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PUBLIC HEALTH REPORTS

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VOLUME 103 SUPPLEMENT NO. 1 1988

REPORT OF THE SECOND PUBLIC HEALTH SERVICE AIDS PREVENTION AND CONTROL CONFERENCE

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<i>Robert E. Windom, M.D.</i>	

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ARTICLES - POLICY

Public Health Service Plan for the Prevention and Control of Acquired Immune Deficiency Syndrome (AIDS)

Foreword

The PHS Executive Task Force on AIDS has developed this framework within which the Public Health Service is working to control and prevent acquired immune deficiency syndrome (AIDS) by the year 2,000. Our comprehensive plan is based on the state of the art since the isolation of the human T Lymphotropic Virus-III and development of the blood test to detect evidence of infection by the virus.

The plan includes broad-scale information and education activities in addition to research efforts to de-

velop a vaccine, and treatments to fight the AIDS virus and restore functioning of the immune system.

Within each of these areas the PHS agencies have developed comprehensive plans of action. Programs to effect behavior changes for persons at risk and provision of up-to-date information on AIDS are important features of the plan, which assumes that a vaccine and effective therapy may not be immediately available. This outline and the specific plans of action are dynamic—as new information becomes available, steps will be modified accordingly.

The plan was developed as a continuation of the Public Health Service's extraordinary efforts to deal with this tragic disease almost since the first cases were reported in 1981.

James O. Mason, MD, DrPH
Acting Assistant Secretary for Health

PURPOSE:

This document provides an outline for the key goals and objectives that must be met to achieve prevention and control of AIDS. The plan calls for action by Federal agencies, State and local health departments, professional organizations, and volunteer groups. Many of the specific objectives cannot be expressed in measurable terms because of inadequate current information, but they are included here even though modifications will be made as more data are generated.

I. PROBLEM:

- A. AIDS is a very serious, often fatal, disease caused by the virus HTLV-III.
- B. The incidence of AIDS and infection with HTLV-III is increasing steadily in the United States.
- C. More persons are known to be infected with HTLV-III than have become ill. The incubation period for AIDS in adults may range from 1 to 6 years or more and in infants from 6 months to 5 years or more.
- D. Infected persons may be capable of transmitting infection for many years, even though they may remain asymptomatic.
- E. The ability of HTLV-III to persist in the infected individual results in a population of persons who may be at risk for years for development of severe illness.
- F. HTLV-III infection is transmitted by infected sexual partners through exchange of body fluids, through equipment used to administer intravenous drugs of abuse, through contaminated blood and blood products, and from infected mothers to infants. Members of all population groups thus exposed are at risk.
- G. No effective vaccine or therapy exists.

II. ASSUMPTIONS:

- A. A person with a repeatedly reactive HTLV-III antibody test is infected with HTLV-III and able to transmit the virus to others.
- B. Psychosocial and medical problems will increase as the number of AIDS cases grows and HTLV-III infection spreads.
- C. The more HTLV-III infection is disseminated throughout the population before effective control measures begin, the harder it will be to bring it under control.
- D. Because there is no means of intervention during the long incubation period to prevent severe AIDS, a vaccine that prevents infection will be an effective tool for control only after it has been in use for several years. On the other hand if early therapy becomes available to reduce infectiousness in those already infected, and if persons at risk take responsible preventive measures, control of AIDS will be realized much sooner.
- E. It is unlikely that a vaccine or therapy to substantially limit transmission will be generally available before 1990.
- F. Broad scale prevention and control activities, emphasizing educational and information exchange, must begin in the absence of available vaccine and specific therapy. They should be based on current best public health judgment.
- G. Demonstration and evaluation projects are needed to determine the efficacy and cost effectiveness of prevention and control strategies.

III. GOALS:

- A. By 1987 reduce increase in transmission of HTLV-III infection.

- B. By 1990, reduce increase in the incidence of AIDS.
- C. By 2,000, eliminate transmission of HTLV-III infection with a decline in the incidence of AIDS thereafter.

IV OBJECTIVES:

- A. Continue to clarify the epidemiology and natural history of HTLV-III infection.
 1. Maintain current epidemiologic surveillance of AIDS cases in the United States.
 2. Monitor the incidence of HTLV-III infection by geographic areas and among major high-incidence groups.
 3. Define diagnostic criteria for AIDS and other conditions associated with HTLV-III infection.
 4. Evaluate the usefulness of surveillance of other AIDS-related conditions.
 5. Determine:
 - a. How frequently and under what circumstances HTLV-III infection persists in an infected individual.
 - b. The efficiency of virus transmission by route of exposure, magnitude of exposure (dose), and other conditions.
 - c. The severity of disease in relation to time and source of infection.
 - d. The time frames for development of antigens and antibodies to HTLV-III in blood of infected individuals.
 - e. The role of host factors and cofactors, including interaction with other organisms, in disease risk.
 6. Develop and evaluate new diagnostic tests for HTLV-III and improve existing assays.
 7. In order to clarify risk factors and protective factors for HTLV-III infection and AIDS, conduct epidemiologic investigations in various groups including:
 - a. Homosexual/bisexual men.
 - b. IV drug users.
 - c. Persons with hemophilia.
 - d. Recipients of units of blood or blood components containing HTLV-III.
 - e. Both seropositive pregnant women to determine pregnancy outcome and the infants born to them.
 - f. Heterosexual partners of infected individuals or of those at risk (e.g., prostitutes).
 - g. Members of households of infected individuals.
 - h. Health care, dental, and laboratory workers.
 - i. Populations in countries where AIDS becomes prevalent.
- B. Continue to implement national, State, and community risk reduction and education programs as early prevention and control measures.
 1. Provide current information on AIDS to all segments of the American public. Special efforts will be made for:
 - a. Individuals at increased risk for AIDS to effect behavior change, which currently is the only mechanism available to prevent infection.
 - b. Health care providers to increase diagnostic, treatment, and counseling services.
 - c. Researchers to increase dissemination of their findings to speed the development of vaccine, therapy, and other intervention measures.
 - d. Other groups including unions, management, blood collection agencies, high-risk group organizations, and educational authorities to disseminate accurate information to those who may have a responsibility for persons with HTLV-III infection.
 2. Develop specific prevention and control recommendations through consensus building among key individuals and groups.
 - a. Convene representatives of relevant groups and organizations to generate specific recommendations for the control of AIDS among the following groups at high risk:
 - (1) Homosexual and bisexual men, including representatives of black and Hispanic groups
 - (2) IV drug users
 - (3) Heterosexual persons with multiple sex partners
 - (4) Female partners of men at high risk, with special emphasis on perinatal transmissions
 - (5) Haitians and central African entrants to the United States.
 - (6) Recipients of blood and blood products, organs, and tissues and artificially inseminated women.
 - b. Convene representatives of State and local government agencies and professional and community groups concerned with research, the provision of care, educational aspects, and psychological aspects of AIDS to assist in coordinating appropriate programs.
 3. Encourage the implementation of community risk reduction and health education programs to effect behavior change regarding high-risk sexual practices and the use of IV drugs.

Strong efforts will be especially useful in those geographic areas where high-risk groups do not have high rates of infection.

 - a. Provide targeted education for groups and individuals at risk regarding specific high-risk behaviors.
 - b. Provide risk reduction programs for high-risk groups and individuals to enable them to make the needed changes in their behaviors.
 4. Provide medical referral and counseling programs to persons who request testing or who know their antibody status as a result of blood or plasma donations.
 5. Continue to reduce opportunities for virus transmission through blood and blood products
 - a. Encourage voluntary donor deferral.
 - b. Screen all units of blood and plasma.
 - c. Require donor deferral lists for persons with reactive tests.
 - d. Inactivate HTLV-III in all blood components and products where feasible.
 6. Encourage testing for donors of organs, tissues, cells, and semen for antibody to HTLV-III.
 7. Reduce opportunities for virus transmission through environmental measures.
 - a. Encourage hospital and laboratory personnel to follow recommended precautions with patients or specimens known or suspected to be HTLV-III positive.
 - b. Use effective disinfectants on contaminated equipment.

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- c. Encourage proper personal hygiene among infected persons.
- C. Design and evaluate improved prevention and control measures.
 1. Develop and evaluate better approaches for detecting infection.
 - a. Determine antigenic, genetic, and other variation among HTLV-III isolates.
 - b. Develop and evaluate new antigen tests.
 - c. Cooperatively develop guidelines for use of currently available and new tests.
 2. Develop and evaluate active immunoprophylaxis.
 - a. Convene scientific advisory committees to plan for development and evaluation of vaccines.
 - b. Characterize HTLV-III antigens biochemically and structurally to determine the specific component parts of the virus against which the antibodies generated by a vaccine would react.
 - c. Develop specific candidate vaccines including subunit products, synthetic peptides, genetically synthesized antigens, and others.
 - d. Develop new means of preparation, packaging, preserving, and transporting vaccine.
 - e. Develop new, effective methods for delivering vaccine to substantial numbers of people.
 3. Develop and evaluate passive immunoprophylaxis, using artificially prolonged antibody.
 4. Develop and evaluate drug and biologic therapy including antivirals, immune stimulants, and combinations of these.

- a. Evaluate existing candidate compounds in laboratory systems and clinical trials.
- ii. Design, produce, and evaluate new drugs based on results with existing compounds.
- c. Develop new immune stimulants and test available stimulants in animals or clinical research objects; investigate reconstitution of immune system, e.g., bone marrow transplantation.
- d. Test immune stimulants combined with antiviral therapy against HTLV-III.
- e. Evaluate host factors and possible cofactors.
5. Develop and improve animal models to accomplish studies that cannot be done with humans or *in vitro* systems.
 - a. Test candidate vaccines and drugs in chimpanzee and rhesus monkeys, which are the only animals shown thus far to be infected with HTLV-III.
 - b. Use existing animal models and seek new species for study of animal retroviruses related to HTLV-III, e.g., feline leukemia in cats and retrovirus infection in nonhuman primates. Study agents that control these viruses.
6. Assure that adequate facilities exist to support studies in the development and evaluation of vaccines, antivirals, and immune stimulants listed above.
- D. Design and promote prevention and control programs that will enhance effectiveness by incorporating new intervention tools (vaccines/antivirals) as they become available.

Designing a National Disaster Medical System

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Synopsis

The National Disaster Medical System (NDMS) is a partnership of private and public sectors to

provide care to the victims of great disasters. The system is being developed as a voluntary cooperative effort of four major Federal agencies, State and local governments, and the American professional and hospital communities.

A medical response component will include 150 disaster medical assistance units capable of clearing or staging operations in a disaster. Each unit will comprise three 29-person teams containing physicians, nurses, medical technicians, and support personnel and will include a 16 person unit command and support element. An evacuation component will be founded on the military aeromedical evacuation system, augmented by civilian aircraft and other transportation resources. A hospital component will enroll 100,000 pre-committed beds in hospitals throughout the nation.

The system is designed to care for up to 100,000 casualties arising from a massive peacetime disaster or an overseas conventional military conflict.

The National Disaster Medical System will be implemented over a period of 3 to 5 years. The authors recommend that all parts of the American health care community join in support of the system.

ARTICLES—POLICY

Coolfont Report: a PHS Plan for Prevention and Control of AIDS and the AIDS Virus

Foreword

In 1985, the Public Health Service's Executive Task Force on AIDS published a comprehensive plan that included a set of objectives to control and prevent the spread of acquired immune deficiency syndrome by the year 2000 (1). In the year since the plan was developed, considerable progress has been made. Our knowledge base has expanded many fold during 5 cumulative years of experience with AIDS and the AIDS virus. New information permits tentative long-range demographic projections, a better understanding of pathogenesis, a refined approach to research and development of vaccines and therapeutic agents, a

refocus of prevention and control efforts, and the incorporation of patient care issues.

The Public Health Service (PHS) convened a meeting at the Coolfont Conference Center in Berkeley Springs, WV, June 4-6, 1986. Eighty-five experts in various aspects of AIDS, including clinicians, epidemiologists, public health policy makers, and basic research scientists were invited to review and modify the plan according to current information, needs, and demographic projections through 1991. The following plan is the result of that meeting; it represents a renewed commitment by the Public Health Service to prevent and control AIDS infection and its sequelae.

Donald Ian Macdonald, MD
Acting Assistant Secretary for Health

Purpose

This document provides a framework for the steps that must be taken in five broad areas—pathogenesis and clinical manifestations, therapeutics, vaccines, public health control measures, and patient care and health care needs to achieve prevention and control of AIDS. The current plan is based on estimated changes in the demographics of AIDS through 1991. It calls for concerted action by Federal agencies, State and local health departments, professional organizations, and volunteer groups.

Goals

The following goals were first published in the 1985 plan and remain valid for guiding the continuing national effort.

- By 1987, reduce the transmission of the HTLV-III/LAV infection.
- By 1990, reduce the increase in the incidence of AIDS.
- By 2000, eliminate transmission of HTLV-III/LAV infection with a decline in the incidence of AIDS thereafter.

Background

Five years have elapsed since the initial report of *Pneumocystis carinii* pneumonia from Los Angeles marked the recognition of what has become known as AIDS. By 1984 a human retrovirus, HTLV-III/LAV (human T-cell lymphotropic virus type III/lymphadenopathy-associated virus) had been determined to be the etiologic agent of AIDS. (The International Committee on the Taxonomy of Viruses proposed the name "human immunodeficiency virus" for these viruses (2).) By early 1985, serologic tests for antibody to the virus were licensed and widely available.

In retrospect, when AIDS was initially reported in June 1981, some 5 years already had elapsed since the introduction of HTLV-III/LAV into the United States, and 3 years had elapsed since the first clinical cases had occurred. AIDS cases have been reported from all 50 States, the District of Columbia, and 4 Territories. Cases have been reported from more than 100 foreign countries.

The rapid development and implementation of sensitive and specific assays for HTLV-III/LAV antibodies have permitted screening of donated blood and plasma, and the research use of these

'During 1991 alone, more than 145,000 cases of AIDS will require medical care and more than 54,000 AIDS patients are predicted to die, bringing the cumulative number of deaths due to AIDS to more than 179,000.'

and other assays has elucidated the modes of transmission, the natural history of infection, and a better understanding of the clinical manifestations of HTLV-III/LAV infections.

The predominant defect in AIDS is a profound and, so far, irreversible immune dysfunction that results when HTLV-III/LAV preferentially infects the helper-inducer subset of T-lymphocytes. Although the virus can also infect other cells of the immune system, as well as cells of the central nervous system, it is the infection of these T-lymphocytes that ultimately leads to a breakdown in the ability of an infected individual to mount an immune response. In the past 5 years, more effective therapies for some of the opportunistic infections that accompany AIDS have been found, but no cure for AIDS is yet available.

Studies of the molecular biology of HTLV-III/LAV have revealed that a copy of the viral genetic material becomes an integral and permanent component of the DNA of an infected individual. As a result, such an individual is likely to be a carrier of the virus for the rest of his or her life and, for purposes of public health control, is assumed to be capable of transmitting the virus to others.

The HTLV-III/LAV genome has been completely sequenced and the functions of several of its genes are known. Considerable differences in some genes have been found among various isolates. In addition, related viruses have been identified in man and nonhuman primates. These related viruses cause a range of different diseases. Studies in animals indicate the feasibility of vaccination against retroviruses, and one veterinary vaccine is available for the prevention of feline leukemia virus. Although some promising approaches are under way, as yet no effective vaccine for AIDS exists.

HTLV-III/LAV is transmitted by sexual, parenteral, and perinatal contact with the virus. Although this infection has been most often recognized in homosexual men and intravenous (IV) drug abusers, it is clear that this virus does not discriminate by sex, age, race, ethnic group, or sexual orientation. Behaviors which are high risk for the acquisition of HTLV-III/LAV infection include sexual contact or sharing of drug injection equipment with an infected person. Studies now clearly demonstrate that AIDS is not spread by casual contact, such as sneezing, coughing, or sharing meals with an AIDS patient.

There were 21,517 cases of AIDS reported in the United States as of June 1986. Blacks and Hispanics represent 39 percent of total cases. Women who report no history of IV drug abuse represent half of the 1,400 cases in women. Approximately 304 cases of AIDS occurred in infants and children under age 13. Between 2 and 3 percent of the cases have occurred in transfusion recipients or hemophiliacs.

Projections

The following projections, including those in the table, are based on the Centers for Disease Control (CDC) surveillance data and epidemiologic studies of populations at high risk to infection with the virus.

- Twenty to 30 percent of the estimated 1 to 1.5 million Americans infected with HTLV-III/LAV as of June 1986 are projected to develop AIDS by the end of 1991. The latency period between infection and overt AIDS averages 4 or more years in adults; therefore, most persons who will develop AIDS between 1986 and 1991 will be those who are already infected with HTLV-III/LAV.
- Based on an empirical model that uses reported cases of AIDS, by the end of 1991, the cumulative cases of AIDS in the U.S. meeting the CDC surveillance definition will total more than 270,000. During 1991 alone, more than 145,000 cases of AIDS will require medical care and more than 54,000 AIDS patients are predicted to die, bringing the cumulative number of deaths due to AIDS to more than 179,000.
- The empirical model may underestimate by at least 20 percent the serious morbidity and mortality attributable to AIDS, because of underreporting or underascertainment of cases.

Cumulative cases
Diagnosed during
Cumulative cases

Alive at start of year
Alive at any time

Cumulative deaths
Deaths during year
Cumulative deaths

Persons with HTLV-III/LAV

These numbers refer
to AIDS (see Morbidity and

• In 1985, 9,000 cases of AIDS were reported in the United States. The Centers for Disease Control projects that the number of cases will continue to rise and that more than 145,000 cases will be reported by the end of 1991. The estimate for 1991 is 145,000.

• More than 145,000 cases of AIDS will be reported by the end of 1991. More than 25 percent of these cases will be reported among drug abusers. Between the present and the end of 1991, more than 145,000 cases of AIDS will continue to be reported among recipients and donors of blood.

• Additional cases of AIDS will be reported among women who are pregnant (total) for 1986. More than 9 percent of the cases of AIDS will be reported among patients who report having been infected by a person who was infected by a patient. Studies suggest that major risk factors for AIDS will have been reported.

• Through 1986, more than 145,000 cases of AIDS were diagnosed in the United States and San Francisco. More than 9 percent of cases of AIDS were reported in other localities.

• Homosexuals who use drugs are at high risk to be the population with the highest number of cases of AIDS.

Projected cases of AIDS: United States

Category	1985	1991	1991 range
Cases diagnosed			
Cumulative cases at start of year	19,000	196,000	155,000 to 219,000
Diagnosed during year	16,000	74,000	46,000 to 92,000
Cumulative cases at end of year	35,000	270,000	201,000 to 311,000
Deaths			
Alive at start of year	10,000	71,000	50,000 to 83,000
Alive at any time during year	26,000	145,000	86,000 to 174,000
Deaths			
Cumulative deaths at start of year	9,000	125,000	105,000 to 137,000
Deaths during year	9,000	54,000	36,000 to 64,000
Cumulative deaths at end of year	18,000	179,000	141,000 to 201,000
Infections			
Persons with HTLV-III/LAV infection	1 million- 1.5 million (estimate)		

¹These numbers refer only to those cases that meet the CDC definition for AIDS (see *Morbidity and Mortality Weekly Report* 34:373-375, June 28, 1985) and

do not include other manifestations of infection, such as AIDS-related complex and lymphadenopathy syndrome.

- In 1985, 9,000 cases of AIDS were diagnosed in the United States and reported to the Centers for Disease Control. The empirical model predicts that cases will continue to increase through 1991, that there will be nearly 16,000 cases reported in 1986, and that more than 74,000 cases are projected for 1991. The estimates for 1991 range from 46,000 to 90,000.

- More than 70 percent of the cases will be diagnosed among homosexual or bisexual men, and 25 percent of the cases will occur among IV drug abusers with some overlap to continue between the groups. Because the periods between infection and disease are long and variable, cases will continue to be reported among transfusion recipients and persons with hemophilia.

- Additional cases in heterosexual men and women are projected; the 1,100 (7 percent of the total) for 1986 will increase to nearly 7,000 (more than 9 percent) by 1991. This group includes patients who reported heterosexual contact with an infected person or someone in a risk group. It also includes patients in groups in which epidemiologic studies suggest heterosexual transmission as the major risk factor. By 1991, more than 3,000 cases will have been diagnosed in infants and children.

- Through 1985, fewer than 60 percent of cases were diagnosed in persons outside New York City and San Francisco, but by 1991 more than 80 percent of cases are predicted to be reported from other localities.

- Homosexual-bisexual men and men and women who use drugs of abuse intravenously will continue to be the populations at highest risk for HTLV-

III/LAV infection during the next 5 years. Using estimates published by Kinsey (3), more than 2.5 million (4 percent) of U.S. men between 16 and 55 years of age are exclusively homosexual throughout their lives; an estimated 5-10 million more will have some homosexual contact. An estimated 750,000 Americans inject heroin or other drugs intravenously at least once a week; a similar number inject drugs less often.

- The prevalence of HTLV III/LAV seropositivity among homosexual men and IV drug users parallels the frequency of AIDS in various cities. In 1984-85, 20 to 50 percent of homosexual men who participated in research studies had evidence of HTLV-III/LAV infection. Similarly, seroprevalence estimates among IV drug abusers ranged from 10 percent to more than 50 percent in various U.S. cities. By extrapolating all available data, we estimate that there are approximately 1 to 1.5 million infected persons in those groups at present. Thus estimates of a 20 to 30 percent progression to AIDS by 1991 in this group are consistent with the total number of AIDS cases predicted by the empirical model.

- Uninfected homosexual men have continued to acquire HTLV-III/LAV infections during the past year, but at a lower rate than would be predicted from the increases in previous years and from the increase in the number of potentially infectious persons. This observation is consistent with changes reported in sexual behavior and declines in other sexually transmitted infections in homosexual men. Nonetheless, due to the large present and future populations at risk, hundreds of thousands

of additional homosexual men, IV drug abusers, and others may become infected during the next 5 years.

- Because of heat and chemical treatment of clotting factor concentrates, donor deferral, and serologic screening of donated blood and plasma, only a very small number of additional infections are likely to occur through blood and plasma transfusions.

- Current information is insufficient to predict the future incidence of HTLV-III/LAV infection in heterosexual populations, but increases in heterosexual transmission are likely. Those at highest risk will be heterosexual sexual partners of infected persons and those who have sexual contact with past or present IV drug abusers, bisexual men, prostitutes, or others at increased risk for HTLV-III/LAV infection. As is true for homosexual men, sexual contact with multiple partners will increase one's risk for HTLV-III/LAV infection.

- Additional increases in HTLV-III/LAV infection in infants are expected as more women in child-bearing years become infected

The following five sections summarize the deliberations and recommendations made by the work groups at the Coolfont meeting.

Pathogenesis and Clinical Manifestations

Infection with HTLV-III/LAV results in a broad range of clinical manifestations including an acute retroviral syndrome, asymptomatic disease, chronic lymphadenopathy, and serious diseases including Kaposi's sarcoma and other malignant neoplasms, fatal opportunistic infections, and neurological and psychiatric disorders.

The factors that determine the expression and progression of disease in an individual are largely unknown. Techniques are available to diagnose and treat many of these opportunistic diseases, although they often recur. However, once Kaposi's sarcoma or certain opportunistic infections occur, an ultimately fatal outcome for the patient has been the rule.

- Clinical and epidemiologic studies need to be conducted to

- Clarify the natural history of infection, including the role which may be played by exogenous or endogenous factors in determining which clinical manifestations occur, and

- Continue to expand the spectrum of clinical manifestations

- Basic scientific studies on the virology and immunopathogenesis of HTLV-III/LAV need to be expanded, especially to

Assess target cell susceptibility;

- Identify viral and host cell determinants of transmissibility and pathogenicity including portals of viral entry, mechanisms of cytopathic effects, and dysfunction;

- Further elucidate mechanisms of viral latency and activation;

- Identify and assess direct and indirect immunopathogenic mechanisms;

- Further delineate the pathogenesis of neurologic and psychiatric abnormalities; and

- Ascertain more fully the functions of viral gene products and determine the meaning and mechanisms of genetic heterogeneity.

More suitable animal models for HTLV-III/LAV infection need to be developed to allow more comprehensive understanding of pathogenesis and rapid evaluation of treatment and prophylaxis. Dedicated efforts must be made to maximize efficiency of use of limited animal resources.

Improved methodologies are needed to detect infected and infectious individuals and to identify and quantitate virus, viral antigen, and viral antibody.

