

REMARKS OF HONORABLE JOHN E. FOGARTY, U.S. REPRESENTATIVE SECOND
CONGRESSIONAL DISTRICT OF RHODE ISLAND AT UNIVERSITY OF NORTH
CAROLINA SCHOOL OF PUBLIC HEALTH STUDENT-FACULTY SEMINAR, CHAPEL
HILL, NORTH CAROLINA, MONDAY, MARCH 5, 1962 AT 3 PM

DRAFT

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March 5, 1962

I accepted with special pleasure the kind invitation of
Dr. McGavran to appear on this Student-Faculty Seminar of the School
of Public Health to speak on the general subject of health legislation.
As a layman, it always gives me great satisfaction to appear before
professionally outstanding groups such as this School of Public Health --
one of 12 such schools in the United States to be accredited by the
American Public Health Association.

~~Over~~
Twenty years ago when I began my public service in the Congress
and began to be directly involved in public health legislation, a far-
reaching change was just taking place in the minds of health legislators.
Health legislation was no longer just a response to the ravages of an
epidemic -- as when Congress appropriated one million dollars in 1918
for the Public Health Service to aid in the suppression of influenza
in the United States. The decline of epidemic diseases was producing
a change of emphasis in public health work, and in public health
legislation.

For the first time health legislation was forward-looking,
concerned with what we may call the long-range prevention of disease.

Subsequently A vast research program concerned with the chronic and degenerative
diseases was beginning, in the 1940's; the necessary legislation to

support it was forthcoming, just as, in the 1950's, the legislation was forthcoming to begin to meet the increasing problems of environmental health. I am proud of this increased awareness on the part of those of us in Congress -- and I am even prouder of the general public awareness and spirit that moved us to act. To be sure, there is not enough awareness even yet of these vast and pressing problems -- but there is an ever greater awareness, and this is a hopeful sign.

Now, I have had the good fortune, as most of you know, to be privileged to serve as Chairman of the ^{House} Subcommittee on Appropriations for the Department of Health, Education, and Welfare for a major part of the past 15 years. In the course of this time I have had a liberal education in the general fields of medical and health administration, and have watched and done ^{all within my power} ~~my part~~ to stimulate the explosive growth of Federal support in all areas of public health, especially that of research.

All of you are aware -- I am sure -- that Federal support of research has undergone a tremendous expansion -- from about \$45 million in 1940, to more than \$700 million, today. It is perhaps ^{not} generally recognized -- but equally true -- that this growth has been paralleled by a remarkable increase in non-Federal expenditures in medical research -- from \$42 million in 1940 to more than \$300 million. Today my references to the Federal programs for support ^{of} medical research will be primarily for the purpose of illustrating the virtues of similar approaches in

related efforts.

Long before the research and research training grants programs of today were even dreamed of, a remarkable mechanism for the stimulation of private expenditures by the use of Federal funds was created in Federal matching grants for construction of health facilities and the establishment of health services. As far back as World War I, Congress provided that demonstrations in rural sanitation could be made within the States -- provided that the States would agree to pay one-half the expenses. While the amount of Federal funds available in those days was extremely limited, important ~~policies~~, precedents ⁱⁿ and Federal-State relationships were established during the 1920's and 1930's.

Then, in 1935, the Social Security Act authorized, among other things, the sum of 11 million dollars ^{to assist} ~~for assisting~~ States, counties, health districts and other political units in maintaining and establishing adequate health services, including the training of personnel for State and local health work. These general health grants required that the States appropriate ~~matching funds based on population and special health problems.~~ ^{and categorical grants} These general grants, ~~as well as such programs as the Hill-Burton hospital construction program,~~ have been highly successful in helping States, communities and institutions raise money from non-Federal sources. Without the Federal stimulus ^{would have been} ~~to encourage the putting of private and State money to effective use,~~ ^{much slower in developing} ~~the funds might have never been raised and the facilities might never~~ have been built. ~~I might mention, in passing, that in 1961, for~~

For example, under the Hill-Burton program ^{in 1961} more than 146 million dollars in Federal funds were awarded for construction of facilities with a total cost of more than \$468 million -- ~~in this case~~, every Federal dollar being matched by more than three non-Federal dollars.

