vice President, and Technical Director, representing ESA, Inc.

Dr. Matson, if you would come forward, we would be pleased to hear from you at this time.

Dr. MATSON. Thank you very much, Mr. Chairman. Thank you for the opportunity to address you. Our President and co-founder, Alvin Block, has testified here before this committee on cost-effective technologies for health care for about the last 10 years.

I am an inventor and a researcher, sort of a front-line foot soldier among all these generals of the biomedical community that you had here earlier. But with collaborators in various research groups, we've developed a general approach to early detection and prevention of a number of chronic diseases, like neonatal cancer, brain injury in children, Alzheimer's and Parkinson's diseases in the elderly, and bone loss in women.

Disorders like these account for a large part of the health care budget. Early detection and prevention could reduce overall costs by, really, as much as 20 percent.

To realize the benefits of these developments, we recommend that the Congress clarify regulations concerning predictive medical data, and fund prospective studies of childhood brain injury and elderly degenerative diseases.

Now, we are a biomedical development firm with sort of a history of improving health care with innovative technology and services. Our core technology is in very sensitive electrochemical sensors; we first applied this to the childhood lead poisoning problem in the early 1970s, when we developed tools so that the CDC could go out and define the national scope of that problem. During the 1980s, with SBIR support, we built some very powerful systems that could measure hundreds of biochemicals at the same time. These are critical things like transmitters, toxins, hormones, and what have you.

These systems have found widespread application internationally. We do neonatal cancer screening in Japan. We do antibiotic testing in Europe. We have created a lot of rapid, accurate tests for the U.S. clinical laboratories, and I think from the standpoints of job creation, from increases in foreign trade, from reduction of health costs, there's been a pretty good return on the SBIR's public investment here, probably about 10 to 1 by some rational models.

The potential for the concepts using the systems goes well beyond the conventional applications. They sort of go a step beyond the idea of gene mapping, to measure the expression of both the genome and the environment in these small molecule patterns. And the predictive and preventive power of this approach is potentially much greater; it's sort of like predicting tomorrow's weather from satellite pictures instead of from a global model of what the weather has been and used to be.

With some of our co-workers we have demonstrated a number of key possibilities. With Dr. Beal at Mass General Hospital, with NIH support, we have separated the neurodegenerative diseases—the Alzheimer's, the Parkinson's, multiple sclerosis, ALS—from patterns of their biochemistry. By considering these patterns as a whole, they develop some fairly effective therapies for intervention, things like protecting against free radicals. And that work strongly suggests that if these patterns can be detected early, there is a good chance that early therapy can prevent or delay the damage, with a very large savings in suffering and cost.

With support from private sources, we are following the biochemistry of about 900 to 1,000 severely brain-injured children at the Institutes for the Achievement of Human Potential in Philadelphia. These are children in custodial care. We have found that all of these children are biochemically different, and that 5 to 10 percent of them are so different that the biochemistry is probably why they hurt. It is kind of frustrating, because we can treat these kids now, and we can help them some—kids who can't walk, who can't see, who can't talk, who have brain injury—that we can help them now, but if we had been able to catch them earlier, in all probability they would be normal kids.

Now, if we can detect Alzheimer's or Parkinson's or autism or brain developmental problems of birth trauma very early and intervene—essentially, see the problems coming and dodge—we can save that portion of the health care budget, I think, that goes to custodial care. I would say that's around 20 percent. There's really not anything that has to be invented to do it; it's just a matter of rationally using the tools we've already paid for. It may happen anyway simply because capabilities have a way of being used. But there are two places where Congress can really help in this, I think.

One is in getting some regulatory clarity regarding the use of predictive data. There is a fear that detecting a possible disease is going to lead to discrimination, to job loss, to insurance loss. That has to be addressed, and this is something that might be tackled by the NIH Director's Advisory Council.

Second, there is a need for prospective diagnostic studies of newborn children and of older people. We recommend the funding of two programs, of similar magnitude and structure to the Framingham Heart Study, one for kids and one for the elderly. These could be supported by NINDS or by NIA, the National Institutes for Aging, and run through existing Alzheimer's disease centers for the elderly and through metabolic testing centers, such as the Institutes for the Achievement of Human Potential for Children. I think that if this is done efficiently and with a little luck, we can save a fair amount of money and a lot of pain.

I thank you. If there are any questions, I would be happy to answer them for you.

[The prepared statement follows:]

ESA, INC.

22 ALPHA ROAD
CHELMSFORD, MA 01824-4171
(508) 256-7000
FAX: (508) 256-7060

TESTIMONY OF WAYNE R. MATSON, Ph.D.
VICE PRESIDENT
ESA, INCORPORATED

BEFORE THE HOUSE
SUBCOMMITTEE ON LABOR, HEALTH
AND HUMAN SERVICES,
EDUCATION AND RELATED AGENCIES
COMMITTEE ON APPROPRIATIONS

March 6, 1996

I am Wayne Matson, Founder, Vice President and Technical Director, of ESA, Inc., of Chelmsford, MA. Our President and co-founder, Alvin V. Block, has testified before this Subcommittee on issues of the cost effectiveness of emerging technologies in health care for ten years. I would like to present a status report on studies and devices directed at the early detection and therapeutic correction of a range of debilitating, costly, chronic, or degenerative diseases. These disorders, which encompass such problems as brain injury and developmental problems in children, Alzheimer's and Parkinson's disease in the aged, and arthritis and bone loss in women, account for around 30% of health costs. Generally the tools for fixing such problems when they occur are not particularly good, and the usual outcome for people, such as the older lady with no memory or the "autistic" child, is consignment to custodial care. What we and our colleagues feel is needed and possible are tests that allow early or predictive detection and the specification of preventive therapy.

Our approach has gone a step beyond gene mapping to the measurement of the expression of the genome in the small operational molecules of the body. By doing this, subtle interactions of genes within an individual and environmental effects on the individual are also taken into account. In a computer analogy, we are looking for problems by checking the software instead of the hardware; in a weather analogy, we are trying to predict if it will snow tomorrow from watching the satellite images and knowing what's happened before, rather than using global weather models. The goal of the efforts has been to be able to detect and correct a problem before extensive damage to an individual occurs. Working with collaborators from Massachusetts General Hospital (MGH), NASA Ames, CA, The Institutes for the Achievement of Human Potential (IAHP) in Philadelphia, and others, with support from the National Institutes of Health (NIH), Motorola, and other private foundations, a number of key problems have been resolved.

We are now at the point of having demonstrated the power and scope of the technologies and concepts developed. We have indications that some 7% of brain injured children in custodial care are there because of abnormal biochemistries and that many childhood developmental problems have early biochemical indicators that can be fixed. We have been able to separate various degenerative neurological diseases by operational biochemical patterns that have also yielded approaches to therapy. This approach has been applied to enough other disorders to suggest that it is generally useful for all chronic diseases. As background for a suggested next step, I feel it would be useful to describe ESA's background and the collaborations, support and studies that have led us to this point in our work.

ESA is a biomedical research and technology development firm dedicated to the improvement of health care through innovative instrumentation and services. We have focused our efforts primarily on chronic and environmentally induced disorders that can best be addressed by early detection and prevention. These include such problems as lead poisoning, metabolic disorders, brain injury and cancer in young children, neurodegenerative diseases such as Alzheimer's and Parkinson's in the elderly, and bone loss in women.

Our core technology is in unique electrochemical sensors which, by their nature, can provide high sensitivity and selectivity for critical biochemicals. These sensors are used in a variety of proprietary instruments capable of a wide range of measurements. For the life of the company, we

have focused on adapting the power of these sensors to problems of human disorders, essentially trying to find technical solutions to societal problems. This effort started in 1970 with the development of a total system package of instrumentation and sampling equipment for the measurement of lead levels in children, using finger-stick samples at the part-per-million level. This novel capability allowed the Centers for Disease Control, which had been given the task of determining the national extent of lead poisoning, to perform wide-spread pediatric lead screening across the country. Next, we developed a series of instruments to measure iron deficiency in small pediatric blood samples. This group of devices was capable of operating in store front clinics or mobile vans and essentially brought screening, diagnosis and prevention directly to where it was needed. Subsequently, with internal private funds and substantial support from the NIH Small Business Innovation Research (SBIR) Program, we have developed powerful sensors for the simultaneous measurement of a broad range of biochemicals such as neurotransmitters, hormones, metabolites, antioxidants, and vitamins. This capability has led to a more powerful capability for existing tests and, beyond that, to a completely new approach to early prediction and treatment.

This technology was first applied to widespread screening in Japan. They now routinely test all newborns for neuroblastoma. This is a form of cancer which, if detected early, can be cured with little suffering and at a low cost. If undetected, it leads to an early, painful, and costly death. The screening centers located in each prefecture have proven highly cost effective. More recently, our instrumentation has been adopted by major clinical and research laboratories to provide more cost effective and accurate testing for neurotransmitters and their metabolites for certain heart disorders, cancers and mental abnormalities.

The technology has found utility in a number of other health research areas such as: antibiotic assays in animal feeds to control the occurrence of resistant strains of bacteria ; procedures for measuring food quality and antioxidant levels in supplements; and a means of controlling the effectiveness of natural product remedies or nutraceuticals. Nevertheless, the greatest potential utility of this technical and conceptual approach has only begun to be realized - the ability to use the hundreds of simultaneous measurements to define the interaction of an individual's genetics with the environment to determine his or her state of health.

In studies conducted with NIH support, in collaboration with Dr. M. Flint Beal at MGH, we have shown that it is possible to separate neurodegenerative diseases by their biochemistry. That is when considered as a whole, the pattern of hundreds of compounds in an individual with Alzheimer's disease is uniquely different from normal or other diseases such as Huntington's or Parkinson's. Looking at the specific compounds involved suggests a number of therapeutic approaches involving, for instance, increasing cellular energy efficiency and protecting against oxidative free radicals. If these patterns can be determined early, there is a reasonable chance that damage can be prevented or delayed with a large savings in suffering and cost.

With support from the Motorola Foundation and a Matsuzawa grant from Nippon Chemical, we have been following the biochemistry of 900 severely brain injured children for three years. These children, requiring full-time custodial care, have been brought to The Institutes for the Achievement of Human Potential in Philadelphia for an intensive program of physical and intellectual rehabilitation developed over the last 50 years. We have found that severely brain injured children are biochemically different in ways that can be addressed therapeutically, Perhaps more important, 5-10% are so biochemically unique that their chemistry is almost certainly the cause

of their injury. While therapy started now can help these children some, if they had been tested, detected and treated at birth they would in all probability be normal kids.

In the last 15 years we have worked on several joint activities with CDC and NIH under the SBIR mechanism, and in support of other research programs on contract basis. In addition, we have utilized private grants and our own resources to further the goals of better health. There has been a positive return on the public's investments in all aspects of job creation, balance of trade, reduction of health care costs, and alleviation of suffering. We believe, however, that the possibilities opened up for predictive and therapy directing tests present an opportunity that is beyond our resources or the usual research mechanisms for support.

There really are not many things to be invented or discovered to achieve a society without the suffering or cost of a brain injured child or a non functional parent. It is primarily a matter of using the tools that we have already paid for in a rational and cost effective fashion.

There are two areas that we recommend for action, one is primarily up to the Congress itself and one that requires support.

First, there is a need for legislative or regulatory clarity regarding the acquisition and use of predictive data such as genetic testing or the pattern analysis procedures discussed here. There is potentially a great under utilized wealth of information in clinical data. The benefits of prevention of disease are clear for both the individual and society. However, there is a fear that discovery of a preventable condition might lead to discrimination in insurance or job status. Certainly there must be a path somewhere between the issues of privacy and of rational health care delivery. This may be an issue that could be tackled by the NIH Director's Advisory Council.