Therapeutics

No drug with proven clinical efficacy for AIDS is currently known. Both antiviral agents and immunomodulators are being developed, and several drugs are under clinical investigation at present. The ability of an agent to reverse the disease process or halt its progression may vary depending upon the stage of infection. Research is now in progress to develop new methods to inhibit viral replication and correct the immune deficiencies. A safe and effective antiviral agent is not likely to be in general use for the next several years. Experimental products are also under study for treatment of opportunistic infections and neoplasms associated with HTLV-III/LAV infection.

The following points should be considered in

order to develop in the most effective

- Further multidisciplinary agents for HTLV-III/LAV, including central. Part of of a large of the antiviral toxic effects, thietic compo

- A systematic disease design, implementation trials for criteria for toxicity must

- The most candidate are placebo control to be safe

- An agent can be control in used as the

- New th are compared to control

- Specifically appropriate to control viral system must

- Since ament are like AIDS virus infected and strains.

- New treatment, infections need to be

Vaccines

- A number of beings are clinical years. Field require additional to be infected. A paired before

order to develop drugs for the treatment of AIDS in the most expeditious manner:

- Further expansion of the multiinstitutional, multidisciplinary approach to identify and develop agents for the treatment and prevention of HTLV-III/LAV infection and associated diseases, including central nervous system disease, is necessary. Part of this effort must be the establishment of a large capacity screening program to measure the antiviral and immunomodulator activity and toxic effects of newly identified natural and synthetic compounds.

- A system for classifying HTLV-III/LAV associated disease manifestations which is useful in the design, implementation, and analyses of therapeutic trials must be developed. Standard clinical criteria for the measurement of efficacy and toxicity must be formulated to facilitate the performance of well organized multicenter clinical trials.

- The most efficient design of clinical trials of candidate antiviral agents will require the use of placebo controls. Once an agent has been shown to be safe and efficacious in a clinical trial, this agent can generally be substituted for the placebo control in subsequent clinical trials and can be used as the standard against which other agents are compared.

- New therapeutic approaches must be developed to control or eliminate latent virus and to specifically direct antiviral compounds to the appropriate target tissues. Combination strategies to control viral replication and restore the immune system must be developed and evaluated.

- Since antiviral drugs currently under development are likely to repress rather than eliminate the AIDS virus infection, long-term therapy is expected and with it the emergence of drug-resistant strains.

- New and existing strategies in the diagnosis, treatment, and prophylaxis of the opportunistic infections and neoplasms associated with AIDS all need to be developed, tested, and improved.

Vaccines

A number of vaccine candidates for human beings are currently under development, and limited clinical testing for some could begin within 2 years. Field trials to demonstrate efficacy may require additional years. Vaccines are not anticipated to be useful in individuals who are already infected. A vaccine for general use is not anticipated before the next decade, and its use would

'In the absence of a vaccine and therapy, prevention and control of HTLV-III/LAV infection depends largely upon effective approaches to decrease sexual transmission, transmission among IV drug users, and perinatal transmission from infected mothers.'

not affect the number of persons infected by that time.

The following steps need to be taken:

- Vaccines employing recombinant DNA derived antigens, virus subunits, killed viruses, synthetic peptides, live recombinant or attenuated viruses, and anti-idiotypes will need to be evaluated as potential candidates for human trials.

- Vaccination methods will need to be devised to induce immunity to antigenically distinct strains of HTLV-III/LAV.

- Reliable *in vitro* and *in vivo* systems need to be developed for the evaluation of vaccine immunogenicity safety and efficacy before commencing human trials.

- A program for clinical and field evaluation of vaccine(s) needs to be established, including resolution of difficult aspects of design such as identification of target populations and the definition of parameters of vaccine efficacy.

- Protocols need to be developed for the *in vitro* and *in vivo* evaluation of anti-HTLV-III/LAV immunoglobulin to explore its value in passive immunization.

Public Health Control Measures

In the absence of a vaccine and therapy, prevention and control of HTLV-III/LAV infection depends largely upon effective approaches to decrease sexual transmission, transmission among IV drug users, and perinatal transmission from infected mothers. A strategy to control and prevent AIDS should involve voluntary counseling and testing for persons at increased risk of HTLV-III/LAV infection and imparting to infected patients those Public Health Service recom-

recommendations concerning personal behaviors that must be observed if spread of the virus is to be halted. Throughout this section, serological testing is intended to be voluntary, conducted with confidentiality, and accompanied by appropriate pretest and post test counseling.

Public health activities directed toward the control and prevention of AIDS have required significant funding and staffing at national, State, and local levels. The projected increases in AIDS and HTLV-III/LAV infection over the next 5 years will pose substantial continuing demands for resources for these efforts.

The recommendations of the conference participants concerning public health measures focused on five areas:

1. Information base.

- Information is needed to better determine the size of the population at greatest risk in the United States, particularly the numbers of homosexual men, bisexual men, IV drug abusers, and heterosexuals who have multiple partners.

- Better information is needed on the number of persons infected with HTLV-III/LAV. Extensive and repeated seroepidemiologic surveys are needed to determine the incidence and prevalence of infection by age, race, ethnicity, sex, geographic area, and sexual preference. States should be encouraged to obtain and report data on incidence and prevalence to CDC for publication.

- The Public Health Service should encourage and assist in the evaluation and comparison of all interventions for prevention and control of AIDS and HTLV-III/LAV infection.

- PHS should continue to support key epidemiologic studies.

- The United States should continue to play a role in understanding and assisting efforts to control the disease worldwide, particularly in areas with seemingly different epidemiologic patterns.

2. Information and education.

National information and education campaigns on AIDS and HTLV-III/LAV infection should be targeted to individuals and groups whose behavior places them at high risk for AIDS, other sexually active adults, adolescents, preadolescents, and health care providers. A major target of mass information-education programs is the currently uninfected population, to assure that those persons know how to protect themselves. An additional purpose is to persuade infected persons to take appropriate steps

to safeguard their own health and to avoid infecting others.

- PHS should explore the advantages of using paid radio, TV, and printed media advertising as well as public service announcements to inform the public of AIDS and HTLV-III/LAV infection.

- PHS, State and local health departments, State and local boards of education, colleges, universities, and other organizations should support and encourage comprehensive health education that includes information about AIDS and HTLV-III/LAV infection.

- With the assistance of appropriate organizations, programs should be implemented to provide culturally sensitive, meaningful information and education to blacks and Hispanics, including homosexuals, IV drug abusers, blood donors, women both at risk themselves and also at risk for transmitting infection perinatally, and to other segments of the public.

- Health care providers need current information and training on the diagnosis, psychosocial counseling, and management of HTLV-III/LAV infected persons.

3. Prevention of IV drug abuse transmission.

IV drug abusers serve as the major reservoir for transmission of infection to heterosexual adults and their infants, as well as among themselves. As a group, they are not well organized, often poorly educated, and tend to have less interaction with the health care delivery system than other groups who participate in high-risk behaviors. Efforts to change drug abuse behavior must proceed with the understanding that addictive behavior is not often changed without specific drug treatment.

- A systematically increased capacity for treating IV drug abusers is needed. Until adequate capacity is available, persons in need of treatment should be prioritized. Decisions may vary by locality, but highest priority should be given to those presently on waiting lists for treatment.

- All treatment and prevention approaches should include information and counseling on sexual and perinatal transmission of HTLV-III/LAV, availability of family planning services, and availability of voluntary serological testing for HTLV-III/LAV.

- Until treatment capacity is adequate for persons who continue to abuse IV drugs, studies are needed to evaluate the efficacy and feasibility of promoting safer use of drug paraphernalia (for example, increased availability of sterile needles or

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"works") and education regarding use of sterile needles and sharing of needles.

4. *Prevention of sexual transmission.* Sexual contact will remain the primary mode of HTLV-III/LAV infection for the foreseeable future, with greater increase in the proportion of heterosexual transmission over the next 5 years.

A central goal of local disease control programs should be to reach the greatest number of HTLV-III/LAV infected persons with testing and counseling (provision of pretest and post-test information, including psychological support) about their infections and methods to reduce the likelihood of transmission to others, in order to change high-risk sexual behaviors. At present, only a small proportion of the already infected population has been reached.

Several methods may help achieve this goal, although they may have differing efficacies in various settings and populations. These include encouragement of voluntary serological screening, self referral of sexual and drug abuse contacts, notification and counseling of contacts by health authorities, and targeted educational programs.

- Serological testing of persons whose behavior places them at risk should be encouraged and made widely available. In all communities, appropriate medical care encompasses offering counseling and testing to all persons at risk, including persons with a sexually transmitted disease, IV drug abusers, and persons seen in private practice who engage in high risk behaviors. (Anonymous testing should be available as an option.)

- Self-referral of an infected person's sexual and needle-sharing contacts should be encouraged. In some areas or populations, additional contact notification activities may be offered to infected persons by the health agency.

- Research is needed on the efficacy of counseling or knowledge of personal serological status or both in modifying sexual and needle-sharing behavior to reduce or eliminate the risk of transmission.

- For persons who know that they are infected with HTLV-III/LAV yet continue to practice high-risk sexual or needle-sharing activities, temporary involuntary isolation should be considered an option only in rare instances and after due process. Enforced isolation is not a practical way to minimize spread of the infection, since infected persons probably remain infectious for life. Education, counseling, and social services including

'PHS estimates that the direct health care costs of persons with AIDS will be between \$8 and \$16 billion in 1991. The \$8 billion figure is based on the projection of 71,000 AIDS patients alive in 1991 and 74,000 new cases by then.'

drug treatment—are the main interventions for dealing with this problem and are appropriately applied to recalcitrant infected persons and their potential consenting partners. Uninfected persons must avoid behavior which would permit infection from persons who know or do not know they are infected.

5. *Prevention of transmissibility by blood and blood products.* The risk of transmission of HTLV-III/LAV by transfusion of blood and blood products is extremely low, due to deferral of high risk donors, serological screening of donated blood and plasma, and the heat and chemical treatment of clotting factor concentrates. Nonetheless, some additional measures are appropriate to further reduce this low risk.

- Increase the effectiveness of deferral by all persons at increased risk of HTLV-III/LAV infection by:

- Collecting demographic and other data from donors found to have confirmed HTLV-III antibody. This will require some type of case reporting and subsequent interviews, but it is essential to the continued evolution of the high-risk donor deferral strategy:

- Improving communications to potential donors about self-deferral, taking into consideration their language skills and literacy;

- Exploring the usefulness of providing means at the time of donation for blood donors, who do not self-exclude but who have remaining doubts about their suitability, to designate that their donated unit not be used for transfusion;

- Implementing the use of a signed donor consent form in all blood banks that clearly indicates the absence of specific risk factors for transmission of infections;

- Continue to require that blood and plasma establishments maintain deferral lists of donors who have repeatedly reactive ELISA tests.

- Continue to encourage development and use of more sensitive serologic tests for HTLV-III/LAV infection.

- Recommend that current recommendations for HTLV-III antibody testing for donors of organs, tissues, cells, and semen be made mandatory.

- Encourage increased activities to eliminate unnecessary transfusions.

Patient Care and Health Care Needs

Over the period 1986 to 1991, AIDS and associated conditions will place an increasing burden on the health care delivery system through an increased number of patients and increased aggregate costs of care. The burden will be shared by a larger number of communities, including some which will have a less complete capacity for response. There will be increasing fragmentation and less health care control of services provided if more nonmedical, less traditional, and some unethical providers become involved.

PIIS estimates that the direct health care costs of persons with AIDS will be between \$8 and \$16 billion in 1991. (The \$8 billion figure is based on the projection of 71,000 AIDS patients alive in 1991 and 74,000 new cases by then. An additional 29,000 cases was added to account for the 20 percent underreporting or underascertainment of cases. The cost for treating a patient with AIDS used in the calculation was \$46,000. For the higher range, the \$8 billion figure was doubled.) These sums represents 1.2 to 2.4 percent of the expected total U.S. personal health care expenditures in 1991 of about \$650 billion. Because people with AIDS are concentrated in certain urban centers, however, these costs will be disproportionately borne.

These estimates may be conservative by 10 to 50 percent because of the increased need for care for the large population of patients with the other conditions associated with HTLV-III/LAV infection and the significant nonmedical care costs necessary for management of these illnesses. Development of community-based health and social services support systems can reduce costs and enhance care during this 5 year period.

To improve care for AIDS patients, all sectors of the health care delivery system should work together to

- Develop a coordinated Federal, State, and local response to manage the health services and health financing crisis posed by the escalating AIDS epidemic. This response must reflect the

pluralistic character of the American health care system and must involve the coordinated participation of the public, private, and voluntary sectors, as well as ambulatory, in-hospital, and long-term care providers:

- Explore the feasibility and need for convening a national, blue-ribbon commission representing the necessary constituencies to canvass needs and resources available and to make recommendations regarding how each sector of our society can help to fill financing and resource needs;

- Emphasize the needs of institutional and community-based providers for training, continuing education, and psychosocial support;

- Upon request, assist State and local governments and community-based organizations to assess, develop, and implement comprehensive service delivery systems of care for AIDS patients in a cost-effective manner;

- Develop organized consortia of service delivery systems responsive to the care of AIDS patients; such consortia should include all the necessary components of care (that is, ambulatory, hospital, mental health, and dental health services, counseling, home health care, and hospice care.)

- Explore efforts to set up regionalized consortia of services for AIDS patients;

- Utilize studies of the special health services needs and barriers to prevention of HTLV-III/LAV infection in blacks and Hispanics, and best methods of information dissemination to foster inclusion of culturally sensitive service delivery for children with AIDS, IV drugs abusers, hemophiliacs, and minorities in all appropriate metropolitan areas;

- Initiate demonstrations of the appropriate care needed at different stages of the illness, costs of services, and most cost effective provisions of needed services, including Model Medical Waiver programs; and

- Support health services research on AIDS that emphasizes cost of services for different risk groups, stages of illness, and treatment modalities and assesses potential improvement of methods and increased cost effectiveness of care

References

1. Public Health Service plan for the prevention and control of acquired immune deficiency syndrome (AIDS). Public Health Rep 100: 453-455, September/October 1985.
2. Coffin, J., et al: Human immunodeficiency viruses. [Letter]. Science 232: 697, May 9, 1986.
3. Kinsey, A. C., Fomero, W. B., and Martin, J. E.: Sexual behavior in the human male. W. B. Saunders, Philadelphia, 1948.

Scientific prospective clinical trials reveal that early detection of HIV-infected mothers and subsequent treatment with AZT reduces the transmission rate of HIV to the newborn by a third.

The key to prevention and appropriate treatment is education and counseling of the pregnant woman.

I think that the Kassebaum-Kennedy amendment address these issues in a responsible way.

This amendment shows that the Senate is on the side of counseling and voluntary testing as advised by our Nation's top public health experts. Education and prevention remain our best weapons against this horrible epidemic.

I thank Senators KASSEBAUM and KENNEDY for developing this dialog, and hope this amendment is a position we can maintain in conference.

The PRESIDING OFFICER. Is there further debate on the amendment? If not, the question is on agreeing to the amendment.

The amendment (No. 1852) was agreed to.

Mr. HELMS. Mr. President, I move to reconsider the vote by which the amendment was agreed to.

Mrs. KASSEBAUM. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mrs. KASSEBAUM. Mr. President, I appreciate the comments of the Senator from North Carolina. I am glad to start off with such a positive amendment and share with him that I think it is important to debate these amendments, just the value of amendments as they are presented. I think that we both share the desire to move forward on this legislation. I appreciate the comments of the Senator from North Carolina.

Mr. HELMS. I thank the Senator from Kansas.

Mr. HELMS addressed the Chair.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. HELMS. Mr. President, I thank the Chair.

Mr. President, as the Senate proceeds to the consideration of the proposal to reauthorize the so-called Ryan White CARE Act of 1990, there are so many ironies, that I feel obliged to call attention to some of them. Although the homosexual activists of America have created a virtual minefield for any Senator who dares raise a question about the legislative history of this proposal.

These homosexual activists have managed to convince the news media, and a surprising number of Senators, that it is irrelevant to talk about who and what really caused the death of Ryan White—Ryan White, the 18-year-old hemophiliac who died of AIDS because tainted blood was pumped into his veins, blood that was tainted in the first place by a homosexual conduct somewhere generations back.

The Centers for Disease Control was quite candid in the early 1980's as to

when and how the AIDS disease was brought to America. The CDC may be somewhat politically correct now.

In any event, I have in hand a volume which I obtained on loan from the Library of Congress, a book authored by Randy Shilts entitled "And the Band Played On." Newsweek magazine described this book in 1987 as "compelling and often shocking, impassioned, and path breaking, the best book yet on AIDS."

The Washington Post described it as "a monumental history."

Time magazine called the book "stunning and impressively researched, a richly detailed narrative."

The Chicago Tribune described it, "It reads like a good medical sleuth story. But it is not fiction. It is a painstakingly detailed history."

Mr. President, let us emphasize how virulent the AIDS virus is. A Canadian airline flight attendant, who knew he had AIDS and whose name is a matter of record, flew into the United States, and over a period of time—I am quoting from page 147 of Mr. Shilts' book—the Canadian airline flight attendant "established sexual links between 40 patients in 10 cities. The role played by the flight attendant was remarkable," Mr. Shilts says. And he continues, "At least 40 of the first 248 homosexual men diagnosed with HIV or AIDS in the United States as of April 12, 1982 either had had sex with the flight attendant or had had sex with someone who had."

Mr. Shilts continued, "The links sometimes were extended for many generations of sexual contacts, giving frightening insight into how rapidly the epidemic had spread before anybody knew about it."

Mr. President, I include those details to emphasize the virulence of HIV, AIDS, and it has been that way since the very beginning. Yet, I know of not one homosexual organization that has advocated abstinence from engaging in the incredibly offensive and revolting conduct that has led to the proliferation of AIDS; not to this good day has there been even a hint that abstinence should be followed. No. The homosexual activists have gone precisely in the other direction, demanding more and more Federal funds for research and special funding for personal care available to no other Americans suffering and dying of other diseases like cancer, heart disease, diabetes, and Alzheimer's.

This is a unique piece of legislation. It was in 1990, and it still is. There has never been a bill like this for any other disease.

The ferocity of the lobbying and the intensity of media criticism of anyone raising a question about all of this has caused many in Congress to go along with the questionable demands of the homosexual lobby.

I myself, Mr. President, have taken the heat, but I will not be deterred. The Senate probably will pass this bill again, and the House has already

passed it. And it may become law because President Clinton will rush and sprain his ankle grabbing a pen to sign it.

I have intended to have my say, and I have intended to offer a number of amendments for the consideration of Senators to vote for or against as they please. But I think the Senate ought to go on record.

Let us examine some of the support the American taxpayers are forced to give to a comparison of diseases. Let us start off with AIDS.

This year, \$2,700,000,000 for AIDS. That is the tab Congress has demanded that the American taxpayers furnish.

That is more money than for any other disease.

The Congressional Research Service breaks down the money like this:

This year, \$1,548 billion for research, \$491 million for so-called prevention or education programs—and I will get into that in just a minute—and \$664 million for treatment. And this is only for fiscal year 1995.

The fiscal year 1996 request totaled a whopping \$2.9 billion—\$1.819 billion for research, \$526 million for prevention or education, and \$555 million for treatment programs.

Now, the disease AIDS ranks No. 8 in America among all of the diseases in terms of causing death. The No. 1 killer is heart disease followed by cancer, followed by stroke and lung disease, diabetes, Parkinson's disease, Alzheimer's, and so forth.

But do they get money like this? No. AIDS is No. 8—No. 8—yet AIDS gets more Federal money than any of the other diseases. If memory serves me correctly, the original 1990 Ryan White bill was funded with money taken from a fund originally allocated for Alzheimer's disease. The Federal Government spends \$91,000 for every patient who dies of AIDS. The Federal Government spends \$5,000 for each American who dies of cancer.

I know the advocates of this Ryan White reauthorization bill will claim that comparisons are odious, but there is a great big odor rising from the manner in which Congress is falling all over itself to do what the homosexual lobby is almost hysterically demanding that Congress do.

Now, then, I am a little bit fascinated by a clause in this existing bill that is now the pending business, language which authorizes—and let me quote from the bill—"appropriations of such sums as may be necessary for each of the fiscal years 1996, 1997, 1998, 1999, and 2000."

Supporters of the bill say, "Oh, well, do not worry about that, Jesse. That does not mean anything. It still will have to go through the authorization and appropriations process each year."

Well, if that is so, Mr. President, if it does not mean anything, let us take out that reference to "such sums as may be necessary." I will bet you a quarter not one of the proponents will agree to that. Of course, it means something.

While I am at it, let me raise a question about the provision in this Ryan White bill's title V which creates new education and training centers related to homosexuality and AIDS.

Mr. President, this bill is silent in seven languages about teaching the importance of abstinence. It is not even mentioned. Abstinence, I say again and again and again, is the only way AIDS will ever be brought under control. And the activists do not even use the word or permit it to be used.

There is general agreement among scientists that the biggest risk for contracting HIV or AIDS is the number of sexual partners homosexuals have. The more promiscuous a homosexual, the greater his risk of contracting HIV or AIDS, and, by the way, infecting innocent people like little Ryan White, whose name is being exploited in this legislation, who had nothing to do with that. He was innocent.

Reliable surveys, Mr. President, show that many homosexuals average 16 different sex partners every month, 182 partners per year. And my source for that is a document "Hepatitis B Cohort Study of 1980," and I have it available for any Senator who wants to see it.

Now, is it not clear, Mr. President, that AIDS is a chronic disease of sexually promiscuous people? And a lot of innocent people like Ryan White are caught up in it, unknowingly and without any misconduct on their part.

Let me move on, Mr. President, you would not believe the stonewalling that has been going on in and by the Clinton administration to prevent my staff and me from obtaining statistical information about how these millions and billions of dollars of the taxpayers' money are to be spent and have been spent in the past. You call HHS—and we have the date and time and the name of the people we talk with—and they say they do not know, that there is no monitoring going on.

Stonewalling, that is what we have. But I say this, and I say it with all the sincerity I possess, that before the Senate Appropriations Committee acts on this bill, S. 641, I hope Senators HATFIELD and BYRD and all of the members of the Appropriations Committee will insist on credible documented information about who has received the Ryan White funds since the enactment of the 1990 version of the Ryan White CARE Act.

That is all I ask. If Senator ROBERT C. BYRD says it is all right, after he has looked at the information, I will be reasonably satisfied because I trust Senator BYRD. We do not belong to the same party. We do not agree on everything. But I respect him as an honorable gentleman. I think the American people will be appalled by what their hard-earned tax dollars are supporting in fact. Nobody knows now. I am sure NANCY KASSEBAUM has no idea what is going on because I know this lady. I know her inclinations, and I know her character. But a lot of things are going on that have not been discussed or dis-

closed to the Congress of the United States let alone the American people.

For example, I have a brochure from the Gay Men's Health Crisis.

By the way, I hate to use the word "gay" in connection with sodomy. There is nothing gay about these people. "Gay" used to be a beautiful word. It has been corrupted, but that is another argument for another day.

This Gay Men's Health Crisis organization put out a brochure describing various and sundry methods of homosexual sex. Now, I have been around the track a long time, and I have seen a lot of things in my lifetime, but I can just imagine how the average American would react if they could see what this is all about. Not once—I reiterate, not once—is abstinence mentioned as the way to avoid HIV infection. They do not want abstinence.

Senators may be interested in an advertisement by another homosexual outfit, the so-called Whitman Walker Clinic in Washington. This advertisement says: "If you visit a bath house remember to always use a latex condom. Used properly latex condoms prevent HIV, AIDS and other sexually transmitted diseases."

Now, this statement is blatantly false. It is inaccurate. It is misleading. And yet taxpayer funds are being used to circulate this falsehood, giving false hope to homosexuals in their many and various liaisons.

Then there is the Washington Blade, which is a homosexual newspaper published here in Washington, DC. They have a pink section—they call Lights Out. The implications are obvious on that. This pink "Lights Out" section is dedicated exclusively to advertising for anonymous dates, sexual encounters. No names are given. You just pick this one that sounds good to you, and there you go. Decency prevents me from reading the so-called classified ads out loud on the Senate floor. Suffice it to say here comes the Whitman Walker Clinic again. This time implying, "Just do it, but do it with a condom." And they know that is not so. They know that it is not so. The Whitman Walker Clinic, which receives Ryan White CARE Act money from the American taxpayers, who care for people with HIV or AIDS, leads homosexuals to believe that as long as you use a condom it is safe to have anonymous sexual encounters.

Now, what kind of use of the American taxpayers' money is that? People say, it is hateful for JESSE to talk about this. But somebody needs to talk about it. Somehow the American people need to know and deserve to have an understanding of what is going on, not get up here with all of the plaintive remarks about Ryan White. Let us talk about what killed Ryan White. Who furnished the tainted blood? Where did it come from? I met the little boy one time. I was sorry for him then, and I am sorry that he is dead now. But it was not accidental. There was some-

body who did not care, who furnished tainted blood.