Through the years local health departments have demonstrated their effectiveness in assuming the responsibility for broad community health services. The Congress has tried to enhance this effectiveness under such legislation as the Community Health Services and Facilities Act. ~~As you may recall, this Act aims to expand the health services of the whole community through studies, experiments and demonstrations which will lead to new outside-the-hospital services.~~ One aspect of the Act, the special project grants, is designed largely to assist individual groups and local communities in setting up services that may be new to an area or to test new ideas. It is the communities that will have to take the initiative in taking advantage of the ^{full} provisions of this Act, ~~and it is a challenge to health professionals all over the country to develop and improve their local health services.~~

Not far away from here a community has already taken up this challenge. Health officials in Guilford County, North Carolina, made a careful survey of their community needs and resources. They learned, among other things, that many patients in nursing homes and in their own homes were not getting the care they needed. On the basis of this study Guilford County decided that it would give priority to a program for providing services at home.

Each community must determine its own needs -- establish its own ends and goals -- and plan the action to be taken. There was no intention of covering all communities with one comprehensive national plan from Washington -- ~~this could well have smothered the initiative and imagination of local health officials, had it been undertaken.~~

Rather, ^I it is hoped that this Act will stimulate community ^{ES} ~~action~~ to develop ^{services and} ~~projects that may~~ increase their resources to fill their particular needs.

The Community Health Service and Facilities Act amply illustrates ~~an essential concept in many Federal grant programs.~~ It is the concept that Federal grants and support will stimulate local, non-Federal activities. All too often we hear from critics of Federal aid such expressions as "Federal aid means Federal control" or "Federal aid stifles local ^{initiative} ~~enterprise.~~" But I am certain that critics say these things without evaluating the ^{True} effect of Federal support ^{and stimulation} ~~of any particular activity.~~

While we can see that Federal aid can and has stimulated public health activities in this country, the support has not always been applied to all our areas of need. A proper ^{national wide} ~~national~~ health program has many facets, of which services is ^{but one product.} ~~only one.~~ Another, ^{Vital} ~~Vital~~ to the success of ^{this} ~~the~~ program, is personnel. What can we do to improve services if we lack the trained personnel needed to carry out these services? We have moved forward in some aspects of the personnel ^{shortage} ~~problem,~~ but we are losing ground in an especially dangerous area: we are desperately short of physicians and dentists.

As President Kennedy pointed out in his Special Education message to Congress last month, "Even to maintain the present ratio of physicians and dentists to population we must graduate 50% more physicians and 90% more dentists per year, by 1970, requiring not only the expansion of existing schools but the construction of at least 20 new medical schools and 20 new dental schools."

Those who have investigated this problem are agreed that ^{PRESENT} ~~current~~ methods of financing, through States, municipalities, private foundations and individuals, will not achieve the expansion of existing schools and the establishment of new schools to provide the physicians and dentists we so urgently need.

I believe The answer to the financing problem is ~~that without~~ extensive Federal aid, ~~the job will not be done.~~ I believe that ~~Few of us~~ would deny the logic of the extension of Federal participation to the support of medical education. The shortage of professional health personnel is a national shortage -- it touches every community in our land.

Such an extension is not without precedent. I hardly need remind this group, ~~but I think it is interesting,~~ that the Division of Public Health at this University was established in 1936 -- and that same year it was designated by the United ^{States} Public Health Service as a center to carry out the provisions of the Social Security Act for training ~~of~~ public health personnel. Thus, since 1936, general health grants have been used by the Federal government to provide financial assistance for the training of public health personnel.

It seems to me, therefore, that the question is no longer whether we are going to have Federal support, but when ~~(we are)~~ going to have enough, ~~and~~ *and how should it be provided?* ~~in what form we are going to have it.~~ As for myself, I have little doubt as to what form the aid should take. ~~We already have the prototype of an administrative system, for general Federal aid to medical education. Adaptation of the~~

~~principles underlying the administration of the medical research programs would -- I am certain -- quell the fears of Federal domination that are so often stated as a ground for opposition to Federal aid to medical education.~~

For a number of years now it has been apparent to me, as I have studied the question, that the Federal government should move in three directions to meet satisfactorily the problems of medical education. First, it must directly assist the teaching function of medical and related schools. Second, it should supplement non-Federal sources in providing scholarship, fellowship and loan assistance to medical, dental and public health students as it now does to Ph.D. candidates in the basic sciences. Third, it should ^{provide some assistance} ~~relieve the serious financial~~ ^{for the basic operational costs of these} ~~and administrative imbalances between the research and teaching functions of the~~ ^{institutions.} ~~medical schools, due partly to the tremendous increase in support of medical~~ ~~research.~~