Second there is a need for prospective diagnostic studies of newborn children and older people to create the information needed for effective prevention of childhood brain damage and of adult neurological disease. We recommend the funding of two programs, of similar magnitude and structure to the Framingham Heart Study, one for children and one for the elderly. These could be supported by the National Institute of Neurological Disorders and Stroke and implemented through existing treatment or metabolic testing centers for children and Alzheimer's disease centers for elders, such as those at Massachusetts General Hospital, Johns Hopkins, or The Institutes in Philadelphia. These will provide the base of information for the prevention of brain injury and the amelioration of neurological diseases.

Implementation of these programs and further development of the techniques and concepts can prevent a great deal of suffering and eliminate up to 20% of national health care costs through dramatic reduction in custodial care within 5 years.

Thank you

Mr. BONILLA. Dr. Matson, we appreciate your being with us today. Your testimony today will be entered in the record and reviewed by every member of this committee and the fine staffs that work on this committee.

Dr. MATSON. Thank you, sir.

WEDNESDAY, MARCH 6, 1996.

WITNESS

DAVID R. SMITH, M.D., ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS

Mr. BONILLA. At this time we are a little bit under the gun because we have a vote call, but I would like to go ahead and call the next witness. My hometown pride comes out on this next introduction, because he is the Commissioner for the Department of Health, Dr. David Smith, who is going to be representing the Association of State and Territorial Health Officials.

David, you will understand if, right at the conclusion of your testimony, I'm going to have to run out of here like a jack rabbit to get to the Capitol to cast a vote. But I wanted to get you up before I had to race out of here.

Dr. SMITH. Well, thank you very much, Congressman Bonilla. First of all, I want to thank you and praise you for your leadership in this arena of public health. You have certainly been our biggest supporter at the national level and perspective, as well as the State level, and of course you have helped us a great deal with some of our unique needs in south Texas. So for the record, I would like to commend you for that. It has certainly been a difficult time, that many speakers have alluded to before, the fact that dollars have been short, but you have been there when we needed you for a number of different critical issues, and I want to thank you.

I would also like to thank the staff for their work with the Association of State and Territorial Health Officials, helping us through the process this last appropriations time, and also Mr. Eric Fox, who continues to be a great source of both wisdom and support and advice as we go through, dealing with issues of budget and appropriations. I wanted to thank both of them.

I will be very brief, too. I am here to talk about the health care system that covers all 264 million Americans, as opposed to many other pieces that don't cover all, and I would like to talk more about restoration of dollars more, even, than additions.

We understand some of the difficult times facing us. I think for us, in public health, we are often just happy to get back where we were sometimes, although I will make a point about where we are relative to past budgets and where we think we need to be as we look at fiscal year 1997.

My focus is just going to be, quickly, in three areas, to put them in perspective, because I can't cover the gamut of public health in such a brief time. Let me talk about the Preventive Block Grant; the Maternal and Child Health Block Grant, and the CDC immunization budget.

I think the important message from me here is that there is a return on investment of all of this investment portfolio that we

have called "public health," that we can show outcomes not only in people living longer, quite frankly, but also in the areas of job performance and worker's comp claims. I think, indeed, you will be challenging us to do a better job as we invest in prevention and secondary prevention for the many diabetics that exist in your district, and the programs that are directly funded through programs like the Preventive Block Grant.

I think we are here dealing with the reality versus misperception. So often we think of public health, and people think this is poverty health. Actually, Medicaid is in my agency. I dealt with poverty health when I was the Medical Director for the Brownsville Community Health Center and a practicing pediatrician before I had the opportunity to be Commissioner of Health.

But public health is about all 264 million Americans. It is the water that you have before us, that we don't think about whether or not it's safe to drink. It's our food and whether or not the seafood is edible, whether or not the milk and dairy products are safe, whether or not we are disposing of the nuclear weapons that are going to the Pantex site in north Texas, all 2,000 warheads with 60 tons of plutonium. We don't think about those aspects.

Put in perspective, I think it is important to do that here as we talk about budgets. We spend almost $1 billion a year in medical care in this country. Less than 1 percent of that goes to public health. I think we're just really trying to get somewhere around 1 to 2 percent as the investment in the whole 264 million people.

In the last 100 years we have gained 30 years of longevity. People are living 30 years longer; 25 of those gains in years are due to public health interventions, things like clean water, cleaner air, better diets, vector control—like mosquitoes and the dengue virus that we dealt with in south Texas. Very early antibodies and immunizations, that was it.

The other five is due to our medical care system, for which I was trained at the University of Pennsylvania in pediatrics. But the big gains have been in public health, and we need to keep that in perspective as we look into the future.

So there is a dilemma between our health care system and our medical care system, and I think you've heard that today.

Let me talk quickly about the Preventive Block Grant. In the continuing resolution we have about $145 million. We need to think about that in perspective as we look at 1997. That's about $0.55 per American for prevention. Even if we look at the fiscal year 1995 figure, it's somewhere around $0.60 per American for prevention. I'd love to just get to $1.00. If we look at the projections, we'll just get back to that level.

I think we need to talk about, when we preach prevention, just what are we investing on the front end? Using that money, I would like to just reiterate some of the things that have challenged me in the last year as related to the Preventive Block Grant and how they expended money.

I've sort of had the "who's who" in the microbial world. I've listened to the people from NIH advocating their programs, and very much agree with their assessment because, indeed, in this last year I've dealt with the Hanta virus. We've dealt with dengue fever, e. coli in the Baylor cafeteria. Flesh-eating strep? We've had it. Me-

ningococcus disease. Botulism in two people in the panhandle. Vibrio cholera in our oysters. Leprosy—most people don't even like to call it leprosy anymore; we call it Hansen's disease, and we had 53 new cases. In fact, the Hansen's Center for much of the United States is in your district, in San Antonio. Most people aren't aware of that.

I've had plague, rabies, Legionnaires' disease within the last year. Of course, many of you probably read "The Hot Zone." What isn't in the book is the fact that 100 of the monkeys from Reston, Virginia went to Alice, Texas, and 94 of them died, and they did have Ebola in Reston in 1991.

I have to combat the behaviors of health with that money, smoking, helmets, drugs, all the behaviorally-driven causes of morbidity and mortality. Cancer clusters. The PCB problems of the border, where we've had a look at the water and the contamination of the fish. EMS systems throughout the State get funded through those programs. Fluoridation.

I guess my point is that we're making a good investment in America for $0.55, to deal with all of these things and to be challenged by them on a daily basis. The Maternal and Child Health Block Grant—we're looking at approximately $684 million for fiscal year 1995, authorized $705 million——

Mr. BONILLA. Dr. Smith, I am going to have to ask you to just pause for a little bit until the Chairman returns. He's gone to vote and is going to come back, and I have four minutes to get to the Capitol

Dr. SMITH. All right. I would be happy to do that.

Mr. BONILLA. But thank you for being here this morning.

Dr. SMITH. Thank you, Congressman.

[Recess.]

Mr. PORTER [presiding]. Dr. Smith, please continue.

Dr. SMITH. Thank you, Chairman Porter.

I was right in the middle of talking about the Maternal and Child Health Block Grant. I also want to thank you; I had a very distinguished privilege of hearing you speak at the Institute of Medicine a couple of months ago, during their anniversary celebration. Your passion and understanding of issues of health and public health clearly came across during that presentation, and your leadership certainly has helped at the national level. I want to thank you for that.

I was just talking about Maternal and Child Health Block Grants, as I speak for the Association of State and Territorial Health Officials. We're looking at figures of about $684 million for fiscal year 1995 and an authorized level of $705 million. As we look at even conservative estimates, where we have somewhere around 12 million uninsured children and at least a million women in the Nation that use services from this program, we need to recognize that this is a program that is above and beyond Medicaid. This is often the middle class, middle income, lower middle income, working poor of this country that are using these programs. That investment of only $55 annually is what is going to really fill in the gaps for a lot of these individuals.

Every day I get calls in my office; I am no longer a practicing pediatrician, but those calls are from legislators and congressmen

across my State, saying, "Dave, can we get this family, this mother, into some program for coverage?" They are pleading with me because they make $1 too much or have the wrong disease to fit into one of our categorical programs.

It's the Maternal and Child Health Block Grant that lets us, and it's flexible enough to help these individuals. It's those personal appeals and passion that, quite frankly, stir me every day. In our State we have over 1.5 million uninsured children. This is the program for them, and we try to fill in the gaps with the Maternal and Child Health Block Grant to keep them healthy. And for that reason, we do get a return on the investment. We can get them the immunizations that they need. We can get them that hearing and vision screening that they need, because they are not eligible for Medicaid. Quite frankly, we can get them into school. We can deal with iron, and we can deal with lead, and we know that quite clearly data shows that both iron deficiency and lead can result in a reduction in IQ in a child. Then they are able to less well learn in the setting. In fact, we know iron deficiency alone can drop a kid's functional IQ by 10 points. What does that do to a child's ability to learn, stay in school, not lose attention and drop out? I would argue, quite a bit, and that's something as simple as iron deficiency.

These programs come out of the Maternal and Child Health Block Grant. The folic acid push in Texas, which preceded a lot of the national effort because of anencephaly, and the neural defects, which is where I used to practice, got funded so that we could get vitamins in the hands of women, as well as doing the outreach and marketing, by using the Maternal and Child Health Block Grant.

One other point I would like to make. I know there is a lot of discussion in regard to this block grant related to the use of $75 million for "abstinence only" training. I would love to have the dollars to tackle that issue, but to carve it out from the base funding of this program would result in about an 11 percent reduction in funding for the block grant, and somewhere I would have to find room for 25,000 children and mothers to get services elsewhere, because that money would be diverted. I would love to tackle the issue and certainly get that kind of a program in place, but I'm afraid we're doing a little bit of "robbing Peter to pay Paul."

I would just go back for a second to the Preventive Block Grant that I mentioned earlier. A couple of my friends from Texas said it made Texas not sound like a very appealing place.

The Preventive Block Grant has allowed me to respond to a number of emerging infections in this last year. We've had to deal with biblical diseases—plague, TB, leprosy, and rabies. We've kept dengue fever out of Texas. Our Governor had us invest some of those dollars to deal with the Mexican officials, and we only had 12 cases of dengue appear, which is a hemorrhagic fever, much like Ebola virus. We've dealt with Legionnaires', Vibrio cholera, meningitis—that money goes to the front lines. It deals with the fears of families with cancer clusters. It deals with our research to look at why we're seeing PCBs in our water in some parts of our State. It keeps our EMS systems rolling. We're investing only $0.55 an American through the Preventive Block Grant. I'd love to get to $1.00. But even if you look at the fiscal year 1995 figures, that gets us—if we

get back to restoration—about $0.60 an American. So we're not asking for much, but we think it's time to invest in prevention.

Finally, in immunizations, this should be a time to celebrate the CDC immunization program. We are seeing levels rise in our State. With the help of Congressman Bonilla and much of the private sector, we've more than doubled immunization rates for two-year-olds in the State of Texas, coming up from 32 percent to somewhere around 74 percent. That's a great effort, and these dollars have helped us achieve that.

But we need to look at restoring that program back to 1994 levels of $528 million because I have new challenges now. We have new vaccines coming out, including such things as hepatitis B, varicella, the safer DPT—the diphtheria pertussis vaccine; acellular pertussis. We also have new combination drugs.

But now I'm worried about adults, because we're the most poorly-immunized population in the United States, adults. I was going to ask the committee members their own immunization status for things such as pneumococcal disease, hepatitis B, tetanus—we had a rancher die of tetanus not long ago—as well as some of the more exotic immunizations that we now give to adults.

The other question, of course, is whether your doctor has talked to you about your immunization status as an adult, which sometimes we forget to do.

So I would just conclude by saying that these three, I think, are good examples: the Preventive Block Grant, investing under $1.00 per American; the Maternal and Child Health Block Grant, which States use to fill in the gaps with the middle income, investing less than $55 per individual; and then, of course, the CDC immunization program where in fact we are seeing improvement. If we can't fix measles, what can we fix?

We want to continue to work with you at the Association of State and Territorial Health Officials. If there is anything we can do to further that and promote prevention, and to be accountable—because I believe the business community is going to start asking us for some new outcomes—we'd be happy to do that.