Now, the Gay Men's Health Crisis and the Whitman Walker Clinic are not the only such homosexual outfits receiving Ryan White funds advocating so-called safe sex. As I said earlier, I do not believe Senators could possibly believe the stonewalling by the Clinton administration to prevent us, my staff and me, from obtaining accurate, verifiable statistical information on precisely how these millions and billions of dollars have been spent and will be spent. I think it is a legitimate question for the legislative branch to ask the executive branch. But not the Clinton administration. Nobody. That is off limits. They have got a deal. The Senate is debating whether or not to reauthorize this act for appropriations of such sums as may be necessary, and nobody can tell me and nobody can tell the American people exactly where this money is going and for what it is being spent.

Oh, you hear all of the wonderful stories about how these people say it is being spent. And I suppose some of it is being spent for good purposes. But Congress does not monitor this, and HHS will not let anybody monitor it. So it is sort of a closed shop, do you not see?

Incidentally, speaking of the word "care," I have been the butt of a lot of diatribes lately, like the New York Times, which put words in my mouth that I had not said. And these editorial writers around the country somewhere along the line gave up this responsibility of checking for themselves what the facts are and what was really said. They pick up a report from the New York Times, and they rush to their little hot typewriters or little hot microphone or camera and say, "Oh, you cannot talk about this. This is a hateful thing to do."

It is all right with me what they say. I do not care. I do not talk to them much anyway because they will take a snippet here and a snippet there and about 5 seconds here and 5 seconds there, and they will make the quote say what they want it to say. The first amendment does not require that they be honest or fair about anything.

For the record, Mr. President, let me say that I do not hate anybody, but I have been accused of it in editorial after editorial. I do not hate homosexuals. I do not even know any homosexuals. But what I do not like is for the Congress of the United States to bow and scrape to homosexual pressure and give them Federal funds and rights and privileges that other Americans are denied. That is what I do not like. And, yes, Mr. President, I have a deep sympathy for homosexuals who are dying of AIDS because of their having deliberately—deliberately—placed their lives at risk. I have deep sympathy for anybody who sticks a loaded pistol in his mouth and pulls the trigger. You are playing Russian roulette

either way. And homosexuals are losing and losing and losing, and they do not want to talk about abstinence.

Now, homosexuals know the risk they are running with their sexual conduct. They go on television programs. I saw one or two on "60 Minutes" the other night, 2 or 3 weeks ago. They discussed why they just cannot abstain and why it is so much more intimate not to try to protect themselves from being infected with AIDS or preventing others from being infected. They are not interested in abstinence. They are not interested. In all candor, Mr. President, when you get down to the guts, feathers and all, they do not give a damn.

But the rest of us do. A lot of us are sick and tired of all the pretenses of injured innocence. They are not innocent. They know it. And that is why they are so belligerent in their demands that homosexuality be accepted as just another lifestyle—indeed, a specially protected and encouraged lifestyle. And that is not a reckless statement because I am about to explain what I mean. I do not believe they will ever sell that bill of goods to the American people.

But back to Senator HATFIELD, the distinguished chairman of the Senate Appropriations Committee, and Senator ROBERT C. BYRD, who has served with distinction as chairman of that committee in the past, and he serves now, of course, as ranking minority Member. The Department of Health and Human Services has declined to make any useful information available to my staff or me. They say they have no records of how many homosexual advocacy groups receive or have received Ryan White funds. They have no record of what they do with it. But to that I say, why? Why? And I think the American people are entitled to say, why? It is not HHS money. It is not JESSE HELMS' money, and it is not NANCY KASSEBAUM's and certainly not TED KENNEDY's money, or any of his aides'. It is the American people's money. They have a right to know the full information.

Senators HATFIELD and BYRD and other members of the distinguished Senate Appropriations Committee might start by inquiring officially and formally how much Federal money was delivered to, for example, the Gay Men's Health Crisis Organization in New York, or right here in Washington, how about the homosexual outfit, the Whitman Walker Clinic? Surely, the Appropriations Committee is entitled to know. Surely, the Members of the Senate are entitled to know.

During the past 15 years, Mr. President—and I shall conclude shortly—AIDS has killed 270,000 people in this country.

Heart disease kills more than that in less than 5 months. Less than 2 percent of the deaths last year in America were the result of AIDS.

I go back to Ryan White. I was sorry for that young man then, and I am

sorry for him now. He died at age 18 of AIDS, a disease that he almost certainly contracted from that tainted blood that had its origin as a result of that homosexual airline flight attendant who was the first documented instance of the AIDS disease being brought into North America from Africa.

We will never know, of course, the precise list of individuals who passed the HIV virus along—in what they call the generational series of homosexuals—to drug users, and one or more of them contributed to that blood transfusion that Ryan White got.

But you know one thing, they were involved in it and they know it, too, but they want to obscure that. They usually go around Ryan White to attract sympathy for them, undeserved sympathy. I am talking about the ones who have not caught it yet, but they are playing Russian roulette and they want the discovery to be made so it will be safe for them. I do not think there is ever going to be a protection of that nature developed by science. I find myself hoping that it will be, but I just do not believe it is going to happen.

Ryan White was without blame. He was a hemophiliac who had to have a blood transfusion, but he did not deserve a fatal tainted blood transfusion.

Ryan White was innocent, and I pass no judgment on any member of his family or any other family who has lost in such a way a member of their family. I do not have any real problem—I do not understand it—but I do not have any problem with Ryan White's name being exploited by the kind of people who have acknowledged that they either cannot or will not even try to restrain their impulses to prevent the further spread of AIDS.

Michael Fumento, an associate of the Competitive Enterprise Institute in Washington, has written a book that all Senators should read, but probably will not. The name of the book is "The Myth of Heterosexual AIDS."

I wish some of the people in the press gallery would read it. Mr. Fumento relates that he called the offices of a number of Senators to inquire about the fairness of devoting so much of the taxpayers' money to one disease at the expense of other diseases. He said he asked in each Senate office for a statement on the fairness of it all. And then he wrote:

Wonder of wonders, I got no answer.

He concluded this way:

And while several Senators claim that as President they would be tough enough to deal with America's foreign adversaries, when it comes to AIDS activists, they go crawling for the deepest foxhole.

I am not looking for a foxhole. What I want is for the American people to be informed as to how this money is to be spent, where it is to be spent and by whom it is to be spent. Do not take the word of Senators who say, "Well, we had in our State this situation," or others, "We had our situation and it's terrible," and so forth and so on. Of

course, it is terrible, but that does not address the problem. Let us find out how this money is being spent. That is all I have said at any time along the line. No foxhole for me. We will find out sooner or later what happened.

Mr. President, I ask unanimous consent that an op-ed column written by Mr. Fumento, published on June 19 by the Washington Times, be printed in the RECORD at the conclusion of my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See exhibit 1.)

Mr. HELMS. Mr. President, for the guidance of the clerk, the headline in the article is "Bill Oils the AIDS Squeaky Wheel."

Mr. President, I yield the floor.

EXHIBIT 1

[From the Washington Times, June 19, 1995]

BILL OILS THE AIDS SQUEAKY WHEEL

(By Michael Fumento)

Grab your wallet, folks! The Senate is about to demonstrate its boundless compassion again by spending billions of your dollars. But this time it won't just be unfair to taxpayers but to the great majority of Americans suffering from serious diseases.

The subject of this latest act of largesse is the cynically named Ryan White Act, which is up for reauthorization. With 58 co-sponsors, its Senate approval is virtually guaranteed, though for the moment its passage is blocked by North Carolina Republican Sen. Jesse Helms.

Enacted in 1990, ostensibly to provide care for such victims as Ryan White, the measure was a sham from the start. Young Ryan White was a hemophiliac who won the heart of the nation after he contracted AIDS. He died at age 18. But only 2 percent of AIDS victims in 1990 were hemophiliacs, according to the federal Centers for Disease Control and Prevention. Today it's 1 percent. Less than 2 percent of AIDS victims are under the age of 20.

One wonders how the bill would have fared had it been named the Robert Mapplethorpe Act, after the late homosexual photographer famous for such depictions as bullwhips extending from people's posteriors.

The Ryan White Act was also sold as a means of helping, as National Commission on AIDS Chairwoman June Osborne put it, the "many parts of rural America [that] are about to be blind-sided by the epidemic." Yet then, as now, cases from non-metropolitan areas amounted to 5 percent of those reported.

Predictably, almost all of the money went to those places that had the most AIDS cases. This means not Ryan White's town of Cicero, Ind., but rather New York City, Los Angeles, San Francisco and other areas that also happened to be Democratic strongholds. In other words, it followed the same supply lines as all the Democratic pork of that era. The money went for those who make up the bulk of AIDS victims: homosexual men and intravenous drug abusers.

Further, even on a per-patient level, the bill resulted in allocating several times more money per victim in larger cities than in less-populated areas.

Misnaming and misrepresenting the act has paid handsomely. In its first five years, spending more than doubled from \$276 million in 1991 to \$664 million for this year, for a total of over \$2 billion.

This time around, the bill is sponsored by Kansas Republican Sen. Nancy Kassebaum. When I called her office, her aide cited—

yes—the rural AIDS bogeyman. One wonders if the good senator knows that Kansas has all of 245 AIDS cases last year, just 3 percent of the national total. Of those, eight were children.

In fairness, Sen Kassebaum has rewritten the act so that more money will be authorized for rural areas. But with so few patients there, the money must necessarily flow right back through the old pork pipeline established in 1990.

The biggest difference this time is that the estimated cost will balloon from slightly more than \$2 billion to \$3.6 billion. This even though the AIDS epidemic is declining. New AIDS cases are being reported at a rate well below the 80,000 of last year.

Yet even if the bill weren't such a budget-buster, it would be terribly wrong.

Ryan White provides no money for medical research, so no one will ever be cured of AIDS with all those billions of spending. Along with some allocations for education that are redundant with the \$500 million federal AIDS education budget, the Ryan White Act simply provides money for treatment, drugs, free meals, in-home care and the like.

It's nice that sick people can get such services regardless of their income levels. But for anybody with any disease besides AIDS the sign on the door reads, "Go away!" There is no Gilda Radner Act for victims of ovarian cancer, no Ronald Reagan Act for Alzheimer's disease patients. Some elderly and indigent people with such diseases can qualify for programs like Medicare and Medicaid, but then so can AIDS patients.

No, the Ryan White Act was a gift to one extremely squeaky wheel. Not content with a medical research budget that dwarfs that of every other disease but cancer—despite being only the ninth-greatest killer of Americans—the AIDS activists demanded and got privileges that persons with other diseases can't even dream about.

Quite simply, the homosexual activists want special treatment because they themselves, and their friends, have an extraordinary chance of contracting the disease. Somehow they have translated "Gimme! Gimme! Gimme!" into a cry for compassion. Long gone are the days when AIDS activists begged merely to be treated no worse than the victims of diseases not associated with behaviors society finds distasteful.

I called the offices of both Sen. Kassebaum and the other Kansas senator, Bob Dole, for a statement about the fairness issue. Wonder of wonders, I got none. To a Congress always eager to take money from all of us and give it to some of us to buy votes, fairness is a four-letter word. And while several senators claim that as president they would be tough enough to deal with America's foreign adversaries, when it comes to AIDS activists they go crawling for the deepest foxhole.

Mrs. KASSEBAUM addressed the Chair.

The PRESIDING OFFICER (Mr. SANTORUM). The Senator from Kansas.

Mrs. KASSEBAUM. Mr. President, I would like to answer, some of the questions that were raised by the Senator from North Carolina. I know how much Senator HELMS genuinely cares about this issue. I would like start by saying that many of the 64 cosponsors of this legislation were cosponsors of the legislation in 1990. So they, I hope, are familiar with what was in the bill then and what is in the bill now.

We have had a through hearing on this bill. A GAO report on the funding equities and distribution, which had been requested by Senator BROWN of

Colorado and myself was used as the basis for that hearing. The report had been requested because of our concern about equity of funding for all individuals with AIDS.

I share with Senator HELMS a concern about the fact that sometimes we are not able to do the type of oversight that we should, but with the hearing and the GAO report we were able to propose in this bill changes to provide equity in the distribution of funds.

It is sad, but true, that there are many who have been victims of HIV. Some individuals like Ryan White contracted this disease through contaminated blood. Unfortunately, this illness has had a ripple effect with involvement of individuals from many walks of life but also the family members of those infected have also suffered. So we have to be mindful of all who have suffered. I think that this epidemic must be viewed in the broader sense of the epidemic and the tragedy.

Senator HELMS quoted figures related to the amount of money that has been expended for the major causes of deaths in this country. I lost a niece, several years ago to cancer. She had two small children. I remember through the years of her struggle with cancer discussing Federal Government funding levels for cancer. She questioned why there could not be more expended for cancer research than we were spending on AIDS. I spent time researching this important question in hopes of finding an answer. One thing that became apparent to me was that money that goes into research for HIV is also very valuable for other illnesses like cancer.

The figures that Senator HELMS gave were only for research, and I would like to give figures that include not only the research expenditures but also the moneys that come from Medicare, Medicaid, Social Security disability funding, and the Public Health Service moneys. For HIV and AIDS, it is about \$5.4 billion a year; for cancer, about \$15 billion a year; for heart disease, about \$34 billion a year.

One of the reasons that the Ryan White CARE legislation came into being, Mr. President, was to help provide assistance to those who were not eligible for Medicare; because they were not yet of age to receive Medicare or to receive Medicaid, because they had an income level which would not allow them to qualify. As we all know such medical care services even those that are basic can be very costly.

That was the genesis of the Ryan White legislation. It has grown significantly in funding since 1990, but so have the number of AIDS victims.

I suggested in 1990 that we do such sums. I do not think that this a good approach for defining the level of authorizations. I would propose an amendment, if this would be of any benefit, to say define the funding level for the first year which would be consistent with the appropriated levels reported recently by the House of Rep-

resentatives. The House appropriation figure just recently passed is \$656 million for 1996; then such sums in the following years. At least that puts a benchmark which gives some consistency between the House and Senate.

Senator HELMS mentioned a new title, title V, which was is slated to receive a small amount of funding, \$17 million, in this year's authorization. I would like to explain this program a bit further. Title V is for AIDS Education Training Centers [AETC]. This title is not new. It has been moved from the health professions bill to this legislation. It seemed appropriate to consolidate those efforts related to AIDS into one legislation.

AETC's are not a new program. It has been funded for many years. Under this program, health providers are educated and trained in the best ways to treat individuals with AIDS, particularly children and women. Given the complications and numerous illnesses which individuals with AIDS often acquire, health providers benefit from this type of education. I believe that patients also benefit from better trained physicians and other providers. This explains why there is a new Title V, although we must remember that this is not new, but rather a program moved from the Health Professions program to this legislation.

Mr. President, this is not a piece of legislation that is enthusiastically embraced by everyone. It raises fears. It raises concerns. It certainly raised emotional levels and questions of morality, which Senator HELMS has noted.

I think the Senator from California earlier today, Senator FEINSTEIN, spoke with real eloquence, of two people she personally knew, and how it affects so many. Sometimes people who do not fit the pattern that Senator HELMS has mentioned are also infected.

AIDS touches people, not only those who are ill and/or dying, but it touches many others as well. That is why the Ryan White bill came into being—not to take his name in vain. The intention was to provide services that could be of help to families who are suffering—and to patients—who are infected with this disease.

I yield the floor. I do not know whether there are other amendments to be considered.

AMENDMENT NO. 1853

(Purpose: To require spousal notification in cases in which an individual is diagnosed with infection with the human immunodeficiency virus)

Mr. HELMS. Mr. President, I have some amendments to come before the Senate. I do not intend to second-degree anybody else's amendment, and I hope we can just have up-and-down votes and get this bill out of the way.

Now, Mr. President, I send an amendment to the desk and ask it be stated.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows: The Senator from North Carolina [Mr. HELMS] proposes an amendment numbered 1853.

Mr. HELMS. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the end, add the following new section: SEC. 1. SPOUSAL NOTIFICATION.

(a) PROHIBITION ON THE USE OF FUNDS.—The Secretary shall not make a grant under this Act to any State or political subdivision of any State, nor shall any other funds made available under this Act, be obligated or expended in any State unless such State takes administrative or legislative action to require that a good faith effort shall be made to notify a spouse of an AIDS-infected patient that such AIDS-infected patient is infected with the human immunodeficiency virus.

(b) DEFINITIONS.—As used in this section— (1) AIDS-INFECTED PATIENT.—The term "AIDS-infected patient" means any person who has been diagnosed by a physician or surgeon practicing medicine in such State to be infected with the human immunodeficiency virus.

(2) STATE.—The term "State" means a State, the District of Columbia, or any territory of the United States.

(3) SPOUSE.—The term "spouse" means a person who is or at any time since December 31, 1976, has been the marriage partner of a person diagnosed as an AIDS-infected patient.

(c) EFFECTIVE DATE.—Subsection (a) shall take effect with respect to a State on January 1 of the calendar year following the first regular session of the legislative body of such State that is convened following the date of enactment of this section.

Mr. HELMS. Let me sum up this amendment. I think we had two votes against it the last time.

This amendment requires that States receiving Federal funds for AIDS education and prevention take specific legislative and/or administrative steps to make sure that spouses—that is, the wife or husband—of an individual infected with the HIV/AIDS virus, that the spouse be promptly notified.

Let me say why I think we ought to vote on this again. Some years back, 2 or 3, I forget how long ago, there were several circumstances that led me to draft this amendment at that time.

It began when I received a call from a young woman who worked on the House side of the Congress who said, "Senator, my mother wants to come by and talk with you on a matter of confidence. She doesn't want you to ever use her name," and I shall not. They came, a lovely lady and her beautiful daughter. I shall never forget that visit. The meeting did not last long. After the usual amenities—and I had no idea what the lady wanted to discuss—but after the usual amenities, I seated them. The three of us began to discuss why she had come and what I might be helpful to her about.

At that point, tears welled up if that mother's eyes as she began to tell the story. She took a deep breath and stated the bottom line. She had AIDS, she said, "and I am dying." Her bisexual husband, you see, had infected her with the AIDS virus. He had not informed

her he was infected, and State law in her State forbade the family doctor from telling her—which I consider to be outrageous.

Now, Mr. President, we hear so much about protecting the confidentiality of AIDS-infected patients, yet we hear nothing about the fatal consequences of confidentiality laws. The homosexuals march in Washington, and they demand their rights, but what about the rights of this lovely lady and the thousands of others like her, potentially, who, through no fault of their own, have become infected with the deadly AIDS virus, or may be infected in the future?

Do they not have rights, too? Should there not be laws to protect the innocent spouses, instead of those who hide behind the confidentiality law and, as in this case, are causing others to die?

What a terrible tragedy. Only 12 States protect the lives of spouses of HIV-infected citizens, only 12 States. Eighteen States provide for notification of partners, but they are silent on the rights of spouses. What kind of fair play is that? And you know what I mean when I say "partner."

Does this not lead to the conclusion that some States may appear more concerned with protecting the interests of the HIV-positive spouse instead of the life of the unsuspecting innocent spouse?

This amendment does not require States to initiate a spousal notification program. It simply says that if States want Federal money, which they take from the taxpayer—if States want money to combat the AIDS virus, the AIDS disease, those States are going to have to make a genuine and concerted effort to protect innocent spouses from being exposed to the AIDS virus.

It is time to start treating AIDS as the public health issue that it is, rather than the civil rights issue that it has become. I have no doubt that if we take this step, it will help curb, to some extent at least, the spread of this lethal disease.

Mrs. KASSEBAUM addressed the Chair.

The PRESIDING OFFICER. The Senator from Kansas.

Mrs. KASSEBAUM. Mr. President, maybe, as a clarification of what we did last year, it is my understanding that, in law, from what we had before, that each State is required to set up its own notification system. Is that correct?

Mr. HELMS. Not to my knowledge. But even if it is, if you will forgive me, it will not hurt the Senate to go on record again.

Mrs. KASSEBAUM. No, I have no problem—I was just asking the Senator if he knew if that was not correct that each State is required to set up its own?

Mr. HELMS. My expert is sitting to my left, and sometimes to my right as well, and she says she does not know about that. And so, of course, I do not.

Mrs. KASSEBAUM. Mr. President, I suggest the absence of a quorum for a minute until we look at the language and get some comparison, so maybe we can accept that.

Mr. HELMS. That is fine, just so there is no attempt to second-degree my amendment, because then we will have protracted debate.

Mrs. KASSEBAUM. No, I agree with the Senator. I know the effect of a second-degree amendment.

Mr. HELMS. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. HELMS. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. THOMPSON). Without objection, it is so ordered.

Mr. HELMS. Mr. President, I ask for the yeas and nays on the pending amendment.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

Mr. KENNEDY addressed the Chair.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I hope that this amendment will be accepted by the membership. I intend to vote for it.

The PRESIDING OFFICER. Is there further debate on the amendment? If not, the question is on agreeing to the amendment. On this question, the yeas and nays have been ordered, and the clerk will call the roll.

The legislative clerk called the roll.

Mr. LOTT. I announce that the Senator from Utah [Mr. BENNETT], is necessarily absent.

Mr. FORD. I announce that the Senator from Illinois [Mr. SIMON], is necessarily absent.

The PRESIDING OFFICER. Are there any other Senators in the Chamber who desire to vote?

The result was announced—yeas 98, nays 0, as follows:

[Rollcall Vote No. 332 Leg.]

YEAS—98

Abraham	Daschle	Hollings
Akaka	DeWine	Hutchison
Ashcroft	Dodd	Inhofe
Baucus	Dole	Inouye
Biden	Domenici	Jeffords
Bingaman	Dorgan	Johnston
Bond	Exon	Kassebaum
Boxer	Faircloth	Kempthorne
Bradley	Feingold	Kennedy
Breaux	Feinstein	Kerry
Brown	Ford	Kerry
Bryan	Frist	Kohl
Bumpers	Glenn	Kyl
Burns	Gorton	Lautenberg
Byrd	Graham	Leahy
Campbell	Gramm	Levin
Chafee	Grams	Lieberman
Coats	Grassley	Lott
Cochran	Gregg	Lugar
Cohen	Harkin	Mack
Conrad	Hatch	McCain
Coverdell	Hatfield	McConnell
Craig	Heflin	Mikulski
D'Amato	Helms	Moseley-Braun

published in 1993 by Lexington Books, 866 Third Avenue, New York, NY 10022.

Getting the Word Out, A Practical Guide to AIDS Materials Development by Ana Consuelo Mariella, 1990 by Network Publications, P.O. Box 18830, Santa Cruz, CA, 95061-1830.

The Guide to Living with HIV Infection by John G. Bartlett, M.D. and Ann K. Finkbeiner, published in 1993 by The Johns Hopkins University Press, 2715 North Charles Street, Baltimore, Maryland 21218-431.

Managing AIDS in the Workplace, by Sam B. Puckett, L.L.B., M.B.A. and Alan R. Emery, Ph.D., published in 1988 by Addison-Wesley Publishing Company, Reading MA.

Preventing AIDS, A Guide to Effective Education for the Prevention of HIV Infection, American Public Health Association, 1015 Fifteenth Street, NW, Suite 300, Washington, DC 20005 (202) 789-5600.

Training Educators in HIV Prevention, An Inservice Manual by Janet L. Collins, Ph.D. and Patti O. Britton, 1990 by Network Publications, P.O. Box 1830, Santa Cruz, CA 95061-1830.

We Are All Living With AIDS, How You Can Set Policies and Guidelines for the Workplace, by Earl C. Pike, published in 1993 by Deaconess Press (a service of Fairview Riverside Medical Center, a division of Fairview Hospital and Healthcare Services), 2450 Riverside Avenue South, Minneapolis, MN 55454.

100 Questions and Answers About AIDS by Michael Thomas Ford, published in 1993 by New Discovery Books, MacMillan Publishing Company, 866 Third Street, New York, NY 10022.

Message #1

Subject: Mandatory HIV/AIDS training.

Author: Stec at FAS07.

Date: 01/31/95 02:27 p.m.

On September 30, 1993, President Clinton mandated Federal HIV/AIDS education for all Federal employees. To comply with this Presidential mandate, the Foreign Agricultural Service is presenting the attached mandatory HIV/AIDS training sessions.

Please attend the session scheduled as indicated or arrange to switch session with a coworker.

Supervisors are responsible for disseminating this information to their employees and for certifying that all employees under their supervision attend a session of the mandate training.

Please contact Charlotte Stec, 720-1596, if you have any questions regarding this training.

Message #2

Subject: PL 480 status of PA report.

Author: Rivera JA at FAS15.

Date: 01/31/95 03:13 p.m.