Last month I had the opportunity to address the 58th Annual Congress of Medical Education and Licensure of the American Medical Association. I discussed the future financing of medical schools in this country. I emphasized the need for Federal aid, and I observed that the American Medical Association has not in the past blazed a path in urging increased Federal expenditures for medical research, although this development is of greatest consequence to the medical practitioner and to the whole field of medical care. I reminded the AMA that Federal support of medical research has proceeded with the AMA standing by, ^{neither} ~~not~~ opposing, ^{nor} ~~but not~~ supporting, ^{but} ~~while~~ disapproving in vague terms, on grounds of principle. I urged them to ponder the implications of the fact that the most important long-range influence on the practice of medicine and the health of the whole American people has been fostered and guided under policies to which the American Medical Association has contributed little.

~~Now, I do not underestimate the responsibility and the financial capacity of States, municipalities and private foundations and individuals to play various and important roles in furthering medical education in this country. It would be a fatal illusion, however, to assume that all of the sources combined will produce the required volume of money.~~

Bills have been introduced into Congress to meet these urgent needs ^{for more medical schools.} I myself have introduced three bills -- HR 27, HR 3276, and HR 3438 -- to deal with three separate but related kinds of assistance -- the construction of new facilities, general operating expenses, and funds for scholarships to attract and to aid students.

And I wish to point out explicitly that the requirements for health manpower are to be met not only by medical schools, but also by such institutions as schools of dentistry, osteopathy, and public health. These institutions should be included in a comprehensive plan, and ^{the} bills do extend to these fields.

The general features of the three bills I have introduced are consolidated in a single bill -- HR 4999 -- introduced by Mr. Harris of Arkansas and sponsored by the Administration. Certain of the provisions of the Administration bill are, in my judgment, inadequate, particularly the general support and the scholarship provisions, and I have testified to that effect.

Nevertheless, the Administration bill does provide in a single place all of the required elements of a sound program, and the adjustments required to make it fully adequate relate primarily to the funds provided rather than to the principles involved.

It would make available a total of \$750 million in Federal funds over the next decade for the construction of new and the rehabilitation of old, professional schools. It would ultimately provide about \$17 million per year for scholarships amounting to a maximum of \$2,000 per year to qualified and needy students. It would provide for \$1,000 per year for each student receiving a scholarship to each school for general operating expenses.

I urged the American Medical Association to support this bill and to endorse these principles. I urge you to make your influence felt on the Federal legislators who ~~may~~ have to pass on this bill. ~~For as always, the ultimate success of legislation depends upon demonstrated and clear public support for the measure.~~

When I testified before the House Committee headed by Mr. Harris, I took the opportunity to comment on research facilities construction grants. ~~I noted that, in addition to expanding the capacity of the schools and aiding the students, Mr. Harris' legislation is designed to extend, expand, and improve the existing program of research facilities.~~

~~Observing that I have consistently supported a construction program since its inception in 1956, I commented that the new bill introduces certain much needed amendments to the original legislation.~~

Since 1957 Federal support for medical research and research training has undergone major changes. In sharp contrast to Federal support for medical research, funds for research construction grants were frozen by statute to \$30 million a year until 1961. ~~It can be shown by simple arithmetic~~ ^{shows} that investment in physical resources for research has dropped from one-fifth to one-twentieth of the National Institutes of Health extramural funds since 1957. ~~with the result that support of research resources is badly out of balance with the support of research.~~

At a time when a growing number of highly-trained medical scientists are embarking on their careers, a major national deficit is developing in the availability of modern facilities in which to work. This is, in my view, the greatest single obstacle to the advancement of medical research in this country.

~~The original health research facilities construction program of 1956~~ resulted from a general recognition of the need for Federal assistance to the educational community. The need for assistance had been demonstrated and reiterated by such eminent groups as the Association of American Medical Colleges, the Council on Medical Education of the American Medical Association, the Committee on Consultants to the Secretary of Health, Education and Welfare, and the House of the Congress of the United States. No one pretended that matching grants for construction purposes would meet all of the future needs of the medical schools. ~~The institutions themselves -- and Congress -- were unable to see the issue clearly, in 1956.~~

On the basis of several years' experience with the program -- which has awarded more than \$150 million in Federal funds to universities since 1957 -- I suggested certain modifications which ought to be made in the authorizing legislation. These views I presented to the Harris committee, substantially as follows:

First, the program should be extended for at least five years.

Second, an increase should be made in the appropriation authorization.