[The prepared statement follows:]

David R. Smith, M.D.
Texas Commissioner of Health
Labor, Health and Human Services, Education and Related Agencies Subcommittee
Appropriations Committee
U.S. House of Representatives
2358 Rayburn House Office Building
Washington, D.C.
10 a.m.
March 6, 1996

Chairman Porter, Representative Obey, distinguished subcommittee members, my name is David Smith. I am Texas Commissioner of Health and head of the Texas Department of Health. I am here today as president-elect of he Association of State and Territorial Health Officials.

I appreciate the opportunity to talk with you about some very important programs that affect the health of the citizens of this country: the Preventive Health and Health Services Block Grant, the Maternal and Child Health Block Grant, and the CDC Immunizations Program.

There has been much debate about our current health care system and how we must do more with less. I have followed -- and participated in -- the discussions about health care reform, and the more-recent discussions about Medicaid reform. The primary driving force for these efforts was the recognition that this country cannot continue to spend more and more money on health care. We must get these skyrocketing costs under control. Another driving force for these discussions should have been the realization that comprehensive health care, care than includes primary care and prevention, is not available, accessible or affordable for too many Americans.

Public health -- with its emphasis on primary care and prevention -- is the perfect place to turn for part of the answer to the dilemma of how to do more with less.

It is my contention that the only way we will ever reduce the skyrocketing cost of health

care is by reducing the *need* for health care (sickness care), especially the more expensive forms such as emergency room care and hospitalizations.

Public health has a track record of success for a fraction of the cost of other medical interventions. Our nation's total expenses for health care is about $3,000 per person per year. Our investment in public health functions is about $34 per person. Yet, this meager investment in public health has paid tremendous dividends. Of the 30 years of increased life expectancy in the U.S. since the turn of the century, 25 of those years are attributable to public health activities.

Public health focuses on prevention in large populations, while clinical medicine devotes its most intensive resources to restoring health or palliating disease in individuals. There are endless examples of the benefits of public health programs. A few are: preventing food borne illnesses such as e. coli, and botulism, preventing diseases through proper immunizations and reducing the incidence of stroke, cancer and heart disease through public health education. These are not programs focused solely on poverty populations, but rather on all populations. We all drink water, eat food and play with our pets and drive our highways hoping not to be the next customers of the Emergency Management System.

Diseases, illnesses and injuries not only cause sadness, pain, emotional stress and death, they cost money. Preventing these diseases, illnesses and injuries saves lives and money.

- In measles epidemics in Houston, Dallas and South Texas, almost 1,400 people were hospitalized at a cost of $11 million. The vaccine to prevent the measles would have cost $21,000.
- For every $1 spent for the control of sexually transmitted diseases in Texas, $6 in treatment costs is saved, an annual savings of more than $26 million.
- Overall, conservative estimates of the impact of public health strategies aimed at heart disease, stroke, occupational injuries, motor vehicle-related injuries, low-birthweight babies and gunshot wounds suggest that $68.9 billion in medical care spending can be avoided between now and the year 2000.

Preventive Health and Health Services Block Grant

The prevention block grant allocates funds to every state for use in accomplishing any objective outlined in the nation's public health blueprint, *Healthy People 2000*. Examples of programs in Texas include assistance to local health departments, drinking water fluoridation, and preventive health for chronic disease in adults. This block grant is the glue that keeps public health programs together. The grant allows us to address some of the high priority public health issues as determined by mortality, morbidity and economic cost data.

The Preventive Health Block Grant was funded at $157.9 million in FY 1995. This year, FY 1996, it was reduced to $145.4 million during one of the Continuing Resolution negotiations. We must, at the very least, get this grant back to the FY 1995 level.

The need for this block grant is considerable. Given that an investment in these core public health programs can save valuable resources by preventing disease, the funding amount really should be *increased* this year. This money allows states not only to deal with current public health problems, but it also gives states the flexibility needed to deal with new and re-emerging diseases such as Legionnaires', filovirus infections, diphtheria, plague, drug resistant tuberculosis and invasive streptococcus A, the so-called flesh-eating bacteria, and to be on guard for the next "plague."

Maternal and Child Health Block Grant

In addition to the basic functions, public health has been called on to provide a safety-net system of medical care for those who otherwise might go without. As the cost of health care has risen, so has the income level needed to afford it. Consequently, while at one time public

health's direct care services were for the "poor", today these services are essential for middle-income families, including the "working poor", those *with* jobs but without health insurance or the money to pay for health care. One such program that serves this growing population is the Maternal and Child Health Block Grant.

The Title V Maternal and Child Health Services Block Grant provides funding to build integrated systems of health care that emphasize the efficacy of prevention and early intervention with a focus on the special needs of women and children, including children with special health care needs. Because of the flexibility allowed in the Title V grant, the program can design and assure the delivery of services on the basis of unique state and community-specific needs. Many children in our state are uninsured, yet the majority live in families where the head of the household works (65 - 80%).

Funding for the M&CH block grant has remained constant over the years, but the need for services has increased. Flat funding results in decreased services due to health care cost inflations. The M&CH block was funded at $684 million in FY 1995. This block grant is still tied up in the Continuing Resolution program and therefore has not received an appropriations for FY 1996. The program is authorized at $705 million which is were it should be in FY 1997.

CDC Immunization Program

Immunizing children is one of the most cost effective health initiatives around. It is our goal in public health to immunize all children against vaccine-preventable diseases. These illnesses are serious, even deadly, and we have no excuse for not eliminating them in this country. *Healthy People 2000* set a national goal of immunizing 90 percent of all 2-year-olds by the year 2000. If we cannot "fix" measles, what can we do? Fortunately, our efforts are

working.

The Centers for Disease Control and Prevention's Immunization Program is a key element in achieving the year 2000 goal. This program allows states to improve quality and quantity of immunization service delivery, consolidating purchase of vaccines to stretch limited dollars available for vaccines and increasing community awareness, participation and education regarding the importance of age-appropriate immunizations.

The CDC Immunization Program was funded at $528 million in FY 1994. It then dropped to $463.7 in FY 1995 and was $470.5 in FY 1996. Immunization rates are improving throughout the country. We are making significant progress. But we are far from the 90 percent goal. The immunization program needs to be restored to the FY 1994 level of $528 million if states are to continue to make progress in this critical area and continue to address other barriers to immunizations -- such as transportation, outreach, translation services and marketing.

Conclusion

Appropriate investments in public health will lead to substantial savings in the medical care system through the prevention of disease and injury. Conservative estimates of the impact of public health population-based strategies aimed at heart disease, stroke, fatal and non-fatal occupational injuries, motor vehicle-related injuries, low-birthweight babies and gunshot wounds, suggest that -- for these conditions alone -- approximately $68.9 *billion* in medical care spending could be averted between now and the year 2000.

The cost of treating disease in this country has skyrocketed. We can no longer afford, either in the public or the private sector, to continue to pay the high price of medical interventions. A remedy that is overlooked all too often is a strong investment in public health. An investment in prevention for the population at large - regardless of income level - results in

fewer medical costs down the road. . .for everyone.

The importance of these programs to the health of this nation is clear. Please consider the many benefits of public health when setting the appropriations levels for FY 1997.

* * *

Mr. PORTER. Dr. Smith, thank you for your testimony.

If you're from Texas, how come you don't sound like you're from Texas?

Dr. SMITH. Well, sir, I grew up in Ohio, actually. I was a National Health Service Corps doctor, sort of like Joel Fleischmann, except that I went to Brownsville, Texas. That was my "Southern Exposure." I have been in Texas since that time.

Mr. PORTER. Well, you have to work on your accent a little bit.

Dr. SMITH. I do have boots, sir.

Mr. PORTER. Oh, good. All right.[Laughter.]

Mr. PORTER. Thank you for being with us today.

Dr. SMITH. Thank you.

WEDNESDAY, MARCH 6, 1996.

WITNESS

RALPH CAZETTA, COOLEY'S ANEMIA FOUNDATION

Mr. PORTER. Ralph Cazetta, Director of Patient Services, representing the Cooley's Anemia Foundation.

Nice to see you again.

Mr. CAZETTA. Same here. Good afternoon.

Mr. Chairman, members of the committee, my name is Ralph Cazetta, Director of Patient Services, the Cooley's Anemia Foundation, and with me is Gina Cioffi. We are both Cooley's anemia patients.

We are grateful for your tremendous leadership on behalf of biomedical research, particularly in the midst of last year's budget debate, and again, for hearing our request for biomedical funding priorities.

I also want to acknowledge the leadership provided by the NIH, particularly Dr. Lenfant of the NHLBI, and Dr. Gorden at NIDDK, and thank you all for responding to the needs of Cooley's anemia patients.

Cooley's anemia is a genetic blood disease. It is the world's most common, lethal inherited blood disease. There are an estimated 2 million genetic trait carriers alone in the U.S. today.

The NHLBI recently produced an excellent update on Cooley's anemia research. That report concludes that "many of the landmark advances in biomedical research can be traced back to the basic research in the area of Cooley's anemia." Cooley's anemia patients were the earliest contributors to understanding the molecular basis of blood disorders, such as Sickle Cell Disease.

Today I want to draw upon that publication and articulate on our research priorities.

First, oral iron chelators. A major priority is the development of an oral iron chelator. This is important because our patients undergo transfusions several times a month, causing iron to build up in our organs. It wasn't too long ago that this led to death for Cooley's anemia patients at an early age. My older brother, Nunzio, died from this complication in 1971 at the age of 11.

A major advance occurred with the introduction of the drug desferal in the mid-1970s. This was the last major advance in the treatment of Cooley's anemia. We are still at a discouraging point.

While desferal removes iron, it requires patients to infuse themselves over a period of 10 to 12 hours every day. Over time, other problems develop, including allergic reactions and painful infusion sites, causing further complications.

Because of the long-time support of the Congress for research aimed at developing an iron chelator that patients could take orally, we are in the midst of the first clinical trial on the iron chelator compound known as L–1, due for completion October, 1996. This drug may be our only alternative to certain death for patients that can no longer tolerate desferal.

Toxicity research that led to this clinical trial was sponsored by NIDDK and supported by Congress. We need your continued support to ensure this research moves forward, and we request that NIDDK intensify its search for a new chelator.

Second, new technology for measuring iron overload. We strongly encourage NIDDK's further investigation aimed at improving the technology in the area of measuring iron overload. The use of an MRI device called the SQUID, developed with NIDDK funding, shows great promise, but it still does not permit the accurate measurement of iron loading within the heart. More accurate iron overload readings will prevent patients from entering the critical point that I have encountered. This summer I traveled to Cleveland to obtain a SQUID measurement of iron within my liver and found that I had more iron overload than previously diagnosed. This drastically changed my treatment. As a result, I had to have a port surgically inserted into my chest, and now require around-the-clock infusion of desferal. The port is an extreme measure and a high risk for patients. Many experience life-threatening blood clots and infections.

Third, blood transfusion technology and blood safety. As a patient, I receive 34 blood transfusions per year. This is an average amount of transfusions for patients. It is extremely important to us that research aimed at ensuring the safety of our blood supply be strengthened.

Hepatitis continues to be a major concern. Drugs soon will be on the market for hepatitis A and B; yet hepatitis C, which also impacts our patients, continues to warrant further research aimed at finding a vaccine. Last week, a dear friend of ours succumbed to liver cancer, a consequence of the hepatitis C virus. Also, a number of patients continue to test positive for HIV; therefore, efforts aimed at improved screening reliability continue to be warranted. My volunteer work with AIDS patients reminds me of how difficult the struggle is for all suffering with AIDS. We encourage continued support.

Fourth, establishment of a clinical research network. For the last several years we have advocated the development of a clinical network, under the auspices of the NHLBI, to provide a strong base for future clinical research efforts. This clinical network would allow for the more rapid translation of the many advances in basic research and direct patient benefit.

We are not seeking new building construction nor major expenditures of funds. This clinical network can be implemented in existing institutions, matched to areas with a base population of Cooley's anemia patients.