The monthly Public Law 480 "Status of PA" report is now available on the "u" drive. To access it, go to "pl480" from the Windows' File Manager, since this is a Lotus file, and click on "title1". This report shows Public Law 480, Title I agreements signed, purchase authorizations issued, and sales registered. For information, please call José Rivera at 720-6286.

TRAINING PROGRAM

Please attend the session scheduled as follows in accordance with your last name. This is mandatory training for all Federal employees. If you cannot attend your scheduled session, please arrange to switch sessions with a coworker.

Attendance will be taken. All participants should bring a pencil or pen with them.

A Sign Language Interpreter will be provided for the afternoon session of February 7th only. Employees requiring special ac-

commodations should contact Charlotte Stec.

Date, Time, Location, Last Name, Begins in Letters

February 7, Tuesday 8:30-11:30 a.m., 12:30-3:30 p.m., Jefferson Auditorium, A-BE, BI-CI.

February 8, Wednesday 8:30-11:30 a.m., 12:30-3:30 p.m., Jefferson Auditorium, CL-DI, DO-GA.

February 9, Thursday 8:30-11:30 a.m., 12:30-3:30 p.m., Jefferson Auditorium, GE-HAN, HAR-HO.

February 14, Tuesday 8:30-11:30 a.m., 12:30-3:30 p.m., Jefferson Auditorium, HU-KI, KL-MA.

February 16, Thursday 8:30-11:30 a.m., 12:30-3:30 p.m., Jefferson Auditorium, MC-M, N-PL.

February 17, Friday 8:30-11:30 a.m., 12:30-3:30 p.m., Jefferson Auditorium, PO-RO, RU-SL.

February 24, Friday 8:30-11:30 a.m., 12:30-3:30 p.m., Jefferson Auditorium, SM-TI, TO-WES.

February 28, Tuesday 8:30-11:30 a.m., Jefferson Auditorium, WET-Z.

(For further information or questions, contact Charlotte Stec, HIV/AIDS Coordinator, on 720-1596 or FAX 720-2016.)

[From the Washington Times, Mar. 27, 1995]

MANDATORY FEDERAL AID CLASSES CITED AS PROMOTING GAY AGENDA

TRAINING ADDRESSES RELIGION AS BARRIER

(By Rowan Scarborough)

The Clinton administration's guidelines for mandatory AIDS training of all federal employees call for the "breaking down of audience resistance" to the program's teachings if that resistance is based on "religious beliefs."

The training manuals portray people opposed to condom distribution in schools as "partisans." They tell trainers to use the words "sex partners" instead of "husband and wife" and "injecting drug user" instead of "addict."

Would-be trainers have to discuss their views on "homosexuality for my child" as part of the selection process.

A federal worker who underwent training this month said she was offended when the instructor, a private contractor, began talking about her grandmother's likely sex practices.

"I was shocked and upset when the instructor personalized anal sex for each person in the room by saying our grandmothers probably practiced birth control by participating in anal sex," said the worker, who described the three-hour session on the condition that she not be identified.

"I was highly offended," she said, "I have a very godly grandmother, and I just broke down and cried. I guess they're trying to say homosexuals do it that way and so did your grandmother."

The guidelines are in documents from the departments of Energy, Health and Human Services, and Agriculture. Other departments are believed to use similar guidelines, which are coordinated and approved by the White House.

Aimed at the 2.1 million federal employees, the "Federal Workplace AIDS Education Initiative" was authorized last year by Mr. Clinton, whose campaign received political and financial support from the homosexual community.

Administration rules for AIDS instruction tell trainers:

To avoid certain terms, such as "husband and wife," "homosexual men," "promiscuous," "sexual preference" and "addict."

To deflect "homophobic comments" during a training session by saying, "There is some division of opinion on that point."

To watch out for troublemakers among the pupils. A federal worker who takes an "intransigent point of view" on condom distribution in schools or needle distribution is pegged as a "partisan." A "heckler" is someone who "expresses disbelief, disgust or scoffs at content and processes." A "moralist" believes that "people who are HIV-infected through sex or drug use deserve what they get."

To suggest that a person use his own drug-injection equipment or try "disinfecting with bleach" to avoid getting the human immunodeficiency virus, which causes AIDS.

The Department of Energy's AIDS program is titled, "Walkin' the Talk" and includes a discussion of "serial monogamy," which it defines as an "exclusive sexual relationship with one individual at a time."

"Practicing serial monogamy and therefore having several sexual partners, even over an extended period of times, may place one at risk for HIV infections unless he or she practices safer sex," the program says.

One of the training manuals included a scoring system titled "Values About HIV/AIDS-Related Issues." It was used to select AIDS instructors.

Candidates were asked to rate their opinion on several topics, including "sex without love," "sex outside of a committed relationship," "homosexuality for my child," "stiff sentences for injection-drug users who share needles and other drug-injection paraphernalia," and "laws to protect homosexuals from discrimination in housing, jobs and public accommodations."

Jim Woodall, a vice president of the conservative group Concerned Women for America, said President Clinton should "cease and desist" the training. He said the goals could be achieved by giving employees a Centers for Disease Control and Prevention brochure on AIDS prevention.

"We have been suspecting for a long time that AIDS education is being used as a facade to promote the homosexual lifestyle," Mr. Woodall said. "AIDS education used in public schools and college campuses has now invaded our government, where the president is mandating federal employees to sit down for four hours for this type of education. It's a fraud."

Mr. Woodall's 600,000-member organization is compiling information on the program.

"I do not have any problem with gays relating to gays when talking about sex," he said. "The issue is, the U.S. government is promoting that agenda using taxpayer dollars."

Richard Sorian, White House spokesman on AIDS policy, disagreed with the group's characterization of the program. "The effort has been a very successful effort to supply people with information that allows them to protect themselves and protect their family," he said.

He said Concerned Women for America is misinterpreting some of the training material. For example, he said, the section on "breaking down audience resistance" based on religion is an effort to have workers air those concerns so they can be discussed.

"They are not trying to change someone's religious beliefs at all," Mr. Sorian said. "What they are talking about is beginning the instruction with any concerns they have or religious belief that might make them uncomfortable with the discussion so they can be comfortable in the discussion."

Mr. Sorian said such words as "addict" are avoided for a good reason: "If you say drug addicts are susceptible to HIV, but they don't consider themselves an addict, then they don't recognize themselves as an addict."

He said he has received "positive feedback" from participants who have used the

information to educate others. The program is scheduled to end this week. The White House AIDS office then will know how many workers were reached.

Some federal workers have objected to the training.

A defense Department employee said he walked out during his department's session.

"I don't believe I should sit next to a female and be told how to do intercourse, no matter how sidetracked they go," said the employee, who requested anonymity. "I don't want to be in mixed company and talk about a lifestyle I'm not involved in, that I don't approve of. I don't care to be instructed by Big Brother in things I avoid."

A Drug Enforcement Administration worker who objected to attending AIDS training was ordered to attend or be disciplined for insubordination.

Mr. Woodall said the system "weeds out any people who have a problem with the gay lifestyle."

MARCH 31, 1995.

Senator JESSE HELMS,
Century Post Office Building,
Raleigh, NC.

DEAR SENATOR HELMS: At a time when our total federal budget is under scrutiny, it seems appropriate to study all expenditures. Within USDA,ARS our budgets for agricultural research are particularly tight. Nevertheless, we spend a tremendous amount of time in all types of training sessions. This week we were required to attend a mandatory HIV/AIDS training session which is apparently required by the President of all Federal employees. This results in millions of dollars in lost man hours and consequently wages. We also were required to take a pre- and post-class test. Unfortunately, at least in our agency, there is no way to test out of the class time. Since we are mostly biological scientists we learned essentially nothing. The enclosed material was to be read prior to the class and thereby using more of our valuable time. Some of this material is not appropriate for the workplace (e.g. how to have safe oral sex, page 28), and it does seem to be necessary for government time and money.

I hope you and other congressional members will carefully consider the cost/benefits of our numerous training sessions. The taxpayer's money can be better spent on research in our agency than in peripheral training sessions not suited to us.

Sincerely,

Mr. HELMS. Mr. President, I ask for the yeas and nays on this amendment.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The yeas and nays were ordered.

Mr. HELMS. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. HELMS. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. HELMS. Mr. President, I ask unanimous consent to lay aside the previous amendment so that I can offer another amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1857

(Purpose: To limit amounts appropriated for AIDS or HIV activities from exceeding amounts appropriated for cancer)

Mr. HELMS. I now send an amendment to the desk and ask that it be stated.

The PRESIDING OFFICER. The clerk will report.

The bill clerk read as follows:

The Senator from North Carolina [Mr. HELMS] proposes an amendment numbered 1857:

At the appropriate place, insert the following new section:

SEC. . LIMITATION ON APPROPRIATIONS.

Notwithstanding any other provision of law, the total amounts appropriated for any fiscal year for AIDS and HIV activities may not exceed the total amounts discretionary funds appropriated for such fiscal year for activities relating to cancer.

Mr. HELMS. As the clerk has read, Mr. President, this amendment proposes that the Ryan White CARE Reauthorization Act of 1995 have this provision to guarantee that any and all Federal funds authorized and appropriated for HIV/AIDS will not exceed the total Federal funds authorized and appropriated for and in connection with the disease of cancer.

The leading cause of death in America today is heart disease, followed closely by cancer. HIV/AIDS ranks ninth, No. 9—I believe, as a matter of fact, they lowered it to No. 8. So make that read HIV/AIDS ranks eighth in the number of deaths it causes. It is of interest that HIV/AIDS receives \$2.7 billion per year in Federal funding, which exceeds Federal funding in connection with any other disease. Heart disease, for example, Mr. President, kills more than 720,000 Americans every year, and \$305 million in Federal funds are allocated and appropriated for heart disease. Cancer kills 515,000 Americans, and it receives \$2.3 billion.

I think the arithmetic of all of this, Mr. President, speaks for itself. I want the RECORD to show that I hope a cure for HIV/AIDS is found tomorrow morning, and I encourage every research effort toward this end. However, I have to make it clear that I am appalled at what has become a total politicization of Federal funding for medical research and health services.

The pending amendment stipulates that Congress may not authorize or appropriate more money for HIV/AIDS than is authorized and appropriated in connection with the disease cancer. More people are dying from heart disease and cancer and stroke and lung disease and accidents and pneumonia and diabetes and Alzheimer's and suicide than die from AIDS. Each one of these kills more people than does the disease AIDS, yet AIDS receives a disproportionate amount of the taxpayers' money.

On average, the Federal Government spends about \$91,000 on every person who dies of AIDS. The Federal Government spends about \$5,000 for every person who dies of cancer.

Now, I have my own ideas about priorities, but that is an issue for another

day. And I think I am correct in my impression that Americans agree that this discrepancy is neither fair nor equitable.

In a nutshell, the pending amendment will bring a measure of equity and fairness to the existing priorities in the area of HIV/AIDS funding. As long as cancer kills 18 times as many people as AIDS, and AIDS nonetheless receives more Federal funding, it is time I think that Congress established some new equitable priorities.

Mr. President, I ask that all of my previous amendments be set aside enabling me to ask for the yeas and nays on this amendment.

The PRESIDING OFFICER. The yeas and nays have been requested. Is there a sufficient second? There is a sufficient second.

The yeas and nays were ordered.

Mr. HELMS. I yield the floor.

Mrs. KASSEBAUM. Mr. President, I am not sure if we are ready to propound a unanimous-consent agreement yet or not.

Mr. HELMS. I am certainly ready to hear it.

Mrs. KASSEBAUM. No, I guess we are not. So if I may just for a moment respond to several of the amendments that have been put forward by Senator HELMS. On the amendment that talks about promotion of homosexual activity, I certainly have great sympathy for wanting to limit what the activities might be supported. I will be introducing an amendment which addresses that same issue but perhaps not in the same way as Senator HELMS. I will not get into a definition of the amendment. Since the unanimous-consent agreement has not been put forward yet, I am not sure whether we should go ahead and send our amendments to the desk, but perhaps we will get them all out and then we can decide what to do.

AMENDMENT NO. 1858

(Purpose: To prohibit the use of funds for certain activities)

Mrs. KASSEBAUM. I send to the desk an amendment. I ask unanimous consent to set aside the amendments.

The PRESIDING OFFICER. Without objection, the pending amendment is set aside. The clerk will report the amendment of the Senator from Kansas.

The assistant legislative clerk read as follows.

The Senator from Kansas [Mrs. KASSEBAUM] proposes an amendment numbered 1858.

Mrs. KASSEBAUM. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

At the appropriate place, insert the following new section:

SEC. . PROHIBITION ON PROMOTION OF CERTAIN ACTIVITIES.

Part D of title XXVI of the Public Health Service Act (42 U.S.C. 300ff-71) as amended by section 6, is further amended by adding at the end thereof the following new section:

SEC. 2672. PROHIBITION ON PROMOTION OF CERTAIN ACTIVITIES.

"None of the funds authorized under this title shall be used to fund AIDS programs, or to develop materials, designed to promote or encourage, directly, intravenous drug use or sexual activity, whether homosexual or heterosexual. Funds authorized under this title may be used to provide medical treatment and support services for individuals with HIV."

Mrs. KASSEBAUM. The amendment I have sent to the desk will prohibit the use of the Ryan White CARE Act funds to support activities which promote homosexuality. This provision will assure that the funds allocated under this act would be used to provide treatment for individuals. There would be no funds to be used for promotion of homosexual activities. I offer this amendment because I am aware that some of my colleagues are concerned that the CARE activities may lead to increased sexual activity or to increased drug use. Specifically, some are concerned that needle exchange programs and prophylactic distribution programs may lead to increased homosexuality or drug abuse. Whether or not these concerns are valid, my amendment makes it clear that none of the funds expended under this act could be used for such promotion activities. Rather, this provision would assure that CARE Act funds would be used for treatment. In this regard, it is more narrow than the amendment that has been offered by Senator HELMS in that it clearly states that the CARE Act funds are for treatment only, not prevention or homosexual promotion activities.

I offer this amendment because I would like to have us fully consider some of the language and implications of that language, and that will be set aside at such time as we come to a vote on the legislation.

Senator HELMS also put forward an amendment to ensure that Federal employees will not be required to attend or participate in AIDS training programs. I would for myself think that is a very sensible amendment. Mr. President, it does seem to me that we should not have to require attendance of Federal employees for such programs. I would like to say, though, I do not believe that the intent was to design these programs to change the lifestyle of Americans. I think the intent was to really try to have an understanding of AIDS, what it was about, what type of disease it was. But I really myself strongly will support Senator HELMS and say that in my mind it should not be a required attendance.

Another amendment that Senator HELMS put forward was on the funding. He would hold the funding levels to the same as they are in 1995. Mr. President, the House Appropriations Committee has appropriated \$656 million for 1996. If we take the 1995 level, that is \$651 million. But holding it until the year 2000 when AIDS cases are increasing at 20 percent a year seems to me to be a very difficult way for us to address this

issue at this time. And I think it clearly should be left up to the appropriators. I know that the appropriators today—the Presiding Officer is on the Appropriations Committee—are not going to be frivolous in the moneys they spend. And I have a great deal of confidence that they will take into consideration the needs that are addressed that have to be met in the Ryan White CARE legislation and will consider wise and sensible use of those funds. So that amendment I would just have to oppose because I think putting that type of restraint until the year 2000 clearly would do a disservice to many who are in serious need.

The other amendment was regarding funding equity. And I will be considering another amendment to address that issue because, as I mentioned earlier, it is of great concern. And one of the things where we would differ is what moneys go to research and is discretionary funding and what moneys come from, say, Medicare and Medicaid and the Social Security disability funding. That makes a big difference in the total amount, and I think it is important that there is an understanding regarding that difference. So, I will be putting forward another amendment on funding equity a bit later as we complete this debate.

I yield the floor, Mr. President.

Mr. KENNEDY addressed the Chair.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. I will just take a moment because the Senator from Kansas has outlined what I think has been a very responsible and thoughtful series of options for the Senate to make a judgment and a decision upon. They will be available to the Members as they examine these issues over the nighttime, and then we will have a chance to address them tomorrow and, hopefully, reach a final resolution. I think she has summarized the reasons and justifications for the positions which she has outlined, and I am in very substantial agreement. With some issues along the way we may have some difference. But I think there will be a series of alternatives for the Members to make a judgment on these matters on tomorrow and, I think, for the Members to make a final judgment on these questions tomorrow as well.

What remains will be the Gregg amendment, which deals with the exports of various pharmaceuticals and medical devices that have not been approved by the FDA or, for that matter, approved by the other 21 different countries that have regulatory agencies. He will best describe his amendment. This is a matter which is before the Human Resources Committee, and it certainly was my impression up until this afternoon that that would be a part of the whole FDA reorganization and structure. It is appropriate that it should be because we have a different criteria, for example, for pharmaceuticals and how the FDA treats those versus biotech and medical device leg-

islation. So, I had thought we would be addressing that as part of our total FDA review.

It has been the judgment of the Senator from New Hampshire to offer that measure, which initially, as I understand it, was a Hatch measure to this proposal. And we will have a chance to discuss that in the morning and make some judgment on that issue. And I would certainly invite our colleagues to pay close attention to the debate that will, hopefully, take place at 9:30 if we are able to work through our consent agreement.

Mr. President, I have more extended remarks on some of these measures which I will either make this evening or include in the RECORD. Hopefully, we are at a point where we might be able to consider a consent agreement, and I have been here long enough to know that, if that is possible, it is wise to try to take advantage of the opportunity before it may escape.

Mrs. KASSEBAUM addressed the Chair.

The PRESIDING OFFICER (Ms. SNOWE). The Senator from Kansas.

Mrs. KASSEBAUM. I ask unanimous consent that the name of the Senator from New Mexico, Senator DOMENICI, be added as a cosponsor.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mrs. KASSEBAUM. It is my understanding we are close to being able to put forward the unanimous-consent agreement. I think there still needs to be a couple of additional checks made.

Mr. HELMS addressed the Chair.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. HELMS. If the Senator will yield.

It is perfectly acceptable to me, Madam President.

It will take a unanimous consent to vary the order in which the amendments were presented, is that not correct?

The PRESIDING OFFICER. That is correct.

Mr. HELMS. Just so there will be no accidental mistake made, I ask unanimous consent that all amendments be voted on tomorrow morning in the order in which they were presented.

The PRESIDING OFFICER. Is there any objection?

Mr. KENNEDY addressed the Chair.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Could the Senator state again what the request was? As I understood it, we were in the process of trying to work out a consent request to cover the disposition of the measures tomorrow.

Mr. HELMS. If the Senator will yield. I am not suggesting anything that would vary the unanimous consent that I hold in my hand. I favor that. I simply want to be sure that all amendments are voted upon in the order in which they were presented.

Mr. KENNEDY. I see the Senator from Kansas on the floor.

ash. Times
5/29

Helms holds up anti-AIDS funds

Cites higher toll of other diseases

By Marc LaFountain
THE WASHINGTON TIMES

Sen. Jesse Helms is blocking reauthorization of an AIDS treatment program, apparently questioning whether AIDS should be the No. 1 medical funding priority when other diseases are taking more lives.

Citing a study by the Congressional Research Service, Mr. Helms is stalling the renewal of the Ryan White Comprehensive AIDS Emergency Resources (CARE) Act, which has provided more than \$2 billion for primary and preventive care for AIDS pa-

Congress

Packwood: Congressmen's judgment day looms soon. **AS**
Term limits: Supporters seek to amend Constitution. **AS**
Wrap-up: A look at last week's action. **AS**

tients since its inception in 1990.

The Congressional Research Service examined federal spending and mortality rates for AIDS and other diseases. In March it released a study showing that AIDS was the ninth-most-common killer of Americans in 1991.

But the U.S. Public Health Service and the National Institutes of Health devoted more funds for AIDS treatment and research than for more common killers, such as cancer and heart disease.

Richard Sorian, a spokesman for President Clinton's Office of National AIDS Policy, said the study's figures do not give a complete picture of the money going to major killers besides AIDS.

Medicare and Medicaid, as well as private insurers, spend millions on patients with cancer, heart disease and other ailments, he said, adding that AIDS patients often do not have this coverage.

"We don't believe that it is useful or correct to pit one disease against another," Mr. Sorian said. "I think that the opponents of some of these programs often do that. But the thing that I notice is that they do not, in doing that, propose additional funding for the diseases that they say are being shortchanged. They simply use it

see HELMS, page A11

FROM PAGE ONE

HELMS

From page A1

as an excuse to try to reduce funding for AIDS or whatever program they are attacking."

The Ryan White CARE Act is named after the teen-age hemophiliac from Indiana who received HIV-infected blood in a transfusion and died of AIDS in 1989. Its authority expires this year unless it is reauthorized.

Funding for the program has grown from \$220.5 million in fiscal 1991 to \$633 million this year. The Clinton administration has requested \$723.5 million for fiscal 1996.

Senate and Clinton administration sources confirm that Mr. Helms, North Carolina Republican, has placed holds on the Ryan White CARE Reauthorization Act of 1995. The holds have delayed floor action on the bill since it was reported out of the Labor and Human Resources Committee in February.

With Mr. Helms' objections in

place, the act can be brought to the Senate floor only by Majority Leader Bob Dole of Kansas, one of 57 senators co-sponsoring the bipartisan effort at reauthorization.

But a Labor and Human Resources Committee staffer said Mr. Dole, who is running for the GOP presidential nomination, is urging cooperation and does not want to be forced to override Mr. Helms' objections.

"Senator Dole's staff has encouraged us to try to work with the member who has a hold on this legislation," said the staffer, declining to identify Mr. Helms by name.

The staffer said that the act has enough support to prevent a filibuster and that it will likely come to the Senate floor in the next few weeks.

Mr. Dole's office had no comment.

Reauthorization of the Ryan White CARE Act is a top priority for the Clinton administration, according to Mr. Sorian. He said his office is willing to work with Mr. Helms to pass the act but Mr. Helms has not said why he is

blocking it.

"Senator Helms has not contacted our office with any questions or any requests for any assistance or information," Mr. Sorian said. "He has not publicly stated why it is that he is putting a hold on this legislation, so we couldn't even just proactively send him information about what it is that he is concerned about."

Mr. Helms' office did not return calls seeking an interview. His staff provided The Washington Times with a copy of the Congressional Research Service study.

Mr. Helms was one of four senators to oppose the Ryan White CARE Act when it was enacted. At the time, he said federal funding for AIDS treatment was inconsistent with making homosexuals and intravenous drug users take responsibility for their actions.

"I have never heard once in this chamber anybody say to the homosexuals and IV drug users, who make up over 90 percent of the AIDS population, 'Stop what you are doing,'" Mr. Helms said in 1990. "I think it is about time that this Senate addressed the moral

RYAN WHITE CARE ACT

The Ryan White CARE Act, which was passed by Congress in 1990 and is now up for reauthorization, has provided more than \$2 billion in treatment and services for AIDS patients nationwide. The amount of money Congress has appropriated for the program each year has consistently increased.

Year	Amount
1991	\$220.5 million
1992	\$277.9 million
1993	\$348.1 million
1994	\$579.4 million
1995	\$633.0 million

Source: Office of National AIDS Policy

The Washington Times

issue."

According to the Centers for Disease Control and Prevention, AIDS now is the leading cause of death for Americans between the ages of 25 and 44.

Dornan attacks federal AIDS training program

by José Zuniga

Rep. John Mica (R-Fla.) said yesterday's hearings looking into allegations that President Clinton's federal AIDS training program promotes the "Gay agenda" were "fair and objective."

But Gay civil rights advocates who attended the hearings said they were more like a "lynching" than fair and objective debate. The victim: "HIV/AIDS in the Workplace Training."

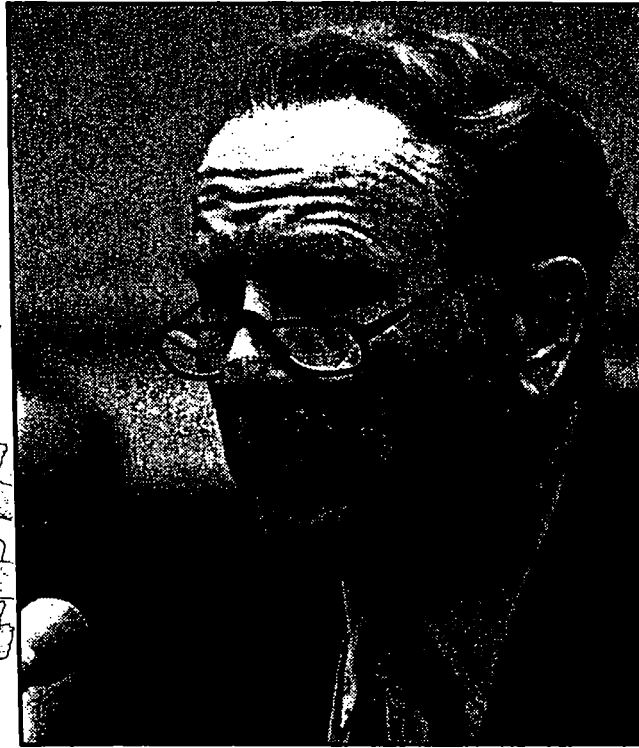
"Rep. Mica certainly put it all out on the table very early in the hearings," said Beth Barrett, public policy associate at the National Gay and Lesbian Task Force. "...His opening statement set the tone and made it abundantly clear these hearings would be anything but fair hearings. Lynching might be a better word."