The present ceiling of \$50 million which was voted last year for a one-year period is hardly more adequate than the \$30 million ceiling it replaced.

Third, a change should be made in the matching requirements, as the present 50-50 matching requirement limits the effectiveness of this program.

The Harris bill approaches these needs, but in what I believe is a too conservative way. It calls for a three-year extension of the program at an annual authorization of \$50 million. This is not commensurate with grant applications, approved and pending, which total over \$100 million, plus additional evidence of intent now on file in the Public Health Service. I urged that the committee consider extending the period of the authorization and increasing the appropriation to at least \$75 million.

Also, the Harris bill in its present form makes no recognition of the problem presented by the current 50 percent matching restriction. Many institutions with strong research capabilities but lacking rich endowments are now unable to build the facilities commensurate with their research potential. It is my firm belief that some provision should be made to permit Federal matching funds in excess of 50 percent in cases where institutional research needs and capabilities are strong but financial resources inadequate.

I am in accord with the provision of the Harris bill which would permit the Surgeon General, in cases of special national or regional need, to support or carry out research construction without matching requirements. I believe this provision is a sound one. However, it does not meet, nor is it intended to meet, the needs of poor institutions in respect to the construction of research facilities for their own use.

As of last fall, the Health Research Facilities program had resulted in capital expenditures of more than \$600 million for health research and related facilities, and had assisted more than 300 academic institutions in every State in the Union in constructing or renovating approximately 20 million square

feet of research space. ~~Again,~~ ^A as with the Hill-Burton program, every Federal dollar has stimulated the investment of more than three non-Federal dollars -- another example of the use of Federal funds to stimulate other funds. But this expenditure is still not enough to provide sorely needed modern, well-equipped facilities this country needs for its research and training effort.

~~I hope that the Harris bill may be modified to incorporate these suggestions. I believe that the need for strengthening the medical schools in their teaching and research functions through additional Federal funds for construction will be apparent to Congress, and that this Congress will take affirmative action of some kind. The Harris bill, quite as much as my own proposals, originate from the common Congressional effort to keep pace with changing needs.~~

~~In retrospect, response to changing needs has been the hallmark of the gradual, year-by-year buildup of the Federal medical grant program. We had, in the National Institutes of Health, an organization with experience in the granting field, and a tradition of the support of excellence in research. Through the years a splendid structure of technical study sections and policy-oriented National Advisory Councils has assured the full participation of the scientific and academic world in the making of decisions relating both to general policies and to specific research grants. The joining of outside advisors, primarily in the universities, with responsible Federal administrators has removed the traditional wall between the Federal government and the scientific and educational community. This is a system which has proved remarkably workable, over the years, and one which it has been possible to adapt successfully to new conditions as these conditions arose.~~

One specific example of a modification in the system to meet new needs is the General Clinical Research Center Program. This program was established in 1959 at the direction of the Senate Committee on Appropriations in recognition of the national need for an improvement of clinical research. The program provides a means for precise observation and control of research with patients and for extension ^{of} laboratory research in animals into valid correlative studies in human beings. This program awards grants to institutions for the establishment of discrete research units and pays for the renovation and equipment of facilities, for costs of the care of research patients (including specialized nursing, diet kitchens, and other services) and for supporting laboratories and certain staff salaries.

So far, 40 grants have been made for a total in excess of \$20 million -- of which more than half a million dollars has come to the University of North Carolina School of Medicine.

Another specific example of the system's ability to change to meet new conditions is the General Research Support Grant now being inaugurated. This grant is made, not for specific research projects, but for general underpinning of the direct costs of research projects selected by the schools themselves and their faculties. This program was conceived and developed to provide research and research training institutions with a means of greater flexibility in the use of their funds. To some extent the granting of funds for specific projects proposed by individual investigators was beginning to limit the autonomy of the grantee institutions and investigators in controlling the character and direction of their work. The new form of support will afford more freedom to the grantee institutions in carrying out their programs.

~~Adoption of this new process under the old system is particularly important in demonstrating that Federal support of medical research has not led to Federal domination but to a productive partnership between the scientific community and the Federal government.~~

~~As of January of this year, 153 schools of medicine, dentistry, osteopathy and public health had been awarded grants totalling \$20 million -- of this amount, \$51,788 has come to the University of North Carolina School of Public Health.~~

The challenge we in Congress face is how to obtain facts and expert judgments which will enable us to draft new legislation and to authorize the establishment of new programs to meet changing needs. This is a heavy responsibility. I think, for example, that the support program has been signally successful. I do not mean that the system for the support of medical research *or any* *other* is perfect. But I do mean that the system is self-correctable, and adaptable to new conditions. This is no small achievement.