Fifth, hormone therapy research. The necessity of hormonal therapy as part of Cooley's anemia management is becoming more apparent now that the patients are living through their teens. But researchers need to assess the potential medical and psychosocial effects of the therapy in terms of self-esteem, body image, social relations, and sexuality.

Other areas of interest to use are fetal hemoglobin enhancement; bone marrow transplantation; and gene therapy research.

Mr. Chairman, my friends are still dying while in their 20s. NIH research dollars are an investment in human life, and the gifts that each individual contributes back to society. We encourage at least a 6.5 percent increase for NIH.

Outside of the biomedical field, I want to tell you that my friends want to live long, productive lives. But many cannot afford to leave the Medicaid-assisted programs. We are working to see changes in the law to allow our patients the opportunity to find work, pay taxes, and contribute to our society, while maintaining health benefits.

With me today is Gina Cioffi, the Executive Director of the National Cooley's Anemia Foundation.

On a personal note, I wanted to mention what Gina and I have experienced within the last two weeks as patients. As I stated in the testimony, we lost a very, very dear friend of ours last week; unfortunately, his funeral was the day that we were supposed to be here to testify. We were fortunate to be with Danny when he passed away. This week, we are facing possibly another loss of a patient; she has experienced a bone marrow transplant to cure Cooley's anemia. She is 40 years old. While her sister's graft has taken, the damage to her heart from iron overload has superseded the transplant, and she is now in congestive heart failure. Her family contacted Gina and me last night to say that she is now giving up; she is tired of the suffering. She stated that since the loss of Danny last week, she is tired of the fight for 40 years. This is something that we're facing, just within two weeks.

I encourage support for all of the Cooley's anemia patients that we represent here today. Thank you.

[The prepared statement follows:]

Testimony
Cooley's Anemia Foundation
Department of Labor, Health and Human Services, and
Education Subcommittee of the Committee on Appropriations

Mr. Chairman, Members of the Committee, my name is Ralph Cazzetta, Director of Patient Services for the Cooley's Anemia Foundation. I am also a Cooley's anemia patient. I am honored once again to appear before your committee. As you know, the Cooley's Anemia Foundation has testified before your committee for well over a decade about Cooley's anemia research, patient care, and public education. With me today is Gina Cioffi, National Executive Director of the Cooley's Anemia Foundation.

Before I begin, I want to express our sincere thanks for your tremendous leadership on behalf of biomedical research. It is indeed heartening for our patients and families to know that the members of this committee, and in particular it's Chairman, are so committed to ensuring that appropriate funding is available to move forward on research into diseases such as Cooley's anemia. Mr. Porter, thank you.

As you know, Cooley's anemia is a genetic blood disease. The World Health Organization identifies Cooley's anemia as the most common, lethal inherited blood disease worldwide. There are estimated to be more than 2 million genetic trait carriers in the U.S. alone.

Mr. Chairman, today, I want to underscore our research priorities.

But, first I would like to note that the leadership provided by the NIH, particularly by Dr. Lenfant at NHLBI and Dr. Gorden at NIDDK, in responding to the needs of the Cooley's anemia patients is exemplary. Their doors are always open to us, they take the time to meet with us and discuss our concerns and we just want you to know from our perspective that they are doing a great job.

As you know, research is a cumulative effort and often the results of basic research can be applied in unforeseen ways. The NHLBI recently produced an excellent update on Cooley's anemia research. That report concludes that "many of the landmark advances in biomedical research can be traced back to basic research in the areas of... Cooley's anemia." Cooley's anemia patients were the earliest contributors to understanding the molecular basis of blood disorders such as Sickle Cell Disease. Cooley's anemia research also has helped to improve the care of all patients who need regular blood transfusions.

All of the areas I will cover today are included as part of the recommendations of the distinguished scientific panel Dr. Lenfant convened to create the recently published progress report, titled "Cooley's Anemia: Progress in Biology and Medicine - 1995."

1. Oral Iron Chelators

A major priority of the Cooley's Anemia Foundation is the development of an oral iron chelator. This is important because our patients have to undergo red blood cell transfusions several times a month, and this in turn causes iron to build up in our major organs. It wasn't too long ago that this led to certain death for Cooley's anemia patients at an early age. My older brother, Nunzio, Jr., died from this complication in 1971 at age 11.

A major advance occurred with the introduction of the drug desferal. While desferal removes the iron, it requires Cooley's anemia patients to infuse themselves over a period of ten to twelve hours or more everyday. As you can imagine, this is a constant challenge for patients. Over time, other problems develop as well, including allergic reactions, painful infusion sites, as well as running out of sites, causing further complications.

Because of the long time support of the Congress for research aimed at developing an iron chelator that patients could take orally, we are in the midst of the first clinical trial on the iron chelator compound known as L-1, due for completion October 1, 1996. While we remain hopeful, I want you to know this is a frustrating time as well. The search has gone on for many years and there has not been an advance since desferal was introduced in the mid-'70s.

Toxicity research which led to this clinical trial was sponsored by NIDDK. Let me clearly state that this research would not have been done had it not been for the support of the Congress -- and the NIDDK. There is just not enough economic incentive for the pharmaceutical industry to engage in research of this type. We need your continued support to ensure this research moves forward, and request that NIDDK intensify its search for a new chelator..

2. New Technology for Measuring Iron Overload

We strongly encourage NIDDK's further investigation aimed at improving the technology in the area of measuring iron overload. Conventional testing of serum ferritin concentration is not accurate enough. New methods of non-invasive measurement need to be further developed. The utilization of a magnetic resonance imagery device, known as the SQUID, shows great promise -- yet it still does not permit the accurate measurement of iron loading within the heart -- the very thing that determines our survival. NIDDK funded the development of the SQUID.

My own personal experience was, after traveling to Cleveland to obtain a SQUID measurement, finding out that I had much more iron overload than previously thought. As a result I had to have this port inserted into my chest, and now require round-the-clock infusions of desferal.

3. Blood Transfusion Technology and Blood Safety

As a patient, I receive thirty-four transfusions of red blood cells per year. This is an average amount of transfusions for patients. It is extremely important to us that research aimed at improving the technology associated with blood transfusions, as well as to insure the safety of our blood supply, be strengthened.

Hepatitis continues to be a major concern as well. Drugs will soon be on the market for hepatitis A and B, yet hepatitis C, which also impacts our patients, continues to warrant further research aimed at finding a vaccine. Also, a number of our patients continue to develop HIV, so efforts aimed at improved screening reliability continue to be warranted. We note the leadership of the NHLBI in this area -- most recently through its sponsorship of a major conference on the safety of the nation's blood supply. Blood is our lifeline and we encourage your continued support.

4. Establishment of a Clinical Research Network

For the last several years we have advocated the development of a clinical network, under

the auspices of NHLBI, to provide a strong base for future clinical research efforts. This clinical network would allow for the more rapid translation of the many advances in basic research during the past decades into new, and potentially, life saving therapies. There is currently a clinical trial of a new oral iron chelator being tested with U.S. patients now underway. This demonstrates the clear need to have the NHLBI move forward with its plans in this area.

We need to be ready to move as soon as the science warrants. The experts believe we are close to many new major advances such as gene therapy -- so this network -- when fully established -- will ensure that a broad geographical cross section of qualified U.S. patients can quickly enroll in approved clinical trials.

I would like to note that NHLBI has been responsive to congressional requests for planning of this network -- and we look forward to continuing to work with them to make this a reality.

We are not seeking new building construction or major expenditures of funds. This clinical network can be implemented in existing institutions matched to areas with a base population of Cooley's anemia patients.

5. Fetal Hemoglobin Enhancement

This promising research is aimed at enhancing fetal hemoglobin production which may thereby ease the anemia associated with this disease, and eliminate the need for transfusions. Considerable investigation currently is underway to develop new switching agents. As the NHLBI report notes: "further research is necessary ... and additional clinical trials are needed to test the effectiveness and safety of these new switching agents as they are identified."

6. Bone Marrow Transplantation Research

We are strongly supportive of research efforts in bone marrow transplantation which also may hold a cure for Cooley's anemia patients. The procedure at this time is limited to only a small number of patients and carries a of very high number of risks. Further limiting its availability is the fact that because it is still considered experimental it is not covered by many insurers. Furthermore, the high cost of the procedure makes it prohibitive for patients who might qualify.

7. Gene Therapy Research

Exciting research in the area of gene therapy has brought us hope of a realization of a cure for Cooley's anemia through the correction of the underlying molecular defect in this disease. We know that this is a long term research effort, and we encourage you to continue to appropriately fund these efforts.

8. Hormone Therapy Research

The necessity of hormonal therapy as a medical treatment is becoming more apparent now that patients are living through their teens. However, research into the medical and psychosocial effects or benefits of the treatment has been limited, in part due to the fact that young adults with the disease only now are reaching the age at which study in this area is feasible. Researchers need to assess the potential medical and psychosocial effects of the therapy in terms of self-esteem,

body image, social relations, and sexuality.

With your continued support, we are confident that the efforts to find a cure for Cooley's anemia will certainly lead the way toward cures in other diseases. Our hope is always tempered by the day to day reality of dealing with Cooley's anemia. Patients are still dying while in their twenties. We still have the challenges of wanting to work, but having difficulty. While this is outside the area of research, let me point out to this committee the need to do away with the Medicaid income restrictions.

Finally, I would like to announce that we will be holding our eighth international conference on Cooley's anemia in New York in 1997. The event is co-sponsored by the New York Academy of Sciences and the Cooley's Anemia Foundation. In the past, NHLBI and NIDDK have contributed greatly to these symposiums, and we are confident they will assist this time well.

This conference brings together clinicians, clinical researchers, basic scientists and allied health personnel. It is important in as far as it is the one place where everyone involved in Cooley's anemia research worldwide is brought together to review and discuss current research.

Then they help to translate the most recent advances in the basic science, always with an eye toward potential clinical applications. Conversely, the basic scientists have an opportunity to learn what the needs are from the clinicians, in order to provide them continued direction.

Finally, we would like to encourage at least a 6.5 % increase for NIH overall, in keeping with The Ad Hoc Group on Medical Research's recommendation.

Thank you, Mr. Chairman. I'll be pleased to answer any questions you may have.

Mr. PORTER. Mr. Cazetta, I often think, as I sit here and listen to the testimony—not only yours, but from many others who come before the subcommittee—that if only the American people would be able to hear this as we are able to hear it, that there might be a much greater understanding of the importance of investment in this area, and perhaps also a greater understanding of how fortunate people are not to be suffering from diseases of the type that you are suffering.

Unfortunately, the cameras aren't in our room watching, as I think they should be. But you are probably aware that NIH has just combined with Maryland Public Television to put on a program called Health Week. It's in the pilot stage right now; I've seen the first pilot, but unfortunately I missed the second one. They are going to attempt to bring to the American people, through public television, insight into what's going on in biomedical research, and a greater understanding of the importance of it. I have been urging Dr. Varmus to do this for some time because I think we need to bring these things down to the human understanding level; not just Members of Congress, but everyone. I think the outreach is very, very important to what happens here.

So again, we thank you for your testimony. It's good to see you again, and we will obviously do our best in this area.

Thank you so much.

WEDNESDAY, MARCH 6, 1996.

WITNESS

JOHN A. CALHOUN, NATIONAL CRIME PREVENTION COUNCIL

Mr. PORTER. Last but not least, John Calhoun, Executive Director, testifying on behalf of the National Crime Prevention Council.

Mr. Calhoun?

Mr. CALHOUN. Thank you, Mr. Chairman. It's good to be here. I am here to talk about some programs that may involve some of the programs in your jurisdiction. As you may know, we are the Nation's focal point for crime prevention, established in 1980, and supported mainly by the Bureau of Justice Assistance, but with some funding from HHS and HUD, as well as private sources such as All State and others. Our work ranges from the award-winning public service advertising to hands-on demonstration programs in various communities, training, technical assistance, and management of our coalition.

Really, the essence of our work, to prevent crime, rests on three fundamental assumptions. One is protection of the individual, but that's not enough. If you're safe and I'm safe behind locked doors and peepholes, we're all isolated.