In his opening statement, Mica, chair of the House Subcommittee on Civil Service, said he believes there "may be a place" for AIDS training in the workplace because "AIDS is a horrific disease." But, he added, "my constituents would be outraged to discover their tax dollars used to force federal employees to learn how to use a condom ... [and] would also object to training aimed at ... changing their personal attitudes and beliefs [about homosexuality]. It is no wonder that many federal workers have found these training programs offensive."

The flap over "HIV/AIDS in the Workplace Training" began almost four months ago when *The Washington Times* reported increasing complaints from federal employees who said the training was either "too graphic" or pushed people to "accept homosexuality as a viable lifestyle."

In the March 5 *Washington Times* article, Rep. Robert Dornan (R-Calif.) who is seeking the GOP presidential nomination, said the AIDS prevention training is "... not AIDS education. It is advancing the homosexual agenda." Dornan then promised to hold hearings to "investigate the matter."

At Thursday's hearings, Dornan reiterated earlier statements made to the press. He also made other sur-



Robert Dornan: "The last time I checked, abusing drugs and having sex in the workplace [were] not specified job responsibilities for any federal worker."

prising and, at one point, shocking comments.

Dornan claimed that while federal AIDS training was "supposedly" designed to foster tolerance in the workplace for people with HIV/AIDS, he is concerned "that it is, instead, being used to aggressively advance a redefinition of the family and, in many cases, a blatant pro-homosexual agenda."

He added that, while the federal government is responsible for job-related training, "it is not the responsibility of the federal government to subject federal work-

ers to seminars that lecture them on how to live their sex lives or use illegal drugs in order to avoid contracting the HIV virus," Dornan said. "The last time I checked, abusing drugs and having sex in the workplace [were] not specified job responsibilities for any federal worker," he added.

At one point during the hearings, Rep. Dan Burton (R-Ind.) asked for the floor and expressed his apparent rage about some aspects of the training. Burton said "it is trash" to conduct graphic "safer sex" presentations where men and women are present together, "where they're talking about putting a condom on an artificial erect penis! It's just *wrong!*" Burton exclaimed.

Dornan and Rep. James Moran (D-Va.) engaged in several testy exchanges. Moran tried to personalize the AIDS epidemic by talking about a clergy friend of his who recently died of AIDS complications. After unsuccessfully trying to answer a string of Moran's questions about "unsubstantiated claims and facts" in Dornan's testimony, Dornan said, "If your priest friend had not sought a cheap thrill he would be alive today."

Dornan's comment provoked an "ooh" from stunned audience at the hearing and a stern rebuke from Moran who labeled Dornan's remark "stupid."

In another surprise comment, Dornan said any training the federal government conducts is "worthless unless it talks about abstinence and, why not, phone sex as the only ways to prevent HIV transmission." Dornan's seeming endorsement of phone sex as a "safer sex" tool drew a chuckle from subcommittee and audience members alike.

As Dornan concluded his testimony, seven representatives from major AIDS and Gay civil rights organizations donned blue rubber gloves and raised their hands. The action, Barrett said, was meant as a reminder of an incident two weeks ago in which Secret Service agents wore rubber gloves while checking in Gay elected officials visiting the White House. Mica warned the group that further disruptions would not be tolerated. There was no further disruption. ▼

Red Cross Tones Down AIDS Materials

4-13-95

Elizabeth Dole Complains About 'Highly Explicit' Pamphlets

By RICHARD L. BERKE

WASHINGTON, Sept. 12 — The American Red Cross is seeking to tone down the content of its multi-million-dollar AIDS-prevention program, a move set off by Elizabeth Hanford Dole, the organization's president and the wife of Senator Bob Dole, who is seeking the Republican Presidential nomination.

Although internal Red Cross documents did not suggest any political motivation by Mrs. Dole, some officials of the organization said the board of governors was reflecting her desires and those of her top aides at a time when Mr. Dole is trying to satisfy the demands of conservatives.

A spokesman for the Red Cross, Roy Clason, said Mrs. Dole was traveling and not available for comment today. He referred questions to the chairman of the Red Cross, Norman R. Augustine. Mr. Augustine, who is also chairman of Lockheed Martin, said the board intervened at Mrs. Dole's request.

"The board of governors might not normally be involved in a policy matter like this," Mr. Augustine said. "But in this particular case Mrs. Dole has some strongly held personal views."

He added that Mrs. Dole had asked him to have the board consider altering the materials and that she was motivated not by politics, but her views.

"There were concerns raised that the material is highly explicit in terms of sexual matters, including illustrations," Mr. Augustine said. "But it didn't have anything to do with politics, but what's best for the Red Cross."

Although many Red Cross officials gave their approvals in April on an expanded AIDS program, Red Cross documents show that the board took the unusual step of reviewing the program, one of the nation's largest, which led to its postponement for several months.

The board then instructed that officials of the organization significantly modify materials like leaflets, videos and instruction manuals that are sent to Red Cross chapters and health clinics around the country.

Among other recommendations, the documents show that board members wanted the materials to place greater emphasis on individual responsibility in preventing AIDS, objected to the drawing of a penis in a handout on condoms and asked that it "be redrawn in a more clinical fashion," complained that

the language in an instructional video was too explicit and raised concerns that the literature did not elaborate more extensively on the risks of drug abuse.

The H.I.V.-AIDS coordinator for the Houston chapter, Shana Ross, said she had written to top Red Cross officials about the monthslong delay but had not received an adequate response.

"It is unconscionable," Ms. Ross said in a telephone interview. "I have to take into account that this is because of who our President is, who her husband is and the fact that he's involved in a campaign now for the Presidency, and he is seemingly los-

Allegations and denials about a political role.

ing ground to opponents who are more conservative than he is."

A spokesman for the Dole campaign, Nelson Warfield, said Mrs. Dole's work at the Red Cross was "strictly separate" from the campaign.

"The Red Cross maintains its neutrality in wars," Mr. Warfield said. "It certainly can manage to stay neutral in a political contest. Frankly, it's demeaning to women to suggest that Mrs. Dole would compromise her professional integrity just because she happens to be the wife of a political candidate."

The documents were made available by senior Red Cross officials who insisted on anonymity. Some officials said it was unusual for board members to make such recommendations, because the content of the material had gone through traditional channels and been approved by professionals in AIDS prevention.

In one document, Red Cross officials questioned the review of the program, asking, "Why after at least five years of having national programs with a foundation of presenting the facts in nonjudgmental and culturally sensitive manner is this foundation being challenged from within the organization?"

Mrs. Dole was named head of the Red Cross in February 1991, and officials said not until the spring, shortly after Mr. Dole announced his candidacy, did the board members begin to express concerns about the

AIDS programs. Mrs. Dole has said that she will resign if her husband is elected President. For now, her policy is to take unpaid leaves of absence whenever she is campaigning with him.

The AIDS program is being financed this year with a Federal grant of \$5 million.

"The continued delay of the introduction of this material is causing harm to my chapter both in the area of credibility with the public and financially," the supervisor of AIDS education in St. Louis, Al Schon, wrote. "A question for many of us has been why the board of governors need to review this course in the first place? The people I have talked to have never heard of the board of governors' reviewing a first aid or water-safety course, and now we wonder why H.I.V.-AIDS has been singled out."

A member of a volunteer panel appointed by Red Cross officials to examine the AIDS program said that the panel's work was completed months ago and that the panel was surprised that the board had raised objections about the material.

"I'm surprised there were concerns," the panel member, Dr. Rodolfo Arevalo, provost of Fort Hays State University in Hays, Kan., said. "Sometimes you have to be very graphic in terms of getting people's attention. It's not like the material is going to be used with children. We've done stuff in the Red Cross before that was just as graphic."

In an internal memorandum based on a board meeting on Aug. 23, the members who asked for the revisions tried to make clear that it was not their intention to politicize the process. "The task force believes that the next generation of these materials can and should communicate relevant American Red Cross principles and support American laws and societal standards, while retaining a nonjudgmental approach," the memorandum said.

Jim Graham, executive director of the Whitman Walter clinic, the largest AIDS service agency in Washington, said in an interview: "All of this has the appearance of partisan political considerations overruling sound public policy. Elizabeth Hanford Dole's agenda in terms of her husband's political aspirations should not determine what the Red Cross does in terms of AIDS policy. And I'm afraid that's been happening."

USA Today; 7-7-95

Republicans have 'selective morality' on AIDS

Selective morality as espoused by Republican U.S. senators seeking headlines is based on blind hatred. There is nothing humorous about the hate.

Sen. Jesse Helms wants to reduce AIDS funding because the disease is spread by "deliberate, disgusting and revolting conduct" (News, Thursday). He says this as debate continues on reauthorizing the Ryan White Care Act of 1990. White, of course, contracted AIDS through blood transfusions when he was very young.

Helms goes on to say money not spent on AIDS should be used for heart disease and cancer research.

A leading cause of these latter diseases is cigarette smoking and the use of smokeless tobacco. Helms represents North Carolina, the leading tobacco state.

As such, he presumably sees nothing deliberate, disgusting or revolting about smokers' behavior. Inhaling toxic and addictive fumes deserves research dollars from taxpayers because it is legal, while sharing needles to use other drugs illegally, the leading cause of new HIV infections, does not.

And then there is the homosexual issue. Two presidential aspirants, Sens. Bob Dole and Phil Gramm, have been actively gay-bashing lately, sounding like they share a common speechwriting staff with Helms. They appeared together at the Conservative Party Victory Fund's annual pig roast in New Hampshire. The biblical book Leviticus is an often-quoted source for labeling male-to-male sex as immoral. It is one of 75 abominations mentioned in Leviticus, a list that gives equal prominence to the abomination of eating pork products.

Todd Jennings
Greenwich, Conn.

Prudent or prurient?

As the debate over AIDS funding screeches onto the front page via Sen. Jesse Helms, a rare Clinton profundity comes to mind. Said he, and I paraphrase: With God's help America can remedy its mounting social ills.

Now I assume AIDS qualifies as a social ill. If so, what advice has God given that guarantees freedom from venereal disease and, if followed, will save lives and decrease the need for future funding?

AIDS activists have long insisted that explicit information must be dispensed if we're to stymie this epidemic. Agreed. But let's not confuse prudent information with prurient propaganda. Teaching the wayward how to circumvent the natural consequences of risky behavior will not halt the spread of AIDS. To the contrary, it will fuel the epidemic.

To win the war against AIDS, we must rely on medical science and the unfailing truths found in God's word, not on political science and the flimsy suppositions of those who pretend to be wiser than God. A Manhattan-type project could unlock the cure and save millions of lives. I pray that happens. But at this particular time it would be a pointless endeavor, for until we as a nation once again acknowledge that



USA TODAY

HELMs: Under fire for AIDS comments.

sexual promiscuity is a lifestyle unbecoming to beings made in the image of God, I fear the cure's vital keys will be withheld.

Greg Tucker
South Lake Tahoe, Calif.

Tobacco far more destructive

It's ironic that while Sen. Jesse Helms re-victimizes our fellow gayfolk, the senator from North Carolina has unabashedly and staunchly supported and fought to subsidize the far more disgusting, damaging and costly addictive tobacco industry — the pushers of nicotine, a drug which claims half a million of our fellow Americans, gay and straight, every year while addicting hundreds of thousands of America's gay and straight youth annually.

The disgusting perversion is in Helms' thinking about AIDS. Any third- or fourth-grader could tell Jesse that AIDS is not a gay disease, as the senator incorrectly believes. It is a disease that does not discriminate as nastily as does Jesse Helms. Anyone can get AIDS, and they do. Children, straight men and women are increasingly the prevalent victims of this non-discriminatory disease.

The punch line to this disgusting joke is that a person of the limited mental and cognitive ability of Helms could rise to a level of leadership in the greatest democracy on Earth.

Rand Knox
San Rafael, Calif.

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Authors: ERIC SCHMITT
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UNITED STATES ARMAMENT & DEFENSE; LAW & LEGISLATION; UNITED
STATES
Names: DORNAN, ROBERT K (REPR)

Abstract: House Republicans are expected to introduce legislation on May 18, 1995 to discharge more than 1,200 members of the armed services whom the Pentagon considers fit for duty but who have tested positive for the virus that causes AIDS. DOD policy bars entry to recruits who test positive for the virus, HIV, but HIV-infected troops already in the military are allowed to serve in the US as long as they are physically able.

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Article Text:

WASHINGTON, May 17 -- House Republicans are expected to introduce legislation on Thursday to discharge more than 1,200 members of the armed services whom the Pentagon considers fit for duty but who have tested positive for the virus that causes AIDS.

Defense Department policy bars entry to recruits who test positive for the virus, H.I.V. But H.I.V.-infected troops already in the military are allowed to serve in the United States as long as they are physically able, although they are barred from deployment overseas, a restriction that the Pentagon says is intended to insure the best medical monitoring of their condition.

Now Representative Robert K. Dornan, a conservative Republican from California who strongly opposes homosexuals' service in the military, intends to add a new restriction when the House National Security Subcommittee on Military Personnel, which he heads, considers its part of the Pentagon budget bill for the 1996 fiscal year.

Mr. Dornan would require an honorable discharge within six months of an H.I.V.-positive diagnosis. He and other Republicans argue that to preserve military readiness at a time when the armed services are paring their forces, the Pentagon should retain only people who are able to serve worldwide.

'Right now,' Mr. Dornan said in an interview, 'H.I.V.-infected troops can't leave Virginia or California.'

Gay rights groups say the measure is intended to drum out qualified, experienced troops who would be costly to replace.

'Dornan's mean-spirited attack on H.I.V.-positive men and women in the military would tie the hands of military commanders, undermine military readiness and cost millions of tax dollars in unnecessary separation and retraining costs to replace people who are not even sick,' said Elizabeth Birch, executive director of the Human Rights Campaign Fund, a gays rights advocacy group.

A Democratic-controlled Congress last year rebuffed a similar measure by Mr. Dornan. But now that Republicans are in control, gay rights advocates and their Congressional supporters acknowledge that they face a

Subcommittee on Military Personnel, which he heads, considers its part of the Pentagon budget bill for the 1996 fiscal year.

Mr. Dornan would require an honorable discharge within six months of an H.I.V.-positive diagnosis. He and other Republicans argue that to preserve military readiness at a time when the armed services are paring their forces, the Pentagon should retain only people who are able to serve worldwide.

'Right now,' Mr. Dornan said in an interview, H.I.V.-infected troops 'can't leave Virginia or California.'

Gay rights groups say the measure is intended to drum out qualified, experienced troops who would be costly to replace.

'Dornan's mean-spirited attack on H.I.V.-positive men and women in the military would tie the hands of military commanders, undermine military readiness and cost millions of tax dollars in unnecessary separation and retraining costs to replace people who are not even sick,' said Elizabeth Birch, executive director of the Human Rights Campaign Fund, a gays rights advocacy group.

A Democratic-controlled Congress last year rebuffed a similar measure by Mr. Dornan. But now that Republicans are in control, gay rights advocates and their Congressional supporters acknowledge that they face a struggle. The measure is expected to breeze through the House National Security Committee and perhaps the full House; there is not yet a companion measure in the Senate.

As of last December, the latest point from which Pentagon figures are available, 1,214 of the 1.6 million members of the armed forces had been found to be carrying H.I.V., for which military personnel are tested periodically. Of that number, 619 were in the Navy, 398 in the Army, 111 in the Air Force and 86 in the Marine Corps.

The military's senior personnel officials have taken issue with Mr. Dornan's position that retaining H.I.V.-positive troops could hurt combat readiness.

'H.I.V.-infected soldiers who are physically fit for duty should be allowed to continue on active duty, provided they conduct themselves appropriately,' Lieut. Gen. Theodore G. Stroup Jr., the Army's chief personnel officer, said in a letter to Mr. Dornan on May 3.

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Access No: 95664560 ProQuest - The Washington Post Ondisc
Title: SENATE VOTES TO CONTINUE AIDS PROGRAM; HELMS FAILS IN BID TO FREEZE FUNDING
Authors: Helen Dewar, Washington Post Staff Writer
Source: Washington Post, Final Edition
Date: Friday Jul 28, 1995 Sec: A SECTION p: 10
Length: Long (729 words) Type: News National
Subjects: Acquired immune deficiency syndrome; AIDS; Government spending; Health care; Legislation; Federal budget
Names: Helms, Jesse A
Companies: Senate

Abstract: The Senate overwhelmingly approved legislation to extend the government's AIDS treatment program after blunting or finessing attempts by Sen Jesse Helms (R-NC) to gut the program.

Article Text:

The Senate yesterday overwhelmingly approved legislation to extend the government's AIDS treatment program after blunting or finessing attempts by Sen. Jesse Helms (R-N.C.) to gut the program.

During two days of debate on the Ryan White CARE Act -- a \$633-million program named for a young Indiana hemophiliac who died in 1990 after contracting AIDS from a blood transfusion -- Helms repeatedly criticized homosexuals, as he often has done in the past, describing their conduct as 'incredibly offensive and revolting.' He referred to AIDS prevention programs in schools and federal offices as 'thinly veiled attempts to restructure values of American families in favor of the homosexual lifestyle.' He also blamed gays for White's death, saying the teenager died of 'blood that was tainted in the first place by homosexual conduct somewhere generations back.'

Few joined Helms in criticism of homosexuals. Conservative Sen. Orrin G. Hatch (R-Utah) praised the legislation as an opportunity to help people who are dying, without regard to 'how those people got [the disease]. And the Senate reauthorized the measure by a vote of 97 to 3, with only Republican conservatives Helms, Robert C. Smith (N.H.) and Jon Kyl (Ariz.) in opposition.

'This legislation represents a compromise, and like most compromises, it is not perfect and will not please everyone,' said Sen. Edward M. Kennedy (D-Mass.), co-sponsor of the bill. 'But on balance, it is a good bill, and its enactment will benefit all people living with HIV everywhere in the nation.' HIV is the virus that causes AIDS.

Helms did win some minor victories, however, including unanimous approval of a provision making attendance optional at workplace AIDS prevention programs that President Clinton has ordered for government offices.

But he failed, 32 to 67, in an attempt to freeze spending levels for the Ryan White program through 2000. As approved, the bill puts no limits on spending for the program, allowing funding levels to be set in annual appropriations bills during the next five years. The House Appropriations Committee recently approved the spending of \$658 million for the fiscal year starting Oct. 1. The administration had requested \$723 million.

The Senate also approved, 54 to 45, a proposal by Helms to bar use of any funds in the legislation to promote or encourage homosexuality or intravenous drug use, directly or indirectly. The bill's supporters feared this could complicate delivery of care by gay-oriented programs.

But later, in what Helms criticized as an attempt to neutralize this provision, the Senate approved by a larger margin -- 76 to 23 -- a proposal by Sen. Nancy Landon Kassebaum (R-Kan.) to bar spending for activities that directly promote drug use or any sexual activity, heterosexual or homosexual.

'There is a great big odor rising from the manner in which Congress is falling all over itself to do what the homosexual lobby is almost hysterically demanding what Congress do,' Helms said during debate.

In the case of conflicting provisions, those adopted by the largest vote margin -- and those that appear to be the final word on an issue -- are given greater weight during House-Senate conferences to draft the final version of a bill.

A bid by Helms to limit federal spending for AIDS from exceeding amounts that Congress appropriates for cancer was rejected, 15 to 84. Helms had argued that cancer kills 18 times as many Americans as AIDS and therefore should receive more money. Kassebaum contended that it does, -- when money spent through mandatory programs such as Medicare and Medicaid is taken into account.

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In action Wednesday, the Senate agreed to a compromise to encourage but not require more HIV testing of pregnant women and infants. By voice vote, it approved a provision to require the 11 states with the highest incidence of HIV infection in newborns to implement a program for encouraging testing of pregnant women.

The Ryan White bill, first passed in 1990, the year White died, currently provides care and treatment to more than 350,000 men, women and children with AIDS and HIV. It supports clinics in every state, 42 cities and many rural areas, paying for outpatient medical care for uninsured poor people infected with the virus.

The law expires at the end of September unless Congress reauthorizes it. The House is scheduled to consider its version of the legislation in September, shortly before spending bills for the next fiscal year are approved.

Title: CLINTON ASSAILS HELMS'S AIDS STANCE; ANTI-GAY REMARKS FUEL
PUSH FOR REAPPROVAL OF TREATMENT PROGRAM
Authors: Ann Devroy; David Brown, Washington Post Staff Writers
Source: Washington Post, Final Edition
Date: Thursday Jul 6, 1995 Sec: A SECTION p: 6
Length: Medium (594 words) Type: News National
Subjects: Acquired immune deficiency syndrome; AIDS; Government
services; Health care; Legislation
Names: Clinton, Bill; Helms, Jesse A
Companies: Republican Party

Abstract: Pres Clinton, seizing on controversial comments about AIDS
sufferers by Sen Jesse Helms (R-NC), called on GOP
congressional leaders to put aside the issue of how people
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Article Text:

President Clinton, seizing on controversial comments about AIDS
sufferers by Sen. Jesse Helms (R-N.C.), yesterday called on Republican
congressional leaders to put aside the issue of how people get the disease
and move ahead to reapprove a major government program that helps treat
it.

Clinton, in letters to Senate Majority Leader Robert J. Dole (R-Kan.)
and House Speaker Newt Gingrich (R-Ga.), called for reauthorization of the
Ryan White CARE act, a multimillion-dollar federal treatment program named
for a young Indiana hemophiliac who died after contracting AIDS. The
act, which provides \$624 million in funding this year, is due to expire in
September unless Congress reauthorizes it. The issue has become caught in
Republican maneuvering, with some conservatives questioning the level of
funding that AIDS programs have received and some seeking to attach
amendments.

Helms, a staunch opponent of gay rights, said in comments published
yesterday in the New York Times that AIDS funding should be reduced
because homosexuals get the disease through their 'deliberate, disgusting,
revolting conduct.' He said, 'We've got to have some common sense about a
disease transmitted by people deliberately engaging in unnatural acts.

Helms also asserted that AIDS gets more funding than diseases that kill
far more people, a contention disputed by Clinton in his letter.

Some Democrats and supporters of gay rights and health care responded
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Government statistics for last year show that 44 percent of new cases
of infection with the human immunodeficiency virus (HIV) occurred in men
who had sex with other men. The use of injected drugs accounted for 27
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Treatment for hemophilia and blood transfusions account for most of the
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Rep. Barney Frank (D-Mass.) blasted Helms yesterday as 'a bigoted fool'
but said he was alarmed that Republican leaders seemed to be stalling on
the legislation.

Reauthorizing legislation was approved unanimously by a Senate
Committee in March and has 61 Senate sponsors, including Dole. A House
committee is expected to take up the legislation within weeks, but some

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Reauthorizing legislation was approved unanimously by a Senate Committee in March and has 61 Senate sponsors, including Dole. A House Committee is expected to take up the legislation within weeks, but some AIDS activists have charged that the legislation is in trouble because of pressure from conservative House Republicans and the presidential aspirations of Dole, who has been moving rightward all year.

The program pays for outpatient medical care for uninsured poor people with HIV. It supports clinics in every state, 42 cities and numerous rural areas.

About 40 percent of Americans with HIV are covered by Medicaid, about 30 percent have private insurance, and the remaining 30 percent have neither.

Clinton called the program 'a model of compassionate caring for people in need,' and added, 'At a time when AIDS is the leading cause of death of young adults, we cannot let reauthorization of the CARE Act be held up by divisive arguments about how people contracted HIV.'

He termed 'a false argument' the contention that people with AIDS get more government funding than those with other diseases. Total federal spending during this fiscal year for AIDS research, treatment and other funding was just under \$6 billion. Cancer spending totaled \$17.5 billion and spending for heart disease, \$38 billion.