Last year I was invited to speak before the Association of Southern Medical Schools and Teaching Hospitals at the Duke University Medical Center. At that time I described very briefly how my own Committee obtains the facts and advice it needs. I would like to restate that, because it ^{may} ~~should~~ prove interesting and perhaps reassuring to this group, today.

First, the professional and administrative leaders in various governmental agencies -- in our case, the various bureaus of the Public Health Service -- work up each year estimates of how much money ^{is} ~~they will~~ need^{ed} for specific activities already authorized by law and by previous appropriations. In addition, requests are made for new activities requiring either special authorization by Congress, or authorization which may be given through the appropriations process.

Detailed written justifications accompany these requests, and, in addition, the officials must answer searching questions by Committee members and our staff.

Second, the Committee seeks the formal opinions, both written and oral, of outstanding non-Federal experts in all fields under consideration. These opinions may take the form of individual advice, or of institutional judgments, or may be incorporated in organized studies conducted for the Congress by a group of experts.

Third, our Committee members obtain informal judgments and suggestions through discussions with individuals and groups -- both professional and non-professional -- in Washington, in our home states, and at meetings such as this ^{from} ~~in~~ all parts of the country.

Through these processes my Committee -- along with a large number of scientists, educators, and administrators -- has come to the conclusion that the Federal government must do more than simply continue to support more research projects, build more research facilities, and train more research people. It has become necessary for us to think not only in terms of the end product we seek -- better health for the American people -- but also in terms of the institutions and the people that comprise the institutions that we must work with. And, above all, I think, we have to educate ourselves on the changing patterns of disease.

~~We legislators~~ travel around the country a good deal, and speak before many groups. One benefit ~~of this~~ is that we gain ideas from ^{my} ~~our~~ hosts and from the questions ~~our audiences~~ ^{ask} and from the exposure ~~we~~ ^{we} have to local problems. But there is another benefit which I gain from meetings such as this.

Whenever I am invited to address an organization, I naturally try to tailor my remarks to fit my audience, to speak on subjects of interest to them. When I was invited to speak before this School of Public Health, I began to consider all over again the role of public health in advancing the health of the nation, and it seemed to me that public health is beginning to come back into its own.

In the first 40 years or so of this century the primary challenge to public health was infection, and the environmental approach to health was, in those days, all important. Then, about the time I first came to Congress, we had seen the rapid decline of most of the major infectious diseases and as a consequence, perhaps, chronic diseases were being recognized as the primary challenge to public health. Changes in health practices began to focus on the needs of individuals, in contrast to the previous period, when the focus was on the needs of the community. We have not seen the virtual conquest of the chronic diseases, in the last 20 years, but we have mounted a broad research program, and we have every reason to hope that in time we will see such a virtual conquest.

But today the problems of our environment have returned to haunt us. New environmental problems have arisen that demand attention, and these are quite different from those of 1900. Today's problems arise from advances in technology; from agricultural insecticides, from industrial practice, from urbanization, and from the uses of nuclear energy. We know that a progressive advance against chronic illness will satisfy only a part of the total health problem -- that environmental factors may enter into consideration of these diseases themselves. We have to consider not only the citizen, but his environment.

Now, I don't believe that any of us here today think that we will ever again have to have a catastrophe-motivated health program for the American people such as we had to have in 1918 in the face of the influenza epidemic. I am sure that all people associated with the Nation's health services -- and I think I may include the legislators who provide the funds for these services -- agree that we have by now amply learned our lesson, and have put our thinking on a preventive medicine basis.

But it is not enough to recognize problems and agree that firm steps must be taken to meet them before they become acute. We are today faced with a situation which might make history repeat itself. I am speaking of the serious outbreaks of hepatitis in recent years.

Just as, early in this century, people had to demand drinking water that was free from harmful bacteria, so, now, 30 or 40 years later, the people will have to demand action again, before water-borne epidemics force action. Hepatitis is now appearing in widely scattered areas, and it appears where water pollution does not seem to be a problem -- but even though we don't know all the details of the spread of this disease, there is considerable evidence that it is water-borne.

We must take heed of these isolated outbreaks of hepatitis. And there are other warnings -- typhoid fever in a small New England community, bacillary dysentery affecting more than half of the residents in an upstate New York community. All of these warnings indicate one thing: we must step up our water pollution control.