So the second piece is to encourage passionate civic investment and involvement. Indeed, research shows that the more cohesive a community, the lower the crime rate.

Third is policies that we know work, such as expanded Head Start and recreation programs, etc.

The underlying causes of crime and violence are really not all that mysterious. When related to kids, we see a colossal isolation on the part of teenagers—isolation from those basic entities that

make a society work: family, community, school, church, future. And our particular thrust, and what I wanted to share with you and the committee today very briefly, was to reconnect kids, to ask kids to give something back, and we are doing that. This was buttressed recently by a Harris Poll that we conducted to look at the effects of crime and violence on teens, and some of the news is, indeed, old news, because it showed that many kinds were disproportionately affected by crime and violence, and many do carry guns for protection, cut classes, cut school, change behavior, and feel it's okay to fight back if you're "dissed."

But the new news, the extraordinary thing that the Harris Poll came out with, was that 90 percent of the youth polled said that, given the chance, if they knew what to do, they would roll up their sleeves and get involved in crime and violence prevention programs.

We created a project called Youth as Resources. It's a very simple model to ask kids to spot social issues about which they're concerned. They craft the projects; they run them. The results have been off the charts, politically described as "social contract theory"—"you are part of us, we need you"—and psychologically described as "bonding." I think of a kid who was working in a domestic violence shelter. We asked her why she did it and she said, "I want them to get the love I never got as a kid."

Another youngster was working with the elderly, and I asked him why he was doing that. He said, "It's the first time in my life I've ever been thanked."

So there is a tremendous sense of dislocation that many youth feel that can generate crime. We are trying to reconnect. As a matter of fact, tomorrow night, if it's not bumped by political news, Peter Jennings on his American Agenda is going to give five minutes to this as one of the most hopeful signs of youth crime and violence prevention. So I hope I will get a chance to watch it, and I hope it's not bumped.

You face very difficult decisions on how to allocate funds. I do not envy you, just hearing the bits of testimony I heard this morning—it's absolutely extraordinary—relating to tetanus and dengue fever, to the very eloquent gentleman who preceded me. But I really bring to this committee something very hopeful, and to the extent that various agencies and budget lines under your jurisdiction might think about this, this is probably one of the most hopeful signs that we've seen in crime prevention, with the exception of our comprehensive community program where we're working with a number of mayors throughout the country, where we're pulling not only citizens together but churches and others to do comprehensive crime prevention programs.

So in a curious sense, I'm not asking you for money. I'm just sharing a very, very hopeful program that may touch Education and HHS or Labor.

[The prepared statement follows:]

Testimony of John A. Calhoun
Executive Director
National Crime Prevention Council

before House Appropriations Committee
Subcommittee on the Departments of Labor, Health and Human Services, and Education

Wednesday, March 6, 1996.

2358 Rayburn House Office Building

Thank you, Chairman Porter, for this opportunity to have the National Crime Prevention Council (NCPC) represented before this subcommittee today. I am John A. Calhoun, NCPC's Executive Director. As you well know, the issue of crime crosses jurisdictional lines of Appropriations Subcommittees, and I have had the privilege over the past few years to appear before several Appropriations Subcommittees. I appear today to discuss how programs under your jurisdictions might be transformed to encourage citizens, especially younger ones, to take part in the struggle to reduce and prevent crime and rebuild their communities.

We at NCPC are the nation's focal point for crime prevention. Established in 1980, much of our work is funded through the Department of Justice's Bureau of Justice Assistance. These funds are buttressed with substantial corporate, foundation, and individual funds as well as specific grants from HUD and from Health and Human Services. Our mission is to prevent crime and build communities in which children can be children and isolated, fearful people can become active, involved citizens.

We are most well-known for our highly acclaimed public service advertising campaign featuring McGruff. As a result of this campaign, we receive hundreds of thousands of requests each year from children and adults and organizations, ranging from police, schools, churches, health and youth-serving agencies, for information regarding crime prevention programs. Through the dissemination of this information, we in turn inspire millions of Americans to roll up their sleeves to protect themselves and to build safer, more caring communities. I should add that the McGruff campaign was the single most successful campaign of the prestigious Advertising Council, garnering $92 million worth of free public service advertising, making it the second most successful campaign in the entire fifty-three-year history of the Advertising Council -- and that includes such campaigns as Savings Bonds, Peace Corps, Red Cross, etc.

NCPC's work is wide-ranging, including: award-winning public service advertising; training and technical assistance; running demonstration programs with youth, schools, core city communities, and with mayors in twenty-eight cities with whom we have helped developed comprehensive community strategies to reduce crime and violence; management of our 136-member crime prevention coalition; a corporate partnership program; and publication of the most relevant and useful crime prevention program information in the country.

To prevent crime and create communities in which there is social cohesion and freedom, we must *all* operate on three levels:

1. Protection of self, loved ones, and property.

2. Passionate civic involvement -- people actively involved in making their schools and communities better.

3. Implementing certain policies that we know work, such as community-oriented policing, head start, job opportunities, recreation programs, during those critical hours between 3:00 and 6:00 pm when the streets are flooded with teenagers who have little to do.

We must lock up the most violent, and we do need more police; but without an equally zealous commitment to prevention we have a distorted policy, one which will fail. We as a society are guaranteeing light, heat, food, and health care — in prison — this is a policy promise costing the American public about $30,000 a year per prisoner. And yet we spend less than $5,000 a year for each child in public school.

We do know some things:

- The major correlate relating to prison is dropping out of high school: and 82% of prisoners are high school dropouts.
- Abusive families produce trouble.
- Mistrusting, uncohesive neighborhoods produce trouble. There are neighborhoods, anomalies, that ostensibly look as if they should be prone to crime and are not. They are not, because of the high degree of support citizens give each other.
- Conversely, tight, caring neighborhoods with citizens who look out and care for one another and each other's children have lower crime rates.
- Teens and guns are a lethal combination.
- Big Brother/Big Sister types of programs work: kids do better in school, feel better about themselves, and their involvement in crime is lower than in comparison groups.
- We know that a caring, reliable adult who gives constancy, has high expectations, and provides support, is essential for every child.
- Finally, through our work in seven Texas cities and subsequently with sixteen cities in conjunction with Attorney General Reno, we know that when key elements in the community are brought together — police, social services, health, schools, public housing, the faith community, foundations, and others — that if everyone agrees to play a role, crime can and will be reduced. We have seen it.

The underlying causes of crime and violence are not mysterious. Some of them include:

- Children, given the collapse of families and increasingly anonymous neighborhoods, are alone and isolated. Many kids do not feel beholden to others. Isolation kills individuals and communities.

- Youth treated as consumers, not contributors, may never develop a positive stake in their communities.

- Parents increasingly raise children alone without the support of a caring network.

- Citizens gripped with crime-related fear lose connection with their communities and withdraw from civic life.

- Lack of employment, housing, and medical services, and easy availability of drugs, can breed crime and violence.

We've got to address the issue of youth. The National League of Cities' opinion survey released on February 8, said, "Three out of five city officials say youth crime worsened during the past year, and an array of problems involving youth are becoming top concerns of government leaders... Youth crime led the list of local conditions that worsened over the past year, which had deteriorated the most over the past five years... Six of the ten community conditions most frequently described as worsening in the past years are those associated with young people: youth crime (62%), gangs (50%), drugs (45%), teen pregnancy (45%), school violence (45%), and family stability (38%). Youth crime and the quality of education were the issues most frequently mentioned as important to address in the next two years." [*1996 State of America's Cities Opinion Research Report*, National League of Cities, Washington, DC.]

Your committee knows well that youth are disproportionately both victims and victimizers. We work *extensively* with young people. In 1987, we created a program called Youth as Resources (YAR). It is an extremely promising new thrust in youth policy and programming. It has mushroomed nationally and has shown promising results.

Rather than adults writing prescriptions for youth, YAR ask youths to spot social issues about which they are concerned, shape their own roles in the community, design and run projects. YAR is based on the belief that many of today's young people are disconnected and ache to belong, to do something deemed worthy, to be claimed.

YAR is locally based, provides small grants to young people to design and carry out projects to meet community needs they deem most important. With the support of funding from local businesses, foundations, and social service agencies, a local board of youths and adults solicits, reviews, and funds proposals written by young people (with adult guidance). We believe the Subcommittee should look at the YAR model in funding the youth development programs under its jurisdiction.

NCPC has also developed a crime prevention curriculum — Teens, Crime, and the Community (TCC) — now in use in more than 500 middle schools nationwide. It is not only cognitive, teaching kids how they can avoid victimization, but the last part of the curriculum asks youth

to design and run projects which would make their schools safer and better. A *wonderful* array of youth-led projects has come into existence, such as graffiti removal teams, student courts, school watch, mentoring, etc.

Our work was buttressed recently by a Harris poll we commissioned. The results, recorded in their document *Between Hope and Fear* gives us some news that is indeed *old* news. Crime and violence affects teens disproportionately:

- Many carry guns for protection;
- Many cut classes;
- Many cut school;
- They change behavior like not going out at night or not using public spaces; and
- Most feel it's okay to respond physically if "dissed."

But the new news is *astounding* and must be noted: nearly 90% of the 2,000 teens polled said they were willing to help participate in crime and violence prevention programs and to help improve their schools and communities *if they only knew what to do*. We must engage youth. Those of you who are parents or grandparents know of teens' colossal energy and commitment — pre-marriage, pre-mortgage, pre-compromise. They are idealistic, and their energy is boundless. Rather than cringe at the arrival of the increasing number of teens, we must welcome them as resources.

NCPC runs a Youth as Resources project in one of the most violent areas in the world — the Robert Taylor Homes in Chicago, twenty-two stories of misery, halls reeking of urine, bullets, and terrible schools.

The heart of Youth as Resources politically described is the social contract theory: it says to youth "You are part of us. We need you." Described psychologically, it seeks to bond youth positively to their communities.

Peter Jennings, anchor of *ABC Nightly News*, each week devotes time to a segment entitled "The American Agenda." I am delighted to report that tomorrow night, March 7, this segment will be devoted to covering what ABC News has determined to be one of the most promising youth development/crime prevention programs in the United States today. That program is NCPC's Youth as Resources program. I hope we'll all have the opportunity to watch the segment.

This Subcommittee faces difficult choices on how to allocate funds. I know you will remember the toll that crime, violence, and fear is taking on America. NCPC would be pleased to assist the Departments of Labor, Health and Human Services and Education in finding creative and cost-effective ways to help direct the energy of youth in the rebuilding of their communities. We also trust that the Subcommittee will encourage the agencies under its jurisdiction, such as the Center for Substance Abuse Prevention, to find publicly proven, locally developed models for achieving positive youth development in the context of healthy communities.

If this Subcommittee funds new CSAP Community Partnerships in fiscal year 1996 or 1997, we strongly recommend that those partnerships be small and neighborhood-based, link grassroots citizen activity with local authorities, and require matching local resources. We also recommend that CSAP Community Partnerships be concentrated on building those entities that make communities work — family, schools, neighborhoods, recreation centers, and jobs.

We also encourage the Subcommittee to continue to fund the essential federal data collection activities of CDC Center for Injury Prevention and Control. Since its creation in 1992, CDC's public health approach has set the benchmark for a new and proven way of approaching violence prevention efforts in this country. This approach includes defining the problem and progresses to identifying associated causes and protective factors, developing and evaluating prevention policies and programs, and implementing successful strategies. CDC then works to transfer this knowledge to state and local government, researchers, practitioners, communities, and others.

CDC's continued efforts are critical to building safe homes, safe schools, and safe communities. We cannot put an end to the growing problem of violence in this country without a comprehensive approach that includes public health. After reviewing other federal violence prevention efforts, George Will concluded in a 1992 Washington Post article: "So as a sound investment in improving the quality of American life, no federal funds are spent better than those that fund the CDC's research."

I thank you for the opportunity to testify before you. I will be pleased to answer any questions you might have.