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Title: CLINTON ASSAILS HELMS'S AIDS STANCE; ANTI-GAY REMARKS FUEL
PUSH FOR REAPPROVAL OF TREATMENT PROGRAM
Authors: Ann Devroy; David Brown, Washington Post Staff Writers
Source: Washington Post, Final Edition
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Title: TO FIGHT AIDS, CALIFORNIA CITIES POINTEDLY SKIRT STATE DRUG LAWS; ADDICTS TURN IN NEEDLES; L.A. LOOKS OTHER WAY
Authors: Christine Spolar, Washington Post Staff Writer
Source: Washington Post, Final Edition
Date: Friday Sep 9, 1994 Sec: A SECTION p: 24
Length: Long (1183 words) Type: News National
Illus: Photograph
Subjects: Acquired immune deficiency syndrome; AIDS; Drug policy; State laws; Medical supplies; Mayors
Names: Riordan, Richard
Abstract: Los Angeles Mayor Richard Riordan signed an order asking police to put needle-exchange programs, which are against the state's drug paraphernalia law, low on their list of priorities. The move by mayors in California cities will help prevent the spread of AIDS.

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Article Text:

LOS ANGELES, SEPT. 8-- For the first night in months, the needles -- shiny silver tips hidden in small, plastic-coated syringes -- slipped freely from hand to hand on this dark street down the crest from Hollywood Hills. No cops, no irate neighbors, no hassles stood between Larry Harris and the 40 'points' he needed to feed his obsession with Crystal Meth.

Harris, a computer technician, flashed a paper identification card at the sign-up table, dumped dozens of old needles into a plastic bin and reached over for a cache of clean needles to stuff in a Seagram's cloth bag. 'Thank you, Dick Riordan,' he said as he headed out of the alley.

He was referring to Republican Mayor Richard Riordan, who has become an unlikely champion for AIDS activists seeking to distribute clean needles to help drug addicts avoid contracting HIV, the virus that causes the killer disease.

Earlier this week, the mayor of the nation's second largest city declared an emergency and signed an order asking the police department to put needle-exchange programs -- which are against the state's drug paraphernalia law -- low on their list of priorities and endorsing their work. The move, approved earlier by City Council, follows the arrest of an AIDS activist two months ago for violating the law.

Riordan's action comes a year after San Francisco Mayor Frank Jordan instituted a local emergency order so that the city could provide funds for clean needles to help stem the spread of the disease among drug users, heterosexual partners and their children.

The 'emergencies' in this state's two largest cities as well as Oakland, Berkeley and several northern California counties are devices to skirt the state law. California, which has produced some of the leading research on the effectiveness of needle-exchange programs, remains one of 10 states in the nation that ban the practice.

~~Gov. Pete Wilson, a fellow Republican facing a stiff reelection challenge this year, has twice vetoed measures from the state assembly to legalize the practice, citing concern that it encourages illicit drug use.~~

'There is a contradiction,' said Samuel Friedman, principal investigator with the National Development and Research Institutes in New York City, which tracks the disease.

'Five years ago, you could say the evidence wasn't available and you had to be cautious about thinking about needle exchange. At this stage, the studies are there that show programs can be effective ... but other concerns -- politics, rhetorics, whatever -- have gotten in the way,' Friedman said.

In the past 1 1/2 years, three separate studies published by the federal Centers for Disease Control and Prevention, the General Accounting Office and the National Academy of Sciences have found that needle-exchange programs are effective and do not lead to increased drug use. A study sponsored by the CDC, which examined each of the nearly 40 needle-exchange programs operating in the country, found that more people were lured into treatment by such programs. The National Academy of Sciences study, released in July, recommended that the federal ban on funds for such programs be lifted.

In Los Angeles, Riordan had been considering the usefulness of needle-exchange programs ever since he ran for office two years ago, aides said. At the core of the debate was how fast the disease could spread in a city with the second-highest percentage of intravenous drug users in the nation after New York -- and where its own health department had reported that about one out of every 10 users carries the AIDS virus.

'This is not a political issue for' Riordan, said Deputy Mayor Robin Kramer. 'He endeavored to look at it as a public health issue and as an efficiency and cost issue.'

For those on the streets, city AIDS coordinator Ferd Eggan said the decision by City Council and Riordan was an attempt to avoid what he called the 'disaster' that occurred in New York until health officials signed a waiver that allowed for people who participate in needle-exchange programs to avoid prosecution. In New York City, drug-user infection rates leaped from 10 to 50 percent in two years.

'This is not an isolated circle of infected people,' said Eggan. 'They spread it to their partners and then their children. Injection-drug users are the bridge to the rest of the community.'

For those at the corner of Selma and Cosmos streets in Hollywood, the hassle-free exchange is a sign that someone, as one young woman who exchanged needles said, 'finally realizes this is good for the whole community.'

Wednesday night is exchange night at Selma and Cosmos streets in a commercial section of Hollywood. Clean Needles Now, one of two nonprofit exchange programs in the city, works for three hours to distribute needles, condoms and bleach to a young, largely white crowd wearing leather jackets and skin-tight pants. Some drive up in old, battered cars. Others pedal in their orders on 10-speed bikes.

Vicky, who does not want her last name used, is a 24-year-old woman from St. Louis. She said she has been shooting heroin, about \$20 a day, for the past year. 'It doesn't make me happy. It makes me so I'm less

Interview

A Time Of Change At NIH: An Interview With Harold Varmus



NIH Director Harold Varmus: "We need to rethink how our business is done."

NIH Director Harold Varmus has warned that the era of rapidly increasing NIH funding is over and that biomedical researchers must adjust to "a steady state" of research funding. What will this mean? Varmus discussed this and other issues with News Editor Bruce Agnew on June 13. Excerpts from the interview follow:

What should NIH—and biomedical researchers generally—be doing to adapt to a "steady state" of research funding?

We need to rethink how our business is done. I think there has to be a higher rate of success in applying for awards. One way to do that is to change the nature of the awards, or the nature of the review process. There

are other ways to make the enterprise work more smoothly. We could shape a grant portfolio that would be quite different from what we have now—for example, by offering more grants of predetermined size, by planning to have a certain number of active investigators as opposed to just funding whatever application gets to the top of the pile. I'm not sure which strategy is the best.

What strategies are you considering?

I think there's a great advantage to what we've come to call the "modular grant" or the "chunk grant" of predetermined size. There's a tension here between those folks who would rather get along with a little less money and supplement it with grants from a variety of other sources, and other investigators who have heavy demands on their budgets and need full cost recovery. I'm quite sympathetic with the latter group because my own lab does mouse genetics; all of us who have animal costs recognize that there is a point below which you simply cannot get an adequate number of animals to do the study you want to do.

Nevertheless, I think there is a significant cohort of investigators who will find a way to get their best ideas

tested in the laboratory if they have at least some money. The idea of developing a certain number of grants in each institute that people can apply for—maybe \$50,000, \$75,000, \$150,000 per award—I think could be a very healthy development. We're just testing that idea now on a small scale in the National Heart, Lung and Blood Institute.

Where would investigators get the rest of the funding they need?

I can't pretend to know the answer to that. We know that when young people start out these days, they frequently feel that they're going to have a hard time getting NIH grants because many study sections are particularly dependent on preliminary data for making decisions. So it is common for new investigators to try to find other ways of being funded. It may be by university grants, state grants, grants from voluntary agencies, or sometimes they hook up with a program grant or a center grant.

One of the things that we lack is a true cross section of what goes on in a [university] research department to sustain the funding of the investigators in that department. I think it would be important to do a survey—I'm not sure who should do it—to look at a few dozen representative university research departments and ask, "How are you funded? By whom? To what extent?" This might allow us to get a cross section of what the funding profile is really like.

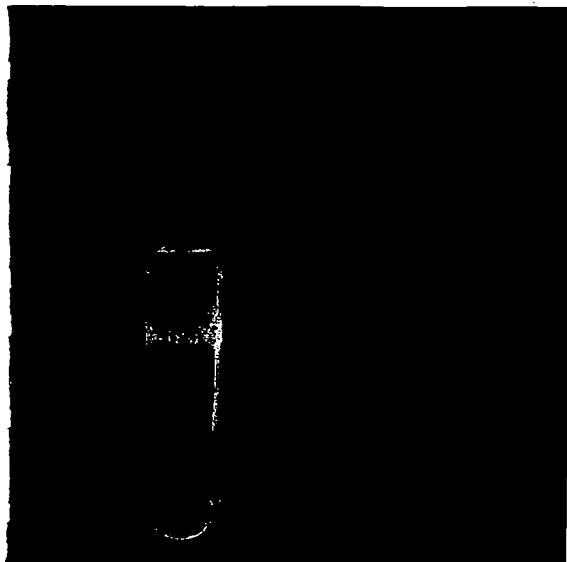
We also have to think about how we want labs to look. Labs like my own—like the lab I had at the University of California at San Francisco [UCSF], where I had 20 trainees working with me—may become a thing of the past.

I can imagine a situation five or 10 years from now in which people who've been trained as Ph.D.s in the biological sciences spend many more years than they have in the past working at the bench. I can imagine, for example, having four or five investigators working together, each with one or two students, to develop a consortium with shared technologies and shared resources. And I think we're going to find more people with Ph.D.s remaining in a kind of super-technical capacity, where they don't have an independent research program but work with another investigator who's actually receiving grants directly.

What other ideas are worth considering to adapt to a "steady state"?

Well, [among] the things that are out there are the idea of restricting the number of institutions in which we support science.

But there are good reasons for having institutions in 435 defined localities—in each congressional district. That's right: 435 is the magic number. We have 1,700



laboratory worker extracts purified DNA (fluorescing orange under UV light) from a sedimentation tube. [Courtesy National Cancer Institute, Bethesda, Md.]

stitutions or more that receive money, and I think that there are lots of ways to respond to that.

One option, which I don't necessarily support, is that we should have gradations of support. For example, the percentage of the project cost that we fund would be dependent on the priority score, it could be dependent on the overall research activity of an institution—so that we would pay a higher percentage of a project's cost at some places than we would at another place.

We've heard people go even further and say that we could convert entirely to an MRC [British Medical Research Council] type of system in which NIH sets up lots of people who would be university affiliates at NIH-endorsed institutions; we would fund a certain number of investigators at each institution.

ould they be like intramural scientists?

ll, not necessarily intramural scientists. The idea would be that we'd have a certain number of positions at certain institutions. Either through block grants or through competition for that fixed number of grants, we would have an investment at some schools, but we wouldn't be funding research at institutions all over the country. This would reduce the number of applications we receive because people couldn't actually apply unless they were from certain places.

don't buy this, myself. I'm not sure it's politically or scientifically appropriate, but you've asked what I'm hearing about, and these are things I'm hearing about.

Another issue is the role of investigator-initiated [R01] awards as opposed to RFAs [Requests for Applications issued by individual institutes] and the role of centers contracts as balanced against individual awards. Though I'm often self-described as being an R01 type person, I also recognize that there's a virtue in fund-

ing centers and institutions. A center or institution can be as sustaining for researchers as the NIH intramural program or a Howard Hughes investigatorship.

I think one should look carefully at how many such centers we want to have, whether it be general clinical research centers or cancer centers or other kinds of center programs. I think what we're balancing here is a security system that allows you to do some work as opposed to achieving the ideal level of independence in which people have their own research grants. We have to look carefully at the efficacy of these programs and make some judgments about how all of us want to operate for the next 10 years or so.

Could squeezing harder on indirect costs help?

It could. I think we have to recognize that the problem of indirect costs cannot be solved by a simple stroke of the sword and that institutions of higher learning are currently under a lot of stress. One thing that everyone is sensitive to at the moment is the need to find better ways of negotiating the costs of facilities—rental allowance, the cost of utilities, and so forth. Those are the most contentious costs in some ways because we know that there is tremendous variation depending on the nature and location of the school, and we need to find some way of normalizing those costs. Normalizing in this case does not mean making them uniform across the spectrum, but instead finding a better means of cost accounting and negotiation so that we don't put so much effort into rate determination.

I think all of us are concerned about having an appropriate building program. We don't want to foreclose on the possibility of building new facilities. On the other hand, we don't want our grantee institutions to be gambling by building—that is, putting up a building in the hope that they'll be able to fill it with investigators who will then amortize the cost of the building through indirect costs. I think that is not the way we can play this game for the long haul.

That's the way a lot of the game is being played now. I understand that, but I don't like it.

We got a letter from one of our readers that said, Why take any budget cut out of new and competing grants, why not just cut the intramural research program?

Well, that's easy to say. But the fact is the intramural research program comprises less than 11 percent of the NIH budget, and it is doing some very, very good work. It is being reviewed, and we take our review responsibilities here very seriously. Furthermore, the intramural research program may in the near future be one of the best places in which to nurture young researchers. I would like to see more new investigators come to NIH for five years or more of work in an environment that has some stability to it.

The criticism in the past that the intramural program was too ingrown—that there was too much hiring from within—might have been fair. I'm insisting, as is Michael Gottesman [NIH deputy director for intramural research], that recruitment of scientists into the tenure-

track program here [at NIH] be the result of completely open searches. I think that anyone in the country who wants to do science in an intense manner ought to be very attracted to these positions.

If NIH could count on budget increases of 5 percent a year, after inflation, what would you do?

That's a question I really don't want to answer at this stage. Because if we take reductions in our budget—this is a peculiar way of answering your question—those reductions will not be applied uniformly across the portfolio. So what that suggests is that there will be some things that are more protected than others. I'm not prepared to show my hand yet because I haven't really thought them all through. But there will be some areas of science where I will be reluctant to allow shrinkage to occur.



*"Some areas of patient-oriented research are among the most important things we do," Varmus says.
[Courtesy NIH Clinical Center, Bethesda, Md.]*

A lot of clinical-research people are going to say, Oh, oh, he's talking about shrinking clinical research.

Not necessarily. In fact, I would say that there are some parts of the clinical research enterprise that we have a special responsibility to sustain. Clinical research is a very broad area, so I would never characterize my speaking about this as laboratory vs. patient-oriented or basic vs. applied research. Some areas of patient-oriented research are among the most important things we do.

Other people will say, Well, he's a molecular biologist, he's going to fund molecular biology.

[Laughing] Well, I can't deal with everyone's paranoia. All I can do is try to apply rational decision-making to what we end up doing. And I think we're going to do that. I think that anyone who's looked on for the last year and a half will see that, yes, I'm a molecular biologist, but I've probably put more energy into thinking about patient-oriented research than anything else.

How about saving money by cutting training programs?

I personally believe that we should not retreat from our

commitment to train. NIH only supports a minority of trainees in biology, and that minority is among the most successful in the grants process.

I think we need to look carefully at how training is done. I'm a strong supporter of the report that was recently issued by COSEPUP [the National Academy of Science's Committee on Science, Engineering, and Public Policy]. I think graduate students need to go through a Ph.D. program understanding that there are many possible outcomes. I don't think COSEPUP retreated from the importance of doing a strong laboratory research project for thesis work, which is the heart of doctoral training. But I think we need to ensure that our students retain some broad perspective as they go through graduate training, and that our graduate faculties understand that there is substantial and respectable diversity of occupations.

Now, this doesn't mean that the majority of students that go through intensive graduate training at one of our leading research institutions are not going to be research investigators. I think that's not true. But it provides options, and I have seen, even at UCSF, an interesting trend toward diversification of occupations.

I don't see anything wrong with that. I think biology is going to be a major staple of life in the next century, and it's going to be important that we have people who understand how science works involved in many kinds of activities.

You don't think we're training too many graduate students?

It's very hard to judge. And I don't think that's the way to think about the problem. It only becomes a problem if you say we're only training them to be recipients of R01s. But we can't control the pipeline in that way. We shouldn't, because we're training people to be biologists for the next 40 or 50 years. I'm willing to prognosticate for five to 10 years, but I'm not willing to prognosticate for 30 or 40 years.

The second thing is that we should not—and cannot—regulate the flow of students into biomedical science at the level of awarding NIH fellowships. The flow is being regulated at other points. It's not just a shortage of grants that is influencing the mental state of people who get degrees in biology. The availability of jobs is a major factor. Academic jobs in particular are very difficult to get right now.

And it's not simply Ph.D.s who are at issue. I'm quite concerned about urging M.D.s to be investigators. But there is a serious problem in clinical research because of the loss of revenues for academic health centers at the same time that we're going to have a series of new opportunities for clinical research, generated by novel therapies and other new approaches to medicine.

What is the outlook now for NIH's budget?

I may be proven wrong, but I still take the view that this year we're going after a [fiscal year 1996] budget that will keep up with inflation. I don't think we'll quite get there. But my optimistic nature tells me that we will be above the current fiscal year [budget of \$11.3 billion] by 1 or 2 or 3 percent—something in that range. Nevertheless, we still

may be below inflation. And that presents an immediate problem for our grantees, who have become accustomed to receiving a 4 percent increase each year for continuing grants. We may be giving them a 2 percent increase, or even no increase, depending on what our budget is.

There is a reason why we may have to do that. The biggest determinant of how many new grants we can support is the way in which we handle our commitment base [of multiyear grants that were awarded in previous years]. It's extremely important to be able to support new grants: That's where the new ideas are, that's where the new people are. I'm very concerned about ensuring that folks entering the marketplace just out of their postdoctoral work have a fair shake at getting started.

If you have to cut your budget, what's most vulnerable?

Anyone who's run a research institution has to say that you will put your money where the most exciting science is. But [if the budget is cut] a lot of things will get done more slowly. That's a big cost because, for example, if there's going to be a treatment for Alzheimer's disease that has a significant effect on delaying the onset of severe symptoms in the year 2015 instead of the year 2010, the amount of money the nation is going to lose because of that delay is really very considerable. So the slowing down of research is a serious problem.

The other issue is what's lost by not taking more

chances on things that are very unpredictable. Retrospective analyses of the great NIH-supported discoveries tell us that most were not predictable. When you get squeezed, the tendency is to emphasize what is reasonably predictable—what has to be done because you can see the outcome.

It must be difficult to try to respond when congressmen or others who aren't familiar with science ask just what discoveries will be delayed, for just how long, by a specific budget cut.

We found that difficult, too. When Mr. [Sen. Arlen] Specter [R-Pa.] was trying to defend NIH in the budget process, he asked for what he himself called "sound bites," things that were clear indicators of what we would and wouldn't be able to achieve with and without money. What we tried to do for him was outline about 15 or 20 areas where there was recent progress, so we could see what the promise was; it is very likely that although we will be able to get there eventually, things would move more slowly if funding were cut.

I think anyone reading those descriptions of the budgetary impacts [which were sent to Specter at his request] will recognize that we're not saying we're going to cut off research in these areas if we don't have money; that would be silly. But we're not going to be able to pursue them as effectively as we would if we sustained current levels of activity.

Perspectives

***Newt Gingrich and Robert S. Walker:* A CONSERVATIVE APPROACH TO 21ST-CENTURY SCIENCE**

When the American people elected a Republican Congress in November 1994, they voted for historic change at all levels of government and society. Scientific research is no exception. What separates this Congress from those of the past, however, is an understanding that support for fundamental scientific research must be an even greater part of our worldview and our overall approach to government than it has been before. In 1983, we co-founded the Conservative Opportunity Society, a group of House members dedicated to ending the welfare state, eliminating wasteful bureaucracy, and realizing the potential of the information revolution. Additionally, we

are members of the Congressional Space Caucus, and, as such, we are committed to seeing America remain on the cutting edge of scientific research.

The budget proposal passed by the U.S. House of Representatives—which would balance the federal budget by the year 2002—demands a complete reorganization of priorities across the federal government. But we feel that by increasing funds in certain areas of research, decreasing them in others, and simultaneously restructuring the tax and regulatory codes, we will create a healthier and more productive research environment than our country has previously enjoyed.

The basic research supported by NIH is extremely important to the welfare of our nation. It is imperative that our congressional policies are aimed at moving NIH-supported research forward, while assuring that the highest quality and caliber of science occurs at the component institutes. Returning the federal government's focus to fundamental science is the best way to keep NIH-supported research focused and preeminent.

The legitimate questions are, How do we determine which fundamental science should be funded? and How does the federal government establish priorities in research and development? We base our answers on six criteria. The list reflects the 104th Congress's general philosophy toward funding and is not necessarily specific to NIH:

1) Government efforts should focus on long-term, noncommercial R&D with a potential for significant scientific discovery, leaving economic feasibility and commercialization to the marketplace.

2) Federal funding of R&D for specific processes and technologies should not be carried out beyond the demonstration of technical feasibility. Private investment should take the lead in the manufacture of new products.

3) Revolutionary ideas and pioneering capabilities that make possible the impossible should be pursued with controlled, performance-based federal funding. That is, each project must meet technical milestones to continue to receive federal support.

4) The federal government should avoid funding research in areas that currently receive or may soon receive funding from the private sector, such as those that involve evolutionary advances or incremental improvements. Programs in this category include subsonic aeronautics and clean coal technology.

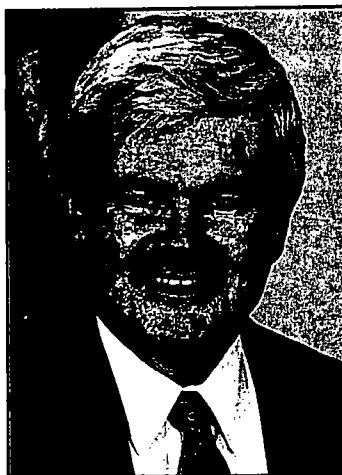
5) Government laboratories should confine their in-house research to areas in which their technical expertise and facilities have no peer. Other research should be contracted out to industry, private research foundations, and universities.

6) All federally funded R&D programs should be relevant and tightly focused to the agency's stated mission; those that are not should be terminated.

In the House Budget Committee proposal, real science—the basic research that will make our nation competitive in the global marketplace—is a priority. Physical-sciences research supported by the National Science Foundation (NSF) is one such priority. Our proposed budget streamlines NSF responsibilities, yet funds physical-sciences research at current levels plus 3 percent annual growth, a rate that maintains pace with anticipated inflation. It should be recalled that as part of the 104th Congress's reforms, the procedure of "baseline budgeting" has ended. That process created an arbitrary projection of spending levels and called any reduction in that estimate a "cut." We believe our budget is honest and reasonably meets the needs of the scientific-research community.

The general science responsibilities of the Department of Energy (DOE) remain a priority within the federal budget. Reflecting the priorities of our six criteria, the overall DOE R&D budget would see a \$1.1 billion reduction by fiscal year (FY) 2002 from the current fiscal year total of \$5.35 billion. However, the proposed budget makes funding available for essential projects: the human genome project, hydrogen energy basic research, long-term fundamental engineering of an advanced gas-cooled reactor, and other ongoing basic-science research.

The core generic research program at the National Institutes of Standards and Technology also increases



"In the House Budget Committee proposal, real science—the basic research that will make our nation competitive in the global marketplace—is a priority."

Newt Gingrich, R-Ga., Speaker of the U.S. House of Representatives, and Robert S. Walker, R-Pa., Chairman of the House Committee on Science.

from \$265 million in FY 1995 to \$272 million in FY 1996 under the Republican budget. However, direct industrial and commercial subsidies—such as the Advanced Technology Program—that have become the touchstones of pork-barrel science in recent years, are eliminated.

Frankly, this country no longer has the luxury, nor is it a wise use of resources, to continue steering taxpayer dollars in the direction of product-development research that can, and should, be market-driven and conducted by the private sector. Federal control over market decisions could lead to a dangerous nationalization of industries. After all, the government would not want to allow the failure of a private product or service in which it has invested, regardless of the test of the marketplace. In this situation, scientific research would end up in the same kind of category as farm subsidies. When government has a vested interest in a program, it will resort to federal price supports, trade protectionism, and government bailouts—the antithesis of global competitiveness—to save that program.

Two-thirds of the R&D cuts in our balanced-budget proposal are derived from eliminating corporate welfare programs—such as the Advanced Technology Program and the Manufacturing Extension Partnership—that impede rather than enhance the marketplace. Nevertheless, FY 1996 federal civilian R&D spending would still be \$5.4 billion, or 18 percent higher than it was at the beginning of the decade, just six years ago.

Competitiveness became the political buzzword of the late 1980s and early 1990s, and heated debates over how the United States could best remain competitive in the global marketplace have taken place in the halls of Congress and public-policy forums across the country. Our nation's strength depends on our continued leadership in new technologies. But, unfortunately, there is a school of thought that subscribes to the "government as Oz" theory; that is, the bureaucracy knows all and

Technologies

sees all, including the future. Proponents of this theory fervently believe that the government, and only the government, knows best which high-risk and critical technologies should be funded, and that government bureaucrats are better judges of technological advances than the free market.

We are trying to strike a balance. A bureaucratic, pork-barrel approach to developing new technologies is ineffective and not in either our budgetary or scientific long-term interests. The government moves much too slowly to predict accurately the direction of state-of-the-art scientific advancement. For example, in the time that it takes the federal government to go through one budget cycle, one whole generation of consumer electronic products has come and gone. Therefore, a better role for the government would be to focus on providing a vibrant and healthy economic climate that creates a level playing field, spurs the investment of private capital, and encourages risk-taking by private-sector entrepreneurs. Such a philosophy leads us away from supporting targeted research—although there will always be some role for government support of targeted research—and toward the high ground of free and open competition in the world market.