Unfortunately, the State and Federal public health agencies have not attacked water pollution control problems as forcefully as they might have. Congress assumed the leadership in this area in 1948 and has taken the initial steps by passing a Water Pollution Control Act.

The amendments to this program in 1956 and especially in 1961 have greatly strengthened this program with a stepped-up program of waste treatment works construction, through Federal matching grants. In 1961, more than \$54 million was awarded to 651 communities for the construction of waste treatment works at an estimated cost of more than \$312 million -- nearly six non-Federal dollars were stimulated by each Federal dollar spent.

Also, Federal contributions to research in water pollution have been increased and more effective provisions for Federal enforcement of pollution control laws have been included. At least two State governors, in Michigan and Washington, have requested Federal assistance in forcing the abatement of the pollution of State rivers, under the terms of the amendment of this Act.

But even the efforts that we have taken represent only our minimum responsibility to protect the water and water products used by industry and the American people. The Department of Health, Education, and Welfare estimates that more than \$600 million in Federal, State and local funds will have to be spent in the next ten years to replace obsolete plants, meet the demands of a growing population, and catch up on a backlog of 5,000 needed facilities.

Air pollution is another great problem -- as great for the legislator as for the public health workers. Millions of our citizens are living in a sea of air that is unhealthy to breathe: what are we doing about it? Many experts are agreed that there are dangers to our health from these air pollutants. We know of irritation to the eyes, nasal passages, and throat, though there is inadequate evidence of permanent damage to health from continued exposure to sub-acute amounts of contaminated air. Nevertheless, we know that cities with the heaviest air pollution load tend to rank high, both in death and incidence rates for a number of diseases -- including heart disease and cancer, the ranking killers and disablers of our time.

We have had our catastrophies in air pollution. While less dramatic than the influenza epidemic of 30 years before, the atmospheric pollution in Donora, Pennsylvania, in 1948, causing the illness of 6,000 persons and the death of 20, has subtle and far-reaching implications. Our current awareness of the problem makes it unlikely that we will have another disaster such as Donora, although that must still be guarded against. Our concern now is more with the ~~much~~ subtle possibility of developing chronic disease or increasing stresses on those of our citizens already in precarious health.

Congress has responded to this problem by underwriting research programs typified by the Air Pollution Research and Technical Assistance Act of 1955 and the Auto Exhaust Study Act of 1960. Under this legislation the Public Health Service supports research that is aimed at determining the effects of and the identification of specific pollutants, and in the development of criteria for pollution abatement.

You will notice that Congress, in establishing Air Pollution Grants, has attacked the problem of air pollution in a time-honored and proved way -- with research grants to individual investigators; with training grants to individuals and to institutions; and through demonstration grants.

The demonstration grant is of particular importance to groups such as ^{you} ~~as I~~ ~~am now addressing~~. Through these grants you have an opportunity to do community research to develop programs to meet the particular needs of a local community. These grants also provide you with the challenge to evaluate and demonstrate the effectiveness of various methods of preventing and combatting the problems of environmental health.

Looking to the future, I do not need to outline for this group the environmental health problems that are sure to worsen: more must be done in radiological health, general sanitation, accident prevention, and occupational health.

Man's pollution of his ^{own} environment with his ^{own} wastes is not new -- but the extent of this pollution has entered a new dimension, as a result of his new technology. A situation has arisen gradually, wherein the individual is increasingly imperilled by living in his own community. The threat here is great, and is only coming to be recognized. I have told you of the beginnings of a responsible program, under Federal leadership, to cope with these new problems. To put together such a program so many things are needed: the recruitment of more individuals into new fields, the provision of resources for these individuals, and the provision for the widespread application of the results obtained. Today this program is barely launched -- it will take much effort to make that launching successful.

This program is not the responsibility of the Federal government alone. It is the responsibility of everyone. It is the responsibility of the legislators like myself to try to survey the many facets of the problems that lie around us and before us. It is the responsibility of the specialists, such as yourselves, to provide the specialized, detailed knowledge we legislators need to conceive and develop new programs. But, in the last analysis, it is the responsibility of the American people to realize the nature of the threat, too, and to urge that effective action be taken to meet it, in advance of catastrophe.

If you and I, and others interested in the preservation and maintenance of the health of the people of this country will do all we can to educate the public of the needs before us, I am sure we will succeed. If we do as much as we can, we will avoid catastrophes greater than Donora. It will not then be a case of too little, too late.