Mr. PORTER. While I was giving Mr. Albritten the award for "most efficient testimony," maybe I should give it to you. I think you have made the case very, very strongly and very quickly.

Let me ask where the Federal Government comes in in this. If we're to get youth involved in activities of helping communities, how does the Federal Government's role fit into that?

Mr. CALHOUN. I think in a very modest way, to provide seed funding in various communities, and I would probably ask for a local match from community foundations or something like that, or from the city. We've seen this thing spread enormously to about 60 or 70 jurisdictions.

So it's not costly, and I think in the various departments which you help oversee, whether it's runaway and homeless youth or whatever, there are a lot of ways it can be plugged in. Schools are one of the major participants in this; experiental learning, as well as giving something back. As a matter of fact, we did a study, and not only did kids increase in competence, confidence, and self-esteem, but almost 50 percent recorded educational gains, and it wasn't set up as an educational program. They felt better about themselves, did their homework, got better grades, and a lot changed their goals and wanted to go on to college.

Mr. PORTER. Can I ask a broader philosophical question? It may be an unfair question, but I'd like to know what you think.

We have perhaps spent the last 30 years believing that somehow we can make progress in all these areas, and we seem not to have made a lot of progress. Where are we in terms of learning from that process? Are we at a point where we have learned enough so that we can make progress? Or are we at the point of simply saying, "Why aren't we making any?"

Mr. CALHOUN. That presumes an answer.

Mr. PORTER. Yes. It's a "presume question."

Mr. CALHOUN. Well, what gives me the most hope is seeing local citizens pulling together for law enforcement, for schools, for churches. And we have seen communities, even some of the most despairing and hard-hit communities, snap back: a 40 percent reduction in crime in Bridgeport, Connecticut, which is a pretty grim place in spots; seven Texas cities in which we worked, seven of the largest cities, where the mayors were pumping enormous amounts of money mainly into corrections, and seeing the infrastructure and the money in schools shrivel, so "we've got to do something about prevention," and we went in and helped with comprehensive community planning, and crime dropped in every one of those cities.

I think the new element in this whole equation is the sense that a community is not a squishy, but a hard-knuckle, part of the public policy agenda. Nothing will change unless we have the police working with communities and social services in a very concentrated way, where everyone—everyone—can do something. An 87-year-old woman in Oakland said, "What can I do? I'm 87 years old. The drug dealers meet out in front of my house." Someone said, "Turn on your sprinkler." Well, admittedly a very modest and metaphoric statement; they moved a few blocks. But the point is that everybody has to do something.

So citizens have to do more, and Government can assist it.

Mr. PORTER. You are seeing communities do more, which means leadership, doesn't it, at the community level?

Mr. CALHOUN. Exactly. In our experience, if you're focused on a neighborhood, it takes neighborhood leadership; but if it's city-wide, it's the city manager or the mayor and the police chief saying, with all humility, "We cannot do it alone." That was very tough to get out of Texas. They get folks around the table, and interestingly, the recommendations that came out of the seven cities, one-third related to children and families; one-third related to rebuilding neighborhoods, the neighborhood cohesion I was talking about; and one-third related to sanctions. San Antonio did curfews. They did boot camps. But the Southwest Businessmen's Association promised 5,000 summer jobs, and they put money into the city council and into after-school recreation. By the way, that's now one of the highest crime times, is 3:00 to 6:00 p.m. It's no longer at night, because you have a flood of teenagers coming out of school with nothing to do. So crime dropped. And they had a lot of other recommendations relating to parenting and education.

Parent responsibility, by the way, is becoming quite a thing now, putting the weight back on parents in terms of if the kids are truants, bringing the families in. Crime dropped in San Antonio by, I think, 24 percent. I'd like to say it was all us; I'm sure there were a lot of other things involved, but crime dropped in every one of those Texas cities.

Mr. PORTER. Mr. Calhoun, thank you very much for your testimony today.

Mr. CALHOUN. Thank you for your time.

Mr. PORTER. The subcommittee will stand in recess until 2:00 p.m.

[Recess.]

WEDNESDAY, MARCH 6, 1996.

WITNESS

WILLIAM C. WATERS, IV, M.D., DOCTORS FOR INTEGRITY IN POLICY RESEARCH

Mr. PORTER. The subcommittee will come to order.

We continue this afternoon with our public witnesses. Before we begin, I would like to introduce two constituents of mine who are with us this afternoon, Caroline Bird and Jackie Mandell, sitting right there in the back row. Welcome to both of them.

I might say to all of our witnesses this afternoon each witness is to have five minutes to testify. The clerk of the subcommittee will at the end of the five minutes put up a small sign indicating that the time has expired and would you please at that point in time summarize and complete your testimony. Any questions or statements that members of the subcommittee would like to ask or make will then be in order.

The first witness will be William C. Waters, IV, M.D., a practicing physician in Atlanta, Georgia, and Eastern Director, Doctors for Integrity in Policy Research, testifying regarding the National Center for Injury Prevention and Control. Doctor Waters.

Dr. WATERS. Good afternoon, Mr. Chairman and members of the committee. My name is Bill Waters. I'm a practicing physician from Atlanta, Georgia, and the eastern director of Doctors for Integrity in Policy Research. I am here to talk about the National Center for Injury Prevention and Control, NCIPC, and the research that they do especially as it relates to firearms and violence.

You may be aware that there has been some rumblings among your legislative colleagues as well as among members of the academic community across the Nation, both in medicine and without, regarding this issue and the bias apparent in this particular branch. We share their deep concern that the design and conduct of firearms and violence research within the NCIPC seems to be affected by or based upon the political expedient that firearms prohibition or control is inherently desirable and provides a ready solution to many of society's problems, not the least of which is our very complex reality of violence. Our basic complaint then is that the NCIPC is not doing the job with which it was charged by this body. The reason that we feel that it's not doing its job is because of unscientific bias, this is our opinion. This precludes the merging of rational strategies in this debate. There is no way that I can in five minutes tell you everything that you need to know about this complex issue, but I though I'd focus on a couple of comments.

We have a lot of problems with the way the research methodology and approach to research is carried out. We have catalogued these extensively in various articles and this has been catalogued in other entities as well, as you'll hear about. We believe that the research is exclusionary to any conclusion which does not culminate in that firearms should be prohibited or controlled or that they are inherently bad. The approach is narrow and the methods are grotesquely inadequate and inappropriate for the subject under study. This has led to a widely held belief that the research as conducted by NCIPC exists to serve a preordained agenda.

I could go on about some of these things from a methodological or technical aspect, but let me just talk to you about some things you may not be quite as aware of. It is our view that the funded researchers and staff, including at the highest levels, of the NCIPC engage in what we believe to be overt political activism on this thing. And let us be the first to say that we believe that that's incorrect on either side of this issue. I would be just as vocal about this if this were a pro-gun issue. Anti-gun issue, pro-gun issue, it is still wrong to alter science to serve bias agenda, period.

At the Handgun Epidemic Lowering Plan Conference for the last three years, NCIPC staff at the highest levels and their funded researchers have served as faculty. This is a meeting described by its founder as "like-minded individuals who represent organizations.. . . [who will assist them in using] a public health model to work toward changing society's attitude toward guns so that it becomes socially unacceptable for private citizens to have handguns." They then went on to disinvite us by saying that our organization clearly does not share these beliefs and therefore does not meet the criteria for attendance at the meetings, rather suggesting to me, as I presume it would to you, that those who were invited do indeed share those views.

NCIPC funds are used to fund anti-firearms advocates handbooks, such as this one that you will hear more about.

I want to conclude my comments today by saying that I believe that a really great chance has been missed at the NCIPC. I believe that we had an opportunity, and there was a hurrah and a cry among the people who were interested in this field, for something really positive to be done where we could get all of the best scientists together with the best minds and objective strategies and views from all sides of this issue, put our minds together and come up with some real things that we could do about violence and firearms injuries in this society. Where normally we look for scholarly things to be a trustful and open and honest thing, this has been replaced by the shadow of distrust inherent to partisan politics.

In upcoming days, you're going to be told that firearms aspect of the NCIPC is but a small part of what they do and what's funded. But the fact still remains that I don't believe the funds which supported this came from the firearms budget. I know very well that the CDC grant which funded this handgun conference with NCIPC staff, including the most highly funded researchers, the featured speaker was Sarah Brady of Handgun Control, Incorporated, this grant was disseminated by the CDC for the study of rural and farm accidents such as tractor roll-over accidents. This is the kind of things, ladies and gentlemen, that does not engender trust and hope in the hearts of scientists. That's why we're here talking to you today.

There are three critical reasons why I believe that definitive action is needed. One is to protect the integrity of the CDC. It is an organization for which we have the deepest respect, the traditional aspect of it. Second, we are concerned that if we continue in this vein that the hopes of the individuals who produce the biased research will lead to outcomes which are the opposite of that which they hope. And the third thing is that bias in research has a blinding effect which cause us to ignore or to miss the true problem. Abe Lincoln once said that calling a tail a leg don't make it a leg, and I would reiterate the same thing to you gentlemen today.

Careful review of the data regarding this issue on your part we believe will result in your reaching the same conclusion as have we, that biased research is being done. We ask today for your help in preventing the tragedy that is public policy resulting from agenda-based research. Thank you kindly for having me here today to speak.

[The prepared statement follows:]

Statement of Doctors for Integrity in Policy Research
to
Committee on Appropriations
Labor, Health and Human Services,
Education and related Agencies Subcommittee
United States House of Representatives.

by
William C. Waters, IV, MD
March 6, 1996

Mr. Chairman and members of the subcommittee: my name is Bill Waters, IV, MD. I am a third-generation physician in the practice of Internal Medicine in Atlanta, Ga. I am also the Eastern Director of Doctors for Integrity in Policy Research (DIPR), a volunteer organization supported solely by member contributions of approximately 500 physicians from academia and the private sector. We very much support legitimate research on firearms violence, and have a deep respect for the traditional aspect of the CDC.

I am here today to apprise the members of this committee of what we consider to be a very serious problem with the activities of the National Center for Injury Prevention and Control (NCIPC). The committee may be aware that many of their fellow legislators, as well as scholars from a variety of different disciplines, have expressed concern that the design and conduct of research at the NCIPC seem to be affected by or based upon the political expedient that firearms control/prohibition is inherently desirable. To an ever-increasing degree, critics are aware of stated anti-firearms bias and political activism among NCIPC staff and funded researchers. With our colleagues, we are deeply concerned that biased research on the topic of firearms and violence will lead to public policy disasters.

Background

The CDC first became involved in the area of firearms and violence research in the late 1970s. Subsequent organizational efforts created the Division of Injury Epidemiology and Control, later formally titled the NCIPC. In 1993, this body was funded by Congress and charged with the task of scientifically studying injuries, including that resulting from violence. [Herein, to avoid confusion, we will refer to all evolutionary aspects of the CDC pertaining to this issue as the NCIPC] While many of us in the scientific community had high hopes that an eclectic, objective, comprehensive approach to the problem of violence was forthcoming, it became quickly apparent to us that quite the opposite was true. For example, In the late 1980s a number of works appeared, authored by CDC employees, which concluded and estimated, prior to any thorough research on the topic, the numbers of lives and dollars saved by restricting access to firearms.[1] Others stated that "The Public Health Service has targeted violence as a priority concern.... There is a separate objective to reduce the number of handguns in private ownership..."[2]

Our Basic Complaint

The basic complaint of our organization is that the NCIPC is not doing the job with which it was charged by Congress: to scientifically investigate the causes of violence and to propose solutions. We believe that it fails to do so because of unscientific bias. This bias is demonstrated in many ways, as outlined below:

NCIPC staff and funded researchers are quite active in assisting firearms prohibition meetings and organizations which are unequivocally political in nature.

For example, NCIPC researchers and staff - including those at the highest level - were faculty for the Handgun Epidemic Lowering Plan (HELP) conference in 1993 and again in 1995. This was a firearms prohibition strategy conference, described by its organizer as uniting "like-minded individuals who represent organizations ....[who will assist in using] a public health model to work toward changing society's attitude toward guns so that it becomes socially unacceptable for private citizens to have handguns."[3] Quite a few other examples exist.