On the other hand, in certain areas such as fundamental scientific research and collective risk endeavors, the government does and can continue to play an important role. Space exploration is one example, and the National Aeronautics and Space Administration (NASA) has made significant strides with federal funds. Our budget makes programmatic changes within NASA that preserve the basic space science programs, while looking at ways to involve commercial industries in space activities. One such recommendation is to privatize the space shuttle program, which has the potential of saving taxpayers \$1.5 billion over five years. Indeed, NASA itself is moving policy in this direction, although we are somewhat more aggressive in our approach.

Health research is another arena in which investments in basic science produce huge national and global benefits. We believe that the government should continue to play an aggressive role in developing new treatments and cures for the diseases that plague humankind.

This Congress plans to explore novel ways for the R&D tax credit to support science. One option under consideration is to allow business contributions to university research to be eligible for the tax credit. We believe this expansion of the R&D tax credit would steer badly needed resources to the colleges and universities, while creating new and beneficial academic-business partnerships.

In recent years, we have not always made wise investment choices in science. Previous congressional majorities spent 40 years creating a scientific fiefdom that was far too often dedicated toward financing politics, not science. In the meantime, basic-science research was steadily de-emphasized, despite the knowledge that such investments are an essential component of global competitiveness.

Basic science has been a loser because essential funds have been diverted toward pork-barrel science. The 104th Congress is committed to seeing the future of science preserved and assured. The proposed House budget may look different from the old, traditional free-spending, non-prioritizing budgets that are so typical of Washington because it is. This budget funds fundamental science. This budget recognizes that a zero deficit in seven years will give the nation a better chance to invest in its future. This budget is a forward-looking plan that promotes science, while it begins to retire the national debt—a win-win situation for the scientific community and our children.

Today's Congress firmly believes that American science is the foundation for sound economic growth. Our approach to science funding reflects recognition of its priority status in the budget.

John H. Gibbons: R&D CUTS THREATEN "FUNDAMENTAL FABRIC" OF U.S. SCIENCE

Fifty years ago, in an office on 16th Street here in Washington, Vannevar Bush had just finished writing *Science—The Endless Frontier*, a blueprint for American science and technology that has kept us the world leader in research through five difficult decades. His message was simple: The United States is in a time of great change. Science and technology bring great rewards to society—good jobs, a higher standard of living, better health. Discovery is unpredictable, so we must invest in a broad portfolio of research or America will fall behind its world competitors.

On these things we have agreed as a nation for 50

years. What concerns me is that if we simply continue to parrot Bush's vision of half a century ago, we will come nowhere near answering the fundamental questions the American people are asking about the need for federal support of science and technology.

The question is not whether science and technology are good things. The federal government supports a lot of good things. It's a good thing to have health care for elderly people. It's a good thing to have a school lunch program. It's a good thing to have clean air and clean water. It's a good thing to have a strong national defense system.

The question, rather, is how do you structure a budget that gives you all of these good things—and does it without robbing Peter to pay Paul? And does it, moreover, in ways that the American people believe in and can continue to support?

I firmly believe that the American people support and expect federal funding of science and technology. But we have been woefully unsuccessful in explaining to

them what kind of commitment this requires. Had we been more successful with this message over the past decade, we would not be facing the dire fiscal crisis confronting us today. And it is a dire crisis.

In broad outline, we're looking at a Republican budget that by 2002 supports a third less basic research than is currently funded, when inflation is taken into account. This budget cuts research into cancer, AIDS, Alzheimer's disease, and other medical problems. It cuts funding for technology education and training programs that make sure our kids can compete in the global marketplace. It eliminates research about weather, climate, and ozone. It cancels hundreds of projects to develop new technologies that are less polluting or would be used to clean up the environment. And it pulls the plug on joint ventures between government and industry, the kind of cooperation that made this nation a world leader in agriculture, in aviation, in telecommunications, and in virtually every critical technology in today's global economy.

At the National Science Foundation, for example, the House budget would fund 4,000 fewer research awards and provide support for 11,000 fewer scientists, engineers, and students than are provided in President Clinton's fiscal year (FY) 1996 and 1997 budgets. At the Department of Energy (DOE), budget cuts would pare 35 percent from basic science. As many as 10 facilities operated by DOE for collaborative work with universities and industry would have to be shut down. The impact would be borne by those who work in these 10 facilities: 1,000 university scientists, 2,000 graduate student researchers, and at least 3,000 technical professionals. If these cuts obtain, approximately 8,000 people will lose their jobs.

There are those who say we can make these cuts without damaging the fundamental fabric of science that has supported this country for more than two centuries. They are wrong.

The current system of funding for research and development is the product of trial and error and painstaking reassessment since the birth of our republic. It is an incredible tapestry—woven out of the hard work of our nation's scientists and engineers using threads from the private sector, federal funding, university research, and international scientific collaboration—and it is a remarkably sturdy and resilient piece of art. It responds to the threat of new and emerging diseases, as we've seen recently with Hanta virus and Ebola. It supports a space program that can put our minds where our feet can never go. It nurtures the minds of our children and prepares them for the high-technology global economy that will provide the jobs of the future.

It has given us a world largely at peace, and guards our national security. It helps make us better stewards of our planet, and protects the air we breathe and the water we drink. It puts food on our tables—and the tables of much of the world.

It is strong. It is beautiful. It is carefully crafted. But it is not indestructible. Start pulling a thread here or a thread there, and you might not notice it. But how many tapestries do you know of that can stand to have a third of the threads pulled out?

It is tempting to say that Congress doesn't know what it's doing. But I know and respect many of the members of Congress who are pushing these cuts, and I know they are not scientifically illiterate. No, this Congress knows what it's doing: It's cutting government. What it doesn't know is what it's undoing—the work of generations who have woven this tapestry that is a fundamental national resource and needs to be a continuing priority investment.

For example, each of us expects to sit down in front of the television news tonight and see state-of-the-art weather maps using the latest in satellite technology. We listen expectantly for tornado or hurricane warnings when the weather turns bad. But both of these capabilities are absolutely dependent on the National Oceanic and Atmospheric Administration's (NOAA's) weather satellite system—and at the time of this writing, congressional cuts will chop these programs by half. The loss of one of NOAA's main weather satellites—inevitable with cuts of this magnitude—would blind forecasters to developing hurricanes over the Atlantic; loss of a polar orbiting satellite would eliminate weather forecasting for much of Alaska.

Moreover, the Republican budget's proposed cuts of \$38 million from the National Weather Service mean that nine of 988 weather offices will be closed. Twenty more will not be able to install the latest technology in weather radar; they will have to continue to rely on surface observations and satellite data. These aren't just bright and shiny new gadgets. They save lives. The five-minute difference in early warning that new radar systems give us is a margin of safety that we rely on again and again. Lives will be lost—not to mention property and homes—if we make these cuts.

This same pattern is emerging in virtually every agency with federal R&D responsibility. What we must understand—and there are those in Congress who would ignore this at the nation's peril—is that we face a new and uncertain future, where the road maps to success are unknown. Knowledge is the only clear advantage in such a time, and we are squandering this advantage if we allow the proposed science and technology budget cuts to stand.

Knowledge is our key to the future. It lets us get our kids up on our shoulders, to give them the boost they'll need to see the dawn of the new century. As a new grandfather, I am committed to making sure my grandchildren see that dawn from a position of clear advantage.

The president and vice president share that commitment—a vision more powerful than mere ledger



“This Congress knows what it's doing: It's cutting government. What it doesn't know is what it's undoing....”

John H. Gibbons, Assistant to the President for Science and Technology

sheets and calendars. I believe the public shares that commitment.

In the administration's original FY 1996 budget last February, almost alone among domestic discretionary spending, research showed a modest increase. And science and technology continue to be a priority for this president. The revised budget figures released in June call for significant increases above the original budget for health and medical research, environmen-

tal research, and technology transfer, among other programs. This support of research and development is our insurance against a national policy of scientific naiveté.

Lewis Thomas, the late extraordinary essayist of medicine and science, said that the greatest discovery of this century will have been the discovery of the extent of our ignorance. We must not let this ignorance become public policy.

George E. Brown Jr.: THE FATE OF R&D UNDER CONSERVATIVE BUDGETS

One can appreciate the importance of scientific research and development programs only by taking a long view—for it is in the long run that R&D expenditures pay off. For example, the emerging biotechnology industry can trace its heritage through a long series of insights and breakthroughs that lead back to Mendel's pea patch in 1865. Unfortunately, the savage

politics of budget balancing seem to have blinded a majority of the members of Congress to everything but the short-term view of federally supported R&D in the United States. This short-term calculus has resulted in a budget from the House and Senate Republican leadership that will shape appropriations for federal science programs in fiscal year 1996 and beyond.

In their details, these budget documents are not binding upon the committees that authorize and appropriate the dollars to be spent in future fiscal years. However, they present a fairly clear view of how R&D policy comes to be translated through the Republican prism of interests and ideology. In this article, I will concentrate on the views expressed by the Republican budget that came out of my side of the Capitol, the House of Representatives, the budget plan authored by Rep. John Kasich of Ohio.

The House Republican budget would support civilian R&D—federally supported nondefense science research—at the lowest level as a proportion of gross domestic

product (GDP) since Dwight Eisenhower was president. The Republican budget may be a move back to the future, but it won't result in happy days for science and technology.



"There are some who may want to dismiss my warnings as so much partisan posturing, but my words here reflect my deep concern for American science."

*George E. Brown Jr., D-Calif.,
Ranking Minority Member, House
Committee on Science.*

Civilian R&D spending, measured as a proportion of GDP, peaked during the Johnson administration at more than 2 percent, and then stabilized in a band between approximately 0.6 percent and 0.4 percent of GDP for the 20 years between 1975 and 1995. The House budget promises to push federal civilian R&D to approximately 0.27 percent of GDP by the year 2002, the same level as in 1960 (calculations by Democratic staff of the House Committee on Science).

Under the House budget plan, Committee on Science programs, which include every major civilian R&D agency (with the exceptions of NIH and the Department of Agriculture), would drop from almost \$26 billion in 1995 to just \$18 billion in 2000. This \$8 billion reduction will affect civilian R&D across the board.

If you have listened to any of the House debates on the budget, you will be familiar with the argument that "we must not leave our children a legacy of debt." This claim of an obligation from one generation to the next is powerful, and I think we all accept it. But simply balancing the budget is an incomplete accounting of our generational obligation. I believe we also have an obligation to make those investments that will ensure a prosperous economy and improved quality of life for our children.

Reviewing U.S. economic performance between 1870 and 1979, economist Angus Maddison found that per capita productivity increased by 1,100 percent and that approximately 60 percent of this increase can be attributed to improvements in innovation and technology [in W.J. Baumol, S.A.B. Blackman, and E.N. Wolff, eds., *Productivity and American Leadership, The Long View* (The MIT Press, Cambridge, Mass., 1989), pp. 12–13]. These findings and others make a strong case that investments in R&D programs are necessary to ensure that each generation enjoys a better life than those before it. In the world designed by the Republican leadership, I fear we will deliver to young Americans a balanced budget bought at the expense of reduced creativity, innovation, and economic vitality.

Ironically, members of the Republican leadership are among the first to acclaim the importance of R&D. House Speaker Newt Gingrich has cultivated a reputation as a "futurist" and promoter of high technology. When confronted with the contradiction between what they say they want for America and what the budget would do, Republicans in Congress offer platitudes about how the market will lead to greatly expanded pri-

ate-sector R&D if only the government will reduce the tax, regulatory, and litigation burdens on business. With this great revolution in the marketplace, federal programs will be less necessary, less important, and, thus, expendable, they say.

However, we have seen private-sector R&D steadily decline in recent years as companies reduce their spending, especially on speculative, long-term research. This decline appears to be due to international competition and the quarterly report sensitivities of investors, and neither of these will be altered for the better by tax, regulatory, or litigation changes.

Republican leaders in the House have very clear preferences for what types of research they like and dislike, with most current programs falling into the latter category. The House budget, which included details on suggested cuts and funding levels, clearly telegraphed these desires. With a few "winners" in the House

Republican budget, most research programs are either small losers or big losers, and some actually disappear. Among the biggest losers in the Republican budget are technology programs. The Republicans would eliminate the Advanced Technology Program and Manufacturing Extension Program at the Department of Commerce and severely cut the Environmental Technology Initiative at the Environmental Protection Agency (EPA), the Technology Reinvestment Program at the Department of Defense, and technology-transfer efforts and cooperative research and development agreements in virtually every research-oriented agency.

These cuts are based on an ideological belief that the government should not be engaged in work that directly supports the private sector and that these programs amount to nothing more than "corporate welfare." But, as John Adams reminded us, "facts are stubborn things; and whatever may be our wishes, our inclination, or the dictates of our passions, they cannot alter the state of facts and evidence." And the facts are that technology programs of the kind targeted for termination were precisely the ones that accelerated development of jet airplanes, computers, and telecommunication—virtually everything that foreshadows the dawn of the Third Wave we have heard so much about from futurist Gingrich. Although it is easy to count how many dollars may be saved by ending these programs, it is difficult to count the opportunities lost as a result. But if the past is any guide to the future, terminating these programs will have a very strong detrimental impact on our future economy and society.

Of course, there are other losers in the Republican budget. After months of listening to members of the majority party say that our environmental regulations should be based on science, we find that they want to cut funding for environmental sciences. Long-term global-climate-change research is slated for termination at the National Aeronautics and Space Administration

(NASA), the National Oceanic and Atmospheric Administration, EPA, and the Department of Energy. The Social, Behavioral and Economic Science Directorate at the National Science Foundation (NSF) is also a target, having been singled out for termination because of conservatives' allegations that NSF had, as Chairman Robert Walker of the Committee on Science put it, "wandered into" this work for reasons of "political correctness." As a correspondent wrote in a letter to the committee, "Cutting ALL NSF funding for psychology, linguistics, etc.? That's pretty stupid." It would be hard to elaborate on that judgment.

Among the smaller losers in the Republican budget are those programs the Republicans label "basic research." These favored, fortunate few include NSF and NIH. But even these two agencies, under the House Republican budget, together will suffer an 18 percent real cut in funding by the year 2000 compared with 1995 levels. This is far preferable to elimina-

tion, but with friends like these....

Biomedical researchers may take some solace from that relatively benign treatment and can anticipate protection in the Senate by Sen. Mark Hatfield, R-Ore., chairman of the Appropriations Committee. However, they should take heed of the experience of the social sciences program at NSF. Will conservative forces next choose "winners and losers" among areas of health research? Will, for example, prostate-cancer research be encouraged and AIDS research or human-genome studies be cut back? In making these choices, Republicans are responding to an unstable mix of interest-group pressures, limited knowledge, and shifting calculations of political advantage. As a result, programs that win one year could lose the next, causing disruption and delay in research agendas.

And the winners in the Republican budget process are few and far between. Perhaps the biggest winner is NASA's Space Station Program. The Republicans intend to see that the station has the first claim to moneys appropriated to NASA—placing the Space Station above the fray for scarce dollars at that agency. Although I have been a strong supporter of the Space Station, I cannot continue to support it under the House budget assumptions that will all but kill space and earth sciences at NASA.

There are some who may want to dismiss my warnings as so much partisan posturing, but my words here reflect my deep concern for American science. I fear that those with the power now to shape national R&D policy through the budget, authorization, and appropriation processes lack any understanding of science, of technology innovation, or of American economic history. As a result, the long-term interests of our nation will go unrecognized unless I, others in government, and members of the research community protest the Republican ideology. A blind man will walk right off a cliff unless someone shouts to him. I am simply doing my damndest to shout loud and long.

"[P]rograms that win one year could lose the next, causing disruption and delay in research agendas."

Neal Lane: A NEW AGE FOR SCIENCE

Wise Washington watchers agree on one thing: It's never been like this before. Budgets are balancing, priorities are shifting, and everyone is looking to do more with less. It would be naive to imagine that basic research will remain unscathed.

The vulnerability of federal funding for science became clear in May when the House and the Senate Budget Committees released their respective budget resolutions. These resolutions set out seven-year road maps

that seek to balance the budget by the year 2002. They set limits for broad categories of federal spending that would support science, defense, agriculture, and social programs. The Budget Committees also provide specific recommendations on how these funds should be spent. Although the recommendations are not binding, they are indicators of future trends in science funding.

This is only the beginning of the budget process; other committees are taking their turn authorizing and appropriating funds for specific programs within the limits set by the budget resolution. It could be a long, hot summer.

Making any prediction about the future is difficult, but one thing I can say with some certainty is that the trend for federal science and technology funding will be downward. Unfortunately, some programs in other federal agencies are slated for elimination; others, for drastic cuts.

Historically, funding for research, particularly in the physical sciences, has been supported by national security needs. Although it's too

early to predict with great accuracy what Congress will provide for a particular area of science, the traditionally strong bipartisan support for the physical sciences remains. More recently, the focus on health has led to strong support for the life sciences. With the Cold War over, we need to recognize a shift in national direction and global perspective away from defense and toward improving the quality of life in an economically competitive world.

Scientists intuitively know that science is not only exciting but important—that is why we do what we do. Studies have shown that support for research is also a valuable investment in our future, an investment with a particularly high rate of return. But this is a time of transition, one that has notable implications for all of us who care about the future of both basic research and the nation. We must find ways to do more with less. Because we cannot expect to do "more of the same"

with less support, we must explore what we can do differently. This implies real change for the National Science Foundation (NSF) and, thus, for our partners in other federal agencies and in universities and colleges.

I am actually optimistic that we can have a sustainable, healthy science and technology enterprise well into the future—even if things are rocky in the immediate future. The future may not have quite the same flavor that we are used to, but it can be just as vital, just as exciting, and just as rewarding to the society that will be asked to support it.

Frankly, I simply cannot imagine the United States not being in a position of world leadership in the 21st century, and I cannot see how the United States can maintain that position without being a world leader in science and technology. It is not simply a matter of the large economic return on investment in R&D, or even of the knowledge and technologies that we need to serve the national interest. It has to do with this nation's roots, a tradition of bold adventure, of exploration, taking risks, and the romance of discovery. That is what science is all about.

I prefer to think of the current environment as a challenge for us to come out from our laboratories to engage the public in a vigorous, positive discussion about the future of this nation. There is a good case for research, and we must work together to make it.

We must be conscious of our goals, values, and priorities and let them help us direct the way in which we respond to the new budget realities. The mistake would be to allow current budget limitations to direct our purpose and determine our priorities. We cannot fall into the trap of reacting instead of planning.

It is here where the science and technology (S&T) community has to be involved. It has to speak out with a single voice, a voice that reflects a coming together of all the science and engineering disciplines—physicists, biologists, economists and social scientists, geologists, civil engineers, etc.—a formidable challenge. We need not agree about every detail, but we must agree upon common goals and values that will move us positively toward the future. And while the S&T community is not yet a single voice, we are coming together. I sense this from many discussions I have had in recent months with individuals and groups from other government and nongovernment organizations, academe, and industry.

At NSF, we have worked long and hard to come up with a strategic plan that will guide the foundation through times of feast as well as famine. The plan, completed in October 1994, sets three long-range goals for the organization.

The first is world leadership in science and engineering. Although we cannot assume that only America has top-notch scientists and engineers, our nation should be among the leaders in all important fields. It is impossible to predict when and where the major discoveries will occur, so maintaining an active lead in many fields will protect the broadest range of options to ensure our economic and national security as well as the health and well-being of our society.

The second goal is scientific knowledge in service to society. We need to recognize the role that science plays



"We must find ways to do more with less. Because we cannot expect to do 'more of the same' with less support, we must explore what we can do differently."

*Neal Lane, Director,
National Science Foundation,
Washington, D.C.*

in our daily lives and make sure that new knowledge and technologies find their way to those who will use them to improve people's lives.

To attain the first two goals, the third—excellence in education at all levels—is indispensable. Young people learn science through experimentation, analysis, and questioning. Science gives them confidence in dealing with the technology that surrounds them. Only a technologically literate society can survive in today's marketplace.

We at NSF use this plan as a touchstone, a test for all our activities, and we have developed some strategies that we believe will move us toward these goals. We recognize, however, that we cannot realize these goals on our own, particularly in this budget environment. We are emphasizing what we can accomplish through partnerships—perhaps the ultimate in doing more with less. Our partnership with NIH and other research agencies in the National Science and Technology Council's Committee on Fundamental Science (which Harold Varmus and I co-chair in conjunction with the associate director for science in the Office of Science and Technology Policy) is already paying off in coordinated approaches to many issues facing the research community. For example, NSF has joined with several components of NIH in the Human Brain Project, a broad-based federal initiative that supports both investigator-initiated basic and clinical neuroscience research and investigator-initiated informatics-resources research. Our partnership with universities and colleges and their faculties permits us to grapple with difficult questions about how to gain the confidence of the public and private sectors so important to our success.

"We must be conscious of our goals, values, and priorities and let them help us direct the way in which we respond to the new budget realities."

For example, recent NSF-funded research on the behavior of vapors and viscosity by a university physical chemist, in collaboration with industry scientists, led to the development of supercritical carbon dioxide as a substitute vehicle for spray painting, thus reducing toxic emissions. The new spray-painting process not only causes less pollution and reduces labor costs, but also provides better quality. Partnerships made this possible.

NSF's approximately 50 Industry/University Cooperative Research Centers have during the past two decades led to new products and processes, with minimal investment of federal dollars. For example, research at these centers includes an industry-wide statistical process control program in the glass-making industry, a process for recycling plastic bottles, an advanced driving simulator that supports improved automotive

safety research, and a computer-generated scheme for parts delivery that has already saved one major electronics manufacturer more than \$100 million.

Reflecting back on history, or in this case, prehistory, is sometimes helpful in gaining perspective. About 500 million years ago, during the Ordovician period, in some parts of the world, there was great turmoil as mountains were thrust upward because of collisions between tectonic plates. As a result, the existing ecosystem changed. But, interestingly enough, it appears that the tectonic calamity led to a great blooming of marine life forms—a "tectonic miracle of life."

Nature takes advantage of opportunity. We must do the same, while grounding our actions in the strong values and goals that permit leadership in a time of adversity.

Edward E. Penhoet: NIH FUNDING AND THE RISE OF THE U.S. BIOTECHNOLOGY INDUSTRY

Proposed cutbacks in federal funding for NIH would have the doubly unwanted result of reducing medical progress and diminishing U.S. economic growth and preeminence in the field.

NIH funding for biomedical research has been the seed money from which America's worldwide leadership in biotechnology has sprung. More than 80 percent of the NIH budget is used to sponsor research activities conducted primarily by university scientists. Only 20 years after the NIH-supported invention of the basic technique of genetic engineering, the private U.S. biotechnology industry had sales of almost \$8 billion in 1994 and now employs more than 100,000 Americans. Perhaps an equal number or more are employed in federally funded

biotechnology research at the universities and other research institutions.

The proposal in the House budget resolution this spring to reduce NIH funding by 5 percent, then cap NIH's budget for six years, would—when adjusted for inflation—reduce real expenditures for biomedical research by as much as 25 percent. Continued increases in research spending by corporations might absorb a portion of this, but these organizations are already spending substantially more than NIH to convert basic discoveries in biomedical research into products that are useful in health-care settings.

With rare exceptions, the largest-selling products from biotechnology have shared four characteristics. 1) They were generated from collaborations among universities, biotechnology companies, and large pharmaceutical companies. 2) They have created thousands of jobs and positive returns for investors (many of whom are middle-income Americans participating through pension plans or mutual funds). 3) They have returned income in the form of royalty payments to universities, where the money is applied to many other academic programs.

These reciprocal benefits are what Congress envisioned when it passed the 1980 Bayh-Dole Act, which encourages universities to patent inventions produced by federally funded research. 4) They have resulted in a favorable balance of payments for the United States.



"Should we not consider biomedical-funding issues in the context of national priorities?"

Edward E. Penhoet, President and Chief Executive Officer, Chiron Corporation, Emeryville, Calif.

A substantial majority of global biotechnology industry sales are by U.S. companies, a large fraction of which are for export. For example, the combined efforts of the University of Chicago, Amgen Inc. of Thousand Oaks, Calif., and Johnson & Johnson Co. of New Brunswick, N.J., brought to market in June 1989 the largest-selling biotechnology drug, erythropoietin, which promotes the growth of red blood cells in kidney-dialysis patients and others with a hematopoietic deficiency. The first biotechnology product, genetically engineered human insulin for diabetics, was made available in 1982 through a collaboration between the University of California at San Francisco (UCSF), the City of Hope Hospital of Los Angeles, Genentech Inc. of South San Francisco, Calif.—one of the first biotechnology companies—and Eli Lilly and Co. of Indianapolis.

Chiron Corp. scientists, in collaboration with the Centers for Disease Control and Prevention, in 1987 identified the hepatitis C virus, formerly known as hepatitis non-A, non-B. Together with Johnson & Johnson, Chiron rapidly brought to market a test to screen potentially infected units of blood from the worldwide blood supply. Other Chiron-NIH collaborations include studies of vaccines to prevent or treat genital herpes and human immunodeficiency virus-type 1 infection and design of a sustained-release implant for delivering ganciclovir directly to the eye to slow the progress of cytomegalovirus (CMV) retinitis, a leading cause of blindness in AIDS patients. Without some level of federal support, these and many other recent medical advances would have been more difficult to achieve.

The fundamental tools upon which the biotechnology industry was founded came from basic university research. In November 1973, Stanley Cohen of Stanford University in Stanford, Calif., and Herbert Boyer of UCSF, both of whom have been supported largely by NIH grants, described the first construction of a recombinant DNA molecule containing genetic material from two different species. Since then, the financial rewards to their universities have been substantial. Their fundamental enabling technology for DNA cloning has been licensed by all biotechnology companies. To date, Stanford has received \$117.5 million in royalty payments from 311 active licensees, including \$20.6 million in the 10 months from August 1994 through May 1995. In 1993 and 1994, the University of California system received \$68.3 million in biotechnology license payments from its

participation in the Cohen-Boyer royalties as well as royalties for its contributions to Chiron's genetically engineered hepatitis B vaccine, based on research by two of Chiron's co-founders while they were at UCSF.

U.S. leadership in biotechnology has stimulated substantial investment in this country by numerous foreign health-care companies. Many of the largest U.S. biotech companies have foreign partners, including Chiron and Genentech. For example, as part of its strategic partnership with Chiron, Ciba-Geigy Limited of Switzerland has agreed to provide about \$1.2 billion to Chiron in the form of research funding, loan guarantees, and equity capital. This infusion of capital will enable the more rapid research and development of promising products and accelerate their introduction into global markets.

The biotechnology industry in general springs from and recruits much of its human capital from medical centers of excellence, and Chiron has been no exception. Chiron's three founders, each of whom remains in position 14 years after the company's inception, were previously University of California system faculty members: William J. Rutter, Ph.D., chairman of Chiron, was chairman of the Department of Biochemistry and Biophysics at UCSF; Pablo D.T. Valenzuela, Ph.D., senior vice president and president of Chiron Diagnostics, worked with Bill at UCSF; and I was a faculty member in the Department of Biochemistry at the University of California at Berkeley when Chiron was founded. Both Bill Rutter and I remain affiliated with our former universities.

Of 98 Ph.D.-level scientists at Chiron, 33 are from UC campuses; of 171 other scientific positions, 66 are from UC campuses; and of 11 postdoc fellows, three are from UC campuses. Three of the top 12 institutions that received NIH funding in 1994 were UC campuses; thus, NIH funding plays an important role in generating new talent from which companies and groups such as the Food and Drug Administration draw.

Should we not consider biomedical-funding issues in the context of national priorities? As recently as 1993, the United States spent more than twice as much on salaries of major league players in football, basketball, baseball, and hockey as on vaccines to protect children and older Americans from infection. In the same year, U.S. consumers spent almost \$4 billion on nail care vs. less than \$3 billion on biotechnology drugs and vaccines. An independent study commissioned by Chiron and Johnson & Johnson showed that screening donated blood with the hepatitis C test saves the U.S. health-care budget more than \$350 million each year by detecting blood that is infected and thus preventing the transmission of this disease. More than a million potentially serious cases of hepatitis C infection have been prevented globally since the advent of testing in late 1989.

Scrutiny of federal spending in light of current economic pressures may be required, but historically, the benefits of biomedical research have far outweighed the costs. We have reduced defense spending in accordance with fewer perceived risks to our national security, but with the emergence of new viruses and the continuing threat of many other serious diseases, can we afford to be less diligent about our health security?

NIH funding cannot continue to expand forever, as the numbers of problems to solve and people to solve them will become rate-limiting factors. But NIH's support for

biomedical research should not be contracted at a time when it is expanding the horizons of medical knowledge as never before.

Charles M. Vest: **IMPLICATIONS FOR UNIVERSITY** **RESEARCH AND EDUCATION**

In his article earlier in this section, John H. Gibbons, the president's adviser for science and technology, cites the 1945 report *Science—The Endless Frontier*, by Vannevar Bush, adviser to Presidents Roosevelt and Truman, for its support of U.S. competitiveness. Bush and his colleagues at the time also saw science as one of America's investments in the education of its young people.

"The government should accept new responsibilities for promoting the flow of new scientific knowledge and the development of scientific talent in our youth," Bush wrote in that report. The policy basis for federal support of research and education in the United States was outlined in the report, which in turn provided the vision for national science policy and set the underlying social contract that enabled the American research university to define itself as an institution to give bright young men and women from all social and economic strata access to the best in higher education. For most of the past 50 years, the universities and the federal government shared a common vision and commitment that served the nation and the world exceedingly well, as they promoted our health, prosperity, and national security.

In recent years, the nation, led by the federal government, has steadily added missions and requirements to universities without sustaining the resource base to meet these new demands. Perhaps the clearest example is in graduate education. Federal graduate fellowships and traineeships, which are designed to attract the best students into the country's leading universities, fail to pay the full costs of education—particularly tuition costs. The Massachusetts Institute of Technology subsidizes the tuition for National Science Foundation (NSF) graduate fellows and NIH-traineeship students at a growing cost of several million dollars per year. Another example is the withdrawal of the federal government from assisting with the academic infrastructure. Since 1968, the government has had no significant direct grant program for the construction, replacement, and renovation of research facilities. According to the most recent estimates by NSF, the nation has an accumulated backlog of unmet research facilities' needs in excess of \$5 billion. Meanwhile, government agencies expect universities to conduct federally funded research programs at the highest levels of quality.

A government-university partnership in higher education has been replaced over the past two decades with uncertainty and deepening misunderstanding and distrust. Universities are not blameless, however. We have

failed at times to keep pace with the need to modernize our programs and improve our cost-effectiveness. We have overextended our budgets and our faculty members, with research programs that were once sustained by one or two grants now requiring twice that many smaller-sized awards. This system in turn discourages many of our best young people from pursuing careers in academic science, as they see the probabilities of success in the competition for funds fall from one-in-three to one-in-five, see senior faculty mentors lose their research support, and see administrative loads on remaining faculty increase.

It is in this environment of stress that Congress is now debating the future of federal responsibility for supporting university research and education in science and technology. As this article was written in mid-June, outcomes of fiscal year 1996 federal funding for research are unpredictable. Some leaders in Congress are committed to sustaining federal support for science as a core function of a streamlined government. These expressions of support and commitments of leadership are welcome and essential. Nevertheless, early indications are that between 1995 and 2002, the majority's deadline for achieving a balanced budget, cuts of at least 25 percent below 1995 levels, and perhaps much more in real terms, are likely for the nondefense civilian mission agencies—the Department of Energy (DOE), the National Aeronautics and Space Administration (NASA), and the Environmental Protection Agency. Perhaps somewhat smaller reductions in constant dollars await NIH and NSF.

Many in Congress are working hard on behalf of NIH research. By a recent bipartisan vote of 85 to 14 on the Senate Budget Resolution for fiscal year 1996, the Senate signaled its strong intention to protect biomedical research. The House and Senate budget plans also demonstrate favor for NSF in their nonbinding assumptions. However, final funding decisions are yet to be made by appropriations committees this fall. Particularly threatened by this budget cutting, and often misunderstood in the process, are the university research programs of the major mission agencies—the Department of Defense (DOD), DOE, and NASA—which together support more than 70 percent of university research in engineering, computer science, materials,



“Our ability to develop the nation's human capital and future leadership in science is especially at risk.”

*Charles M. Vest, President,
Massachusetts Institute
of Technology, Cambridge, Mass.*

and other fields essential to the development of future biotechnology and health-care industries.

In short, our technology-innovation system is threatened. Our ability to develop the nation's human capital and future leadership in science is especially at risk. If government support of science is abruptly reduced, or even just eroded by inflation, we will see fewer of the "best and the brightest" students enter careers in science and engineering.

Will industry step in for government and support research to the extent the budget-cutters envision? There is no reason to believe that industry will substitute its funds for those cut by government. Industry funds 7 percent of academic scientific research, whereas government funds 57 percent. And NSF reports that companies with R&D budgets of \$50 million or more plan to cut spending by 3.5 percent overall this year. Industry's focus increasingly is fixed on its short-term goal of rapid commercialization. Most industrial research laboratories, such as AT&T Bell Laboratories in Murray Hill, N.J., have been eliminated or converted to new—admittedly important—purposes, leaving most mid- and long-term research to the government and the universities. Industry should fund more of this research in universities, but, in the final analysis, only the federal government has the capacity to sustain the research and development that is the core of our national innovation system.

Beyond the federal budget itself, three more potentially disastrous policy errors loom on the horizon in the current policy climate. First, as budgetary pressures increasingly drive policy, we are in danger of seeing a separation of education from research in federal programs. The beautiful and efficient concept of supporting university research and simultaneously investing in the education of the next generation is the bedrock policy on which we have built the most productive and unique university enterprise in the world. The integration of teaching and research is now in danger of disintegrating because government is paying less and less of the actual cost of the research it sponsors. As a result, tuition and gift revenues that should be going directly to pay for teaching have to be tapped to make up the funding shortfall. Government funding policies, such as NIH policies limiting reimbursement of tuition for graduate students, also are producing incentives for faculty to employ postdoctoral fellows and professional researchers rather than support graduate students. This approach of government is unwise and a far cry from

the eloquent and sensible vision of Vannevar Bush and the policy-makers of his day. We must retain the notion that research and education are integrated, mutually reinforcing activities. If we do not, both will suffer.

Another potentially dangerous policy error could come from policy-makers' failure to recognize research funding as an investment and not a cost. Government spending on research is an investment in the future of our human capital—people and their ideas. It is also a financial investment: Respected studies by the General Accounting Office and by Edwin Mansfield of the University of Pennsylvania in Philadelphia affirm annual rates of return on the order of 25 to 50 percent. No matter how we may quantify it, investment in research and education pays substantial dividends. The greatest of all is education of the next generation.

The third major policy error looming is the inaccurate categorization of research as either basic or applied. Just two years ago, a Democrat-controlled Congress decreed that large portions of federally supported university research should be "strategic" in nature. That is, they should have obvious relevance to defined national needs. Now, just two years later, House Republican leaders have declared that it is most appropriate for the federal government to fund "basic" university research—not "applied" research. Which research is being labeled "applied" seems to depend more on which agency funds it than on its substance. If bias against so-called applied research continues to erode support for the research budgets of DOD, NASA, and DOE, it will badly weaken fields such as electrical and computer science engineering, materials science, and mathematics—the very fields on which our economic future depends. NIH could easily be endangered by such categorization. What is important is research, not modifying adjectives.

Science, technology, and advanced education cannot be turned on and off at will, nor can they undergo major changes of direction every few years. Universities require a reasonable degree of continuity of policy and funding and a long-term perspective of the role and health of the university enterprise if they are to produce the results the nation needs. We thus need to rebuild bipartisan understanding of and support for the mission of the federal government in sponsoring university research. The alternative is a substantial dismantling of the enterprise. We entertain the latter possibility only at our national peril.

Louis Lasagna: **FDA REFORM: WE NEED IT NOW**

The funding of the Food and Drug Administration (FDA) has long been a source of controversy. Although this regulatory agency is huge today compared with its size at the time of the 1962 Kefauver-Harris Amendments—the amendments empowered the agency to

oversee all human testing of experimental drugs and to demand evidence of clinical effectiveness as well as safety—FDA commissioners have recently decried the tendency of Congress to assign new responsibilities to the agency without providing additional resources. FDA has an enormous spectrum of responsibilities in its role of protecting the public health, and inadequate resources will predictably impair its performance in this role for both drugs and foods.

An exception to the problem of FDA's static resources

is the Prescription Drug User Fee Act of 1992, which imposes fees on manufacturers for filing each New Drug Application (NDA). The fees, which are paid directly to FDA, should have allowed the agency to hire hundreds of new reviewers and hence not only eliminate the backlog of old filings but deal expeditiously with new filings, according to goals set in 1992 by FDA Commissioner David Kessler.

Although these drug-filing fees have added substantial income to FDA—\$56,284,200 was reported by Kessler in his projections for 1994—the hiring of new reviewers has lagged. In any case, recruits cannot assume full



“The stakes in this regulatory battle are substantial.”

Louis Lasagna, Dean, Sackler School of Graduate Biomedical Sciences at Tufts Center for the Study of Drug Development, Boston.

reviewing responsibilities without lengthy on-the-job training. (The academic education of M.D.s, Ph.D.s, and Pharm.D.s does not begin to provide the skills and background required for the complex tasks involved in drug regulation.)

Kessler's performance-goal letter stated that 50 percent of the new staff were to be in place by the first quarter of fiscal year (FY) 1995, which will end Oct. 1, and the remainder by the end of FY 1997. At the end of 1994, FDA reported a net gain of 272 new “user fee” employees in the Center for Biologics Evaluation and Research and the Center for Drug Evaluation and Research, the biologics and drug reviewing centers, respectively. This number represents 45 percent of the hiring target of 600 new review staff, but the plan is to add a total of 700, 100 of whom would be assigned to tasks other than reviewing NDAs.

Commissioner Kessler is confident that the goals he has set will be met, but the agency's performance will be carefully monitored (by my own center, for example). The goals require “action” on complete NDAs and on NDA supplements by the agency within specified periods of time (within six months for complete NDAs and 12 months for supplements requiring review of clinical data).

FDA actions include approvals and nonapprovals of applications, although rejections are not what Congress had in mind when it passed the 1992 legislation. Both actions require letters to sponsors, as does a third kind of action, an “approvable” letter. It indicates that an application, in essence, qualifies for final approval, but requires some minor discussion (about the labeling, for example). Nor did Congress have in mind “refusals to file” (returns of an application without full review because its flawed nature is apparent to FDA on a quick examination), which help prevent a backlog at the agency but which, if invoked excessively, will make FDA vulnerable to criticism for violating the spirit of the User Fee Act. FDA considers a sponsor's response to both approvable and approval letters to be resubmissions that reset FDA's clock for another six months.

Another concern relates to the fate of user fees if they

exceed the costs of the act's implementation. Will the excess money be sequestered away in an escrow account for use by FDA in future years or be seized by Congress to reduce the federal deficit, despite the specific intent of the act to preclude such use?

Currently, the Washington policy-setting scene is characterized by a great deal of frenetic activity. Calls for FDA reform have come from many quarters: the traditional pharmaceutical industry, the newer biotechnology industry, congressional members of both parties, the White House, and FDA itself. Not surprisingly, the proposals differ considerably, but at the very least, they demonstrate an acknowledgment of the fact that FDA (like everything else in this world) could stand some improvement.

The following is a partial list of changes that one or another of the above sources has proposed:

- Amend the mission of the agency so that it not only protects the public health but promotes it. That is, FDA should not only prevent fraud and harm from toxic products or products lacking in efficacy, but facilitate the access of sick people to new remedies and devices that are safe and effective.
- Make the relationship between the regulators and the regulated more collegial and less adversarial, with interactions between the parties occurring throughout the drug-development process. This earlier and better communication will increase the likelihood that NDAs will be essentially “self-reviewing,” because all the important questions will have already been addressed before the NDA is submitted.
- Ensure that the 12 divisions of FDA comport themselves with more uniform philosophies and processes, as opposed to the unbelievably great disparity that now exists between divisions—for example, in the willingness to have meetings with the sponsor at any point in the development.
- Use outside experts (scientists in universities or in contract research organizations) to review NDAs (entirely or in part) or NDA supplements that propose a new use for the product.
- Substitute certified summaries for the voluminous NDA filings—most of which now run 100,000 or more pages. The 1985 FDA guidelines for preparing NDAs did not require the submission of all case-report forms, as they did for reports on patients who died during a clinical trial or did not complete the trial because of an adverse event (whether believed to be drug-related or not).
- Create a new, impartial appeals mechanism to arbitrate and resolve scientific disagreements between FDA staff and scientists sponsoring a new drug, biologic, or device. The Byzantine process now in place is not efficient and is not likely to support sponsors' positions. Because arguments between sponsors and FDA staff usually result in FDA adhering to positions opposed by the sponsor, conformists tend to comply with FDA demands rather than fight a losing battle.
- Implement “Good Regulatory Practices” for FDA that will help FDA administrators detect and correct incompetence or obstructionism by FDA staff (just as drug sponsors now have to observe “Good Laboratory Practices” and “Good Manufacturing Practices”). A

"Good Review Practices" initiative is apparently underway at the agency, initiated by the commissioner's top administrators and due to be set in place by the end of 1995.

- Require only FDA notification, not FDA approval, for supplemental filings that involve minor manufacturing or other changes that do not affect a marketed product's safety or efficacy.
- Allow universities or for-profit Institutional Review Boards to supervise the many physician-initiated Investigational New Drug (IND) applications (almost none of which ever result in commercial products) without FDA oversight.
- Exempt biotechnology-product sponsors from the requirement to have a functioning production plant in operation before FDA approval of a particular product.

These proposals strike me as eminently reasonable and in the interest of FDA, the drug industry, and the public.

Although the time seems ripe for legislative moves to correct deficiencies in FDA that have been repeatedly identified by dozens of reviews of the agency (many of which are reflected in the above-mentioned reform proposals), congressional action is never predictable with any certainty, and current guesses about what changes will be made by such potential legislation vary widely. Congressman Ron Wyden, D-Ore., has already introduced a bill, and several others are expected soon.

The stakes in this regulatory battle are substantial. FDA has responded to public pressures (most markedly for AIDS therapies) by speeding the approval of new drugs. Nevertheless, the process of drug discovery and development to marketing has doubled in length over the past three decades and now averages an appalling 14 to 16 years.

With this increase in the length of time it takes to get a drug to market has come a not-unexpected increase in the cost of developing a new drug. To bring a new pharmaceutical product to market today costs hundreds

of millions of dollars, if one counts (as one should) the inevitable failures and the "cost of money"—what could have been earned by investing in resources that have predictable returns.

Making these facts all the more painful are the relentless desires of all governments to contain health-care costs. In the United States, the cost to consumers of purchasing drugs represents only 7 percent of the national health-care budget, but these costs have become an easy target for price-setting authorities (in Europe, for example) and third-party payers such as

health-insurance companies. Increasingly, third-party payers are demanding comparative cost-benefit data to justify payment for a newly approved drug.

Given all of these concerns, it is not surprising that the drug industry should be bedeviled by uncertainty and worry—especially the numerous small biotechnology firms that have no marketed products and a rapidly diminishing reserve of venture capital.

A society that wants to optimize its ability to prevent or cure disease needs a healthy pharmaceutical industry, one that is profitable enough to justify investment in the difficult search for "breakthrough" drugs. FDA reform, by speeding the process of drug development and decreasing its cost, would help significantly to keep the pharmaceutical industry searching for the drugs that are so desperately needed by patients suffering from diseases such as cancer, Alzheimer's, and AIDS. Many of these diseases are now poorly responsive to marketed remedies despite the remarkable pharmacotherapeutic progress of the last half century.

Whether Congress can play a role in FDA reform efforts remains to be seen. But the House and Senate should recognize that medical progress relies not only on industry but on academia, and that cutting the NIH budget or the overhead on academic grants will slow the rate of progress by impeding the transfer of basic scientific discoveries to the bedside.

"Given all of these concerns, it is not surprising that the drug industry should be bedeviled by uncertainty and worry...."

Carol M. Browner: **THE IMPACT OF PROPOSED** **CHANGES IN SCIENCE POLICY** **AND FUNDING**

For a moment, let us imagine what our country would be like today without the steps taken in the past 25 years to protect public health and the environment.

Imagine the Cuyahoga River in Ohio. But don't picture the river as the bustling center of tourism and local business that it is today. Imagine it as it was 25 years ago: so polluted that it burst into flames.

Imagine our children in school today, trying to learn. But imagine that many of today's healthy children are held back by learning disabilities—just one of the long-term health problems we would face today if we had not banned lead from gasoline 20 years ago.

Imagine cities where children, people with asthma, and elderly people stay indoors because the outside air leaves them gasping for breath. Imagine smog in Los Angeles that blocks out the skyline, and coal smoke that pours over Pittsburgh so thickly that taking a walk is a real effort.

These situations no longer exist because—over the past generation—our nation has invested in scientifically based environmental protection. Without scientific

research and its applications, today would be a very different day—one with more problems, more citizens in poor health, fewer thriving local economies. We would be spending far more on handling crises and doing far less to protect our future and our children's future.

Yet today we hear proposals to cut funding for environmental research, to weaken public health and environmental laws and substitute simplistic mathematical formulas for sound science, and to freeze science rather than allow it to evolve.

I firmly believe—as does the Clinton administration—that this is no time to scale back scientific research on environmental problems. Nor should we force environmental decision-makers to rely only on a limited set of scientific tools.

Risk assessment is an important tool that we at the Environmental Protection Agency (EPA) use in most of our major regulatory decisions. But as the National Academy of Sciences recently said, "Risk assessment is a set of tools, not an end in itself." This administration opposes risk-assessment proposals that would freeze scientific progress and unnecessarily delay actions needed to protect the health of our citizens and communities.

Likewise, cost-benefit analysis is an important tool for EPA—we use it in developing major rules, those expected to produce costs of \$100 million per year or more. Cost-benefit analysis should not, however, become the sole criterion used to set all standards. We must not base public-health protection on simplistic mathematical calculations when lives are at stake.

We must continue to develop new scientific tools to address today's problems while we prepare for tomorrow's challenges. At a time when government funding for research and development is generally coming under close scrutiny, the resources we need to do this enormous job are being measured more and more stringently.

That's why I have made changes at EPA to keep our scientific progress sound and productive, changes that have won praise and support from the National Research Council and other leading scientific organizations.

First, we are fully incorporating good science into our planning and budget process. Led by Robert J. Luggett, EPA's assistant administrator for research and development, we have established new procedures for strong, consistent peer review throughout EPA. All of our studies, reports, and other scientific products will receive internal peer review. And we will also seek independent peer review by outside experts for all products involving novel, complex, or controversial issues.

Second, we are expanding our interaction with the outside scientific community. Through EPA's new STAR program—Science To Achieve Results—we reach out to the best and the brightest in the scientific community to help us analyze the most serious risks to public health and take action where it will do the most good. By carefully redirecting existing funds, we propose to double funding from \$42.4 million in fiscal year 1995 to \$83.3 million in the coming year for grants to support

research conducted by scientists outside the agency. This means an unprecedented level of EPA support for outside science, a demonstration of our commitment to fostering good environmental science in a time of budget constraints. In addition, our program of 100 competitive fellowships for graduate students will help to develop the next generation of talented environmental scientists. EPA will provide up to \$5 million this year to fund 100 fellowships. The response to our solicitation was tremendous: We received almost 2,500 applications.

Third, we are restructuring our research program to enhance performance and productivity. EPA's Office of Research and Development (ORD) has been at the forefront of environmental science since its inception 25 years ago, but organizationally, it was becoming a dinosaur.

Under a reorganization that will take effect fully this fall, we have consolidated 12 media-specific (air, water, or soil pollution) laboratories into three national laboratories and two national centers to produce the research that the agency needs to effectively assess and manage environmental risks. These five national laboratories and centers will conduct or support cross-media research pertaining to exposure, health and environmental effects, risk-management, and research interactions between EPA and the outside scientific community.

All of these changes open new avenues for cooperation with our nation's research organizations. I hope our scientific colleagues will look for ways to use these opportunities to establish fruitful partnerships with us.

Despite the progress of the past 25 years, we have not finished the job. Two in five Americans still live in areas where the air is dangerous to breathe. Forty percent of our rivers and lakes are not suitable for drinking, fishing, or swimming. In Milwaukee in 1993, hundreds of thousands of people got sick from contaminated drinking water—and 100 died. Asthma is on the rise. Breast cancer is on the rise. And we face complex global environmental problems.

When I came to Washington at President Clinton's request two and a half years ago, we recognized the need for a new generation of environmental protection: one that is firmly committed to environmental goals but also to flexibility, innovation, and creativity in how we achieve those goals; one that is grounded in common sense and cost-effectiveness; and one that protects more and costs less.

Sound science is a vital part of that new generation.



"By carefully redirecting existing funds, we propose to double funding from \$42.4 million in fiscal year 1995 to \$83.3 million in the coming year for grants to support research conducted by scientists outside the agency."

*Carol M. Browner,
Administrator, U.S.
Environmental Protection Agency,
Washington, D.C.*

REPUBLICAN CONTRACT WITH AMERICA

As Republican Members of the House of Representatives and