Basic information is not always accurately represented by NCIPC staff:

"Firearms play a central role in interpersonal violence" - Dr. Mark Rosenberg (Head of Injury Control Division) in Health Affairs, Winter, 1993: 11 [Guns are used in 60-65% of murders, but this is a numerically small number of violent crimes. Guns are used in less than 13% of the 6.7 million rapes, robberies, and assaults - a statistic unreviewed by Dr. Rosenberg]

"Since the early 1970s the year-to-year fluctuations in firearm availability has paralleled the numbers of homicides." - CDC researcher D.P. Rice, et al: Cost of Injury in the United States: A report to Congress (CDC, 1989): 23. [Of course, this is incorrect during many periods of recent US History. For example, the period 1974-88 was witness to a 69% increase in handgun ownership with a concomitant 14.2% *decrease* in homicide]

"Handguns account for only 20% of the nation's firearms yet account for 90% of all firearms [mis]use, both criminal and accidental." - CDCs Diane Schetsky in vol. 139 American Journal of Diseases of Children (1985): 229. [This statement, which is patently false, was cited as having been extracted from the FBI's UNIFORM CRIME REPORTS. This is impossible, since this entity catalogs no data on gun ownership or gun type.] (Other examples are available on request.)

"Guns also accounted for 97% of the huge increase in violence among men ages 15 to 19 from 1985 to 1991, Dr. Rosenberg said" As reported by Fox Butterfield, The New York Times, Oct 16, 1994: A23. (Regarding interview with the head of the CDCs Injury Control Division, Dr. Mark Rosenberg) [One of the central questions in the issue of firearms and violence is whether the presence of guns plays any role in homicide and other violent crimes. Stating the matter as Dr. Rosenberg did leaves one with the impression that it is a foregone conclusion that guns "account for" violence - hardly a defensible comment. We feel that this demonstrates the mind-set that "guns cause crime & violence" and the lack of a sophisticated approach to the problem of violence in the NCIPC. Dr. Rosenberg said nothing about the guns in private hands during that same period which saved lives, nor did he mention that the groups in America which have the highest incidence of gun ownership have also the lowest rates of homicide.]

Many other examples exist.

NCIPC funds are used to support anti-firearms advocacy publications and activities:

One example is the **Injury Prevention Network Newsletter**, which is published by the Trauma Foundation and supported by NCIPC/CDC funds.[4] In the Spring, 1995 issue is found a number of disturbing items. One is the statement by its editor that the "shattered structure of the Federal office building in Oklahoma City bears mute testimony to how one segment of the pro-gun fringe intends to fight gun control." Another is a set of suggestions for anti-gun activists, including guidelines for picketing gun manufacturers, encouraging local support for gun control, etc.

NCIPC researchers, breaching accepted practice in the scientific community, refuse to release their publicly-funded, original data to other scientists for critical review.

Please see Kates, DB, et al. Guns and Public Health: Epidemic of Violence or Pandemic of Propaganda? University of Tennessee Law Review, 513 (1995).

The NCIPC approach to firearms/violence research is highly exclusionary, narrow in its focus, utilizes research models inappropriate to the subject under study, and thereby seems designed to produce preordained conclusions.

[Of course, research methodology is a technical area, and cannot be fully treated here. This topic is more fully catalogued elsewhere, and the reader is referred to these resources for more definitive information[4, 5, 6].]

Ignoring the vast body of scientific knowledge on the subject of violence: It is only appropriate to expect scientists studying a topic as complex and as serious as violence and firearms injuries to exhaustively consider and include in their analysis all available information and perspectives regarding the problem. The NCIPC has simply not done so. Despite the existence of copious scholarly data, analysis and experience which takes either a neutral or contrary view on the subject, the NCIPC includes in its publications and reports - and thus far to our knowledge has funded - only that research which supports restrictionist/prohibitionist perspectives. Little of the fields of Criminology and Sociology is to be found in CDC analyses, unless authored by their funded researchers. Seldom are epidemiological works mentioned if they conclude that firearms are not the pathogenic "organism" of violence. It seems strange to us that an organization funded by Congress with the charge to use all scientific means to find solutions to the problem of violence would ignore the largest body of authoritative information and methodology on the subject.

Ignoring contradictory evidence: Unmentioned in CDC-funded commentary and research are the many major studies which demonstrate a protective effect of firearms in private hands; often cited is the one (methodologically flawed) study which does not.[8] One NCIPC-funded study claimed to prove that American gun owners engage in unsafe gun-related behaviors, but failed to reconcile these findings with the reality that the firearms accidental death rate continues to decline and that hunting - a sport which requires all participants to be armed - was the safest outdoor participant sport in the last year for which data are available (1991). In another example, a CDC-sponsored analysis calculated the costs to society of firearms violence by, among other strategies, projecting slain felons' lifetime earnings as though they were productive citizens.[9] Equally incredible was that omitted from the tally sheet were the years of potential life saved and legitimate earnings of the 1 to 2.5 million people whose lives are protected by personal firearms each year.[10]

Inadequate methodology: Our organization,[5, 6] among other critics,[7] has been alarmed by the NCIPC's use of research techniques which are grossly inadequate and/or inappropriate to the subject under study. For example, one study counted *simple numbers* of homicides in Washington DC to claim effectiveness of gun control laws when none is present if the obviously more legitimate homicide *rate* data are used.[11] In their efforts to derive inferences about firearms in America, more than once have NCIPC researchers' selection of study groups been of a behavioral and socioeconomic character which would not fairly represent American society as a whole[12] - a fact which has not allayed fears that NCIPC research methods seem designed to serve a pre-conceived goal. And this selection

bias seems as ill-considered as the hackneyed use of single-factor epidemiological methods to study the fantastically complex issue of violence, as when a recent CDC-funded project studied "risk factors" for homicide in the home. Though "home rental" was one of the strongest risk factors for homicide, and firearms one of the least, this did not prevent the author from titling the paper "Gun ownership as a risk factor for homicide in the home." In the same study[12], the research methods used to decide that firearms were "risk factors" would, if one applied them to a study of the homes of diabetics, demand that we list unsugared beverages as "risk factors" for diabetes!

Conclusion

We believe that a great opportunity has been missed at the NCIPC, since there originally was the chance to combine the talents of scholars from all fields and all viewpoints to proactively help solve the problem of violence. It is our view that all hope of seeing this come to fruition within the NCIPC has been lost, replaced by the shadow of distrust inherent to partisan politics.

You are faced with the decision of how to handle funding for the NCIPC. Some have said that the firearms aspect of this branch is but a small part of the injury control effort, and the rest should be left alone. This is for Congress to decide. However, the unsettling fact still remains that, diverted out of funds reserved for the study of farm and rural injuries[13] (such as tractor rollovers, etc.) was funding for a 1992 conference on handgun injuries which included NCIPC-funded researchers and staff and - as the sole non-academic participant - Sarah Brady of Handgun Control, Inc.[14] And we have already commented on NCIPC financial support - presumably not from funds earmarked for study of the firearms issue - of publications serving as guidebooks for activism against firearms and their owners and manufacturers.

Bias among researchers is certain to produce erroneous or misleading results, and is anathema to the process of scientific discovery. True scientists delight in the realization and reconciliation of discrepant findings; they know that knowledge is the offspring of such an endeavor. For us to make progress in the complex investigation of all types of violence demands intolerance of investigator bias as another confounding variable.

It is the firm conviction of our organization that definitive action is needed, for two reasons. First, the CDC must suffer no loss respect because of the actions of the NCIPC; to be effective, a public health agency must have the confidence of the people it serves. Second, there is the very real risk that public policy will be set based upon biased, flawed data. If so, public health tragedies could result.

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[1] see Rosenberg ML, et al "Violence: Homicide, Assault, and Suicide," in Health Policy Consultation, eds Closing the Gap. New York: Oxford, 1987 164-178, and Rosenberg, ML, et al "Interpersonal Violence, Homicide and Spouse Abuse," in J M. Last, ed Public Health and Preventive Medicine, 12th Edition Norwalk, Conn.: Appleton Century-Crofts: 1399-1426 Also, see Rice, DP, et al Cost of Injury in the United States: A report to Congress Atlanta, CDC, 1989

[2] Fingerhut LA and Kleinman JC, Firearm Mortality among Children and youth. Advance Data #178. NCHS November 3, 1989.

[3] Christoffel, K. Personal communication to Dr. Ed Suter, Sept 29, 1993.

[4] CDC Grant # R49/CCR903697-06.

[4] Suter EA, Waters WC IV, Murray GB, et al. "Violence in America - effective solutions." J Med Assoc Ga June 1995; 84(6) 253-263

[5] Suter EA. Guns in the Medical Literature - a failure of peer review. J Med Assc Ga; March, 1994; 83: 133-148

[6] Kates D, Schaffer HE., Lattimer JK, Murray GB, and Cassem EW. Guns and Public Health: Epidemic of Violence or Pandemic of Propaganda? Tennessee Law Review. Spring 1995; 1995;62(3): 513-596. [Also, see references contained in this article]

[7] see comments of Kellermann AL in letter, J Med Assc Ga. June 1995; 83:320-321. Also, in JAMA, June 14, 1995, 273(22). 1759-1762; also, see letter in JAMA, January 24/31, 1996; 275(4): 281.

[8] Max W, Rice DP. Shooting in the dark: estimating the cost of firearm injuries. Health Affairs 1993; 12(4): 171-85

[9] Kleck G and Gertz M. Armed resistance to crime: the prevalence and nature of self-defense with a gun. Journal of Criminal Law and Criminology; Summer, 1995 86(1): 150-187.

[10] Loftin C, McDowell D, Wiersema B, Cottey TJ. Effects of restrictive licensing of handguns on homicide and suicide in the District of Columbia. N Engl J Med 1991; 325:1615-20.

[11] See as an example Kellermann AL, Rivara FP, Rushforth NB, et al. Gun ownership as a risk factor for homicide in the home. N Engl J Med 1993; 329 (15):1084-91.

[12] CDC Grant #7036-40

[13] Handgun injuries: a public health approach. The University of Iowa, January 29, 1992.

Mr. PORTER. Doctor Waters, can you leave that document, that monograph. I haven't seen that and I'd like to see it.

Dr. WATERS. Sure. I'd be happy to.

Mr. PORTER. Do members of the committee have any questions? Mr. Dickey.

Mr. DICKEY. Yes, sir. Doctor Waters, you may have already gone over this but I want to have you state it again. What evidence is there that NCIPC staff and grantees have an anti-gun bias as opposed to simply finding different results from the evidence than you would?

Dr. WATERS. Let me begin by answering the latter part of your question, Mr. Dickey. I wouldn't have any idea what conclusions I would find if I were studying this issue, because a scientist doesn't have any clue, if he's a true scientist, doesn't have any clue what he's going to find until he finds it. So if I found something that didn't support the agenda, for example, of the National Rifle Association or, for that matter, Handgun Control, Inc., it is my duty as a scientist to report that objectively. It's also my duty to be open to the criticisms of my colleagues. That's mandatory in science. If it weren't for each other, we wouldn't be able to keep each other on the right track; that's what has lead to all the medical progress. That's one of the reasons why medical knowledge doubles every ten years. As in every other aspect of medical research, there is that open forum. I guess I could go on literally for weeks about bias in this regard, but we have fully catalogued their approach to science, the approach to research, the activities of the individuals, the way the research is approached.

Mr. PORTER. You would be welcome, Doctor Waters, to submit a longer answer for the record if you would like to do that.

Dr. WATERS. That's great. I appreciate that offer.

Mr. DICKEY. May I ask one more question. Hold up that. What does it show on the front of it?

Dr. WATERS. It shows a handgun shooting a female symbol.

Mr. DICKEY. And what organization put that out?

Dr. WATERS. It is put out by the Trauma Foundation, the Injury Prevention Network Newsletter. Doctor Wheeler, I think was going to make some comments about this later. It has truly egregious comments in here by the editor which I think he may review for you, as well as serving as a source book for anti-firearms owner, anti-firearms manufacturer, and anti-firearms ownership. The whole thing is about that, especially the activists handbook.

Mr. DICKEY. Where did the money come from?

Dr. WATERS. It came from grant No. R49/CCR903697-06 from the Centers for Disease Control and Prevention.

Mr. DICKEY. Is that NIH, Mr. Chairman?

Mr. PORTER. No, that's CDC. Mr. Istook?

Mr. ISTOOK. May I ask just one question. Since obviously we are here concerned with issues of funding and appropriations to CDC, NCIPC, and other entities, do you have any sort of dollar figure that you would say has been expended by either of these or any other Federal entity to promote what you call the overt political activism? I am just asking if you have a dollar figure according to your tabulations?

Dr. WATERS. No, sir, I don't. The reason is because if you study this you would see that this were meant for tractor roll-over accident investigation, which sounds fairly legitimate to me, and it is channelled into these means. So I don't know how you would know, except what we pick up in bits and pieces we can.

I would like to say something else if I may, sir, and that is that I have the highest regard for the people I'm criticizing. It may sound like I'm talking out of both sides of my mouth, but I think these are altruistic people who are doing what they think is right. It is just that I believe that bias in this issue is what is leading the whole thing astray, not character.

Mr. PORTER. Mr. Hoyer.

Mr. HOYER. Doctor, would you allow that bias on both sides of this issue may color conclusions?

Dr. WATERS. Absolutely. I absolutely object to the use of science in terms of setting up to do a study to show that everybody should have a handgun in their house. Believe me, I would be speaking just as loudly against that.

Mr. HOYER. I really believe that this is one of those issues that is difficult to discuss rationally because the emotions on both sides are so high.

Dr. WATERS. I was quoted in the *Atlanta Journal* about a month ago saying that identical thing.

Mr. HOYER. For instance, I'm one of those legislators, as you probably know, that supports Brady and supports the assault weapon ban and supports what is politically called the "cop killer" bullets prohibition, but who believes in, and I do support, safe and lawful use of firearms. I come from an area where we have a large ownership of firearms, we have a lot of hunting, I come from southern Maryland, a lot of duck hunting and goose hunting. But I think the more rational the discussion about this issue the more confident the public will be. I think the public is somewhat confused about this issue as well because the rhetoric on both sides is so hot.

Dr. WATERS. I agree with you. Even though the entities that we're criticizing often counsel physicians to counsel patients on the risks and benefits of firearms, they have never published anything on the benefits. How would this prepare physicians or train physicians to do so, et cetera?

Mr. HOYER. Thank you, Doctor. Thank you, Mr. Chairman.

Mr. PORTER. If members have a question of any of the witnesses, please just address the Chair and we'll entertain all the questions that any member wants to ask.

Doctor Waters, thank you very much for your testimony.

WEDNESDAY, MARCH 6, 1996.

WITNESS

MIGUEL A. FARIA, JR., M.D., THE NATIONAL CENTER FOR INJURY PREVENTION AND CONTROL

Mr. PORTER. Miguel A. Faria, Jr., M.D., consultant neurosurgeon and adjunct professor of medical history at Mercer University School of Medicine in Macon, Georgia, testifying regarding the National Center for Injury Prevention and Control. Doctor Faria.

Dr. FARIA. Thank you, Mr. Chairman and members of the committee. In 1991, the American Medical Association launched a major campaign against domestic violence which goes on to this day. First, as a practicing neurosurgeon and then as a member of organized medicine and editor of a medical journal, I joined in what I considered a worthwhile cause. It was then while researching this topic and attempting to find workable solutions I found the medical literature had failed knowingly to objectively discuss both sides of the issue of domestic violence and street crime. This still goes on despite purported safeguards of peer-review and the alleged claims to objectivity and integrity by government-funded researchers in public health.

Instead of providing and balanced and fair approach based on truth and objectivity, the medical journals echo the emotionalism and rhetoric of the mass media. And, like the public health establishment, thwart the pursuit of free inquiry in scientific research. The latter, incarnated in the CDC's National Center for Injury Prevention and Control, NCIPC, provided politicized result-oriented research based on what only can be called "junk" science to promote gun control as a panacea for solving the problem of violence. Research that does not lead to this aforementioned conclusion is eradicably censored and scholarly articles not published. Moreover, this flawed one-sided pseudo-research is subsidized by the taxpayers.

Despite a surfeit of scientific and epidemiologic studies in the legal and criminologic literature discussing the benefits of firearm possession by law-abiding citizens, the general public is not being informed about this information by the NCIPC and it outlets, the medical journals. As editor-in-chief of The Medical Sentinel of the Association of American Physicians and Surgeons, I feel now a moral duty and professional obligation to inform you about these developments for I deeply believe that in a free society citizens and their elected representatives have a right to know and be presented with all sides of an issue for proper deliberation and eventually sound public policy formulation.

Sadly, the CDC's NCIPC has from its inception, and despite valid criticism from many quarters, continued to pursue a grossly politicized agenda and has abjectly lost sight of its mission. I have always been a staunch supporter of public health in its traditional role of promoting health by educating the public as to hygiene, sanitation, and preventable diseases, and fighting to pestilential diseases. In fact, I have enumerated this in a book that I published last year. But, unfortunately, it has become crystal clear that the NCIPC, in the name of injury prevention and control, has succumbed to ideology in fulfilling its mission and despoiling the functions for which it was created by Congress.

Lastly, I would like to bring to mind the fact that much of the preventable injury research done by the NCIPC, except perhaps for the aforementioned politicized, flawed gun research, is redundant, already being adequately performed by other agencies with more experience and expertise in the field. For example, the Department of Transportation already has a prevention program for reducing automobile injuries. The Department of Labor has OSH which conducts research on injury prevention in the workplace. The Depart-

ment of Justice has an initiative that addresses specifically violence prevention and, in conjunction with other agencies, domestic violence. The Department of Education likewise is involved in violence prevention within the school system. The Department of Health and Human Services is also conducting federally-funded research on violence at a cost of over $50 million. The Department of Agriculture is involved with a study of farm injuries.

In short, because of the complex nature of violence in our society, violence and crime prevention efforts should be addressed by our education and criminal justice systems. Violence is not a disease and, therefore, it is not amendable to the study or treatment with traditional public health measures.

Based on these serious violations of the National Center for Injury Prevention and Control of the CDC in the pursuit of unscientific, biased research and the duplicative and redundant functions, it is my professional opinion this committee should eliminate all funding for this agency for fiscal year 1997. This money could better be used toward achieving the illusive balanced budget or, better yet, could be used in breast cancer research against a pernicious disease that afflicts 185,000 women annual and claims the lives of another 45,000 women a year.

Thank you for allowing me to testify here today.

[The prepared statement follows:]

On Public Health and Gun Control

Miguel A. Faria, Jr., MD

In 1991, the American Medical Association (AMA) launched a major campaign against domestic violence which goes on to this day. I, as an active member of organized medicine, joined in what I deeply considered a worthwhile cause. It was thus while researching the topic of domestic violence and street crime and attempting to find workable solutions, I came to the inescapable conclusion and appalling reality the medical literature on firearms and violence had failed to objectively discuss both sides of this issue. And this, despite the purported safeguards of peer-review and the alleged claims to objectivity and integrity by government-funded researchers in public health and scientific investigations.

What I found, over the subsequent 5 years, particularly as editor of the *Journal of the Medical Association of Georgia* was, frankly, when it came to the issue of guns and violence, medical journals had taken the easy way out of the *mêlée*, presenting only one side, and censoring the other. The side that was being censored, despite the accumulating amount of data supporting it, was that side dealing with the beneficial aspects of firearms and the benefits of self-protection by law-abiding citizens. Instead of providing a balanced and fair approach based on truth and objectivity, the medical literature echoed the emotionalism and rhetoric of the mass media, and thwarted free inquiry in scientific research. In most cases, it provided politicized, result-oriented research based on what can only be called junk science, to bolster the agenda of the gun control lobby.

Why? Because that is the pasture where the CDC's National Center for Injury Prevention and Control (NCIPC)'s milk cow is grazing. That is where the government money is. How? By propounding the erroneous notion gun control is a public health issue and that crime is a disease, an epidemic—rather than a major facet of criminology. So they espouse the preposterous but politically-expedient concept of guns and bullets as animated, virulent pathogens, needing to be stamped out by limiting gun availability, and ultimately, eradicating guns from law-abiding citizens.

They chose to neglect the fact that guns and bullets are inanimate objects that do not follow Koch's Postulates of pathogenicity (which prove definitively a microorganism is responsible for a particular disease); and they fail to recognize behind every shooting there is a person pulling the trigger—and who should be held accountable. The portrayal of guns in the medical literature by the public health/CDC establishment reflects the sensationalized violence in the mainstream media and exploits our understandable concern for domestic violence and rampant street crime, but does not reflect accurate, unbiased, and objective information needed for optimum public policy.

Despite a surfeit of scientific and epidemiologic studies in the sociologic, legal, and criminologic literature that discuss the benefits of firearm possession by law-abiding citizens—physicians and the general public are not being informed about this information by the CDC's NCIPC and its outlets, the medical

journals. As former editor of a state medical journal, I felt then, and as Editor-in-Chief of *The Medical Sentinel* of the Association of American Physicians and Surgeons, I feel now, a deep sense of moral duty and professional obligation to inform you about this other side of the debate which is seldom promulgated and continues to be censored in the public health/ CDC/NCIPC establishment, for I deeply believe that in a free society citizens and their elected representatives have a right to know and be presented with all sides of an issue for proper deliberation and, eventually, sound public policy formulation.

As it regards public funding of the NCIPC's gun control research, I want to bring tc your attention the squandering of taxpayers' hard-earned monies used in this "research." Since at least 1986, Dr Arthur Kellermann (and associates), whose work is heavily funded by the CDC, have published studies purporting to show persons who keep guns in the home are more likely to be victims of homicide than those who don't. Professor Gary Kleck of Florida State University, author of the immensely influential criminological book, *Point Blank: Guns and Violence in America* (1991) and Dr. Edgar Suter, Chair of Doctors for Integrity in Policy Research (DIPR) critically analyzed Kellermann's work. They found (as I and many other scholars have) major conceptual and methodologic as well as factual errors in his published "research" (this, mind you, despite the supposed safeguards of peer review of his work prior to publication). Frankly, these errors now make all of his work suspect for the validity of its conclusions. For example, Kellermann's 1986 claim that a gun owner is 43 times more likely to kill a family member than an intruder, the "43 times" fallacy, was heavily criticized and discussed by researchers. In 1993, his claim had to be downgraded to the "2.7 times" fallacy. But a fallacy is still a fallacy and deserves no place in scientific investigation.(1,2) For even in his 1993 study, he once again used non-sequitur logic, failed to consider the protective benefits of firearms, and used a markedly unrepresentative (dysfunctional) population sample, from which he then erroneously extrapolated to the general population. These errors invalidated the "2.7 times" fallacy as well.(3) Yet, these errors permeate medical journals and remain uncorrected, and because it comes from supposedly objective researchers, it carries a lot of weight with physicians, social workers, professional organizations and even policymakers and the layman, contributing many a time to regrettable, faulty and sometimes catastrophic public policies.

What we do know, thanks to the meticulous and sound scholarship of Professor Kleck (corroborated by such authorities as Professor Don B Kates, Dr. Edgar Suter, investigator David Kopel, and others who have reviewed Kleck's monumental work), is the defensive uses of firearms by citizens amount to 2.5 million uses per year and dwarf the offensive gun uses by criminals. Between 25-75 lives are saved by a gun for every life lost to a gun. Medical costs saved by guns in the hands of law-abiding citizens are 15 times greater than costs incurred by criminal uses of firearms. Guns also prevent injuries to good people and protect billions of dollars of property every year.(3) Yet, the CDC/NCIPC clings to the erroneous figures of Kellermann and other NCIPC researchers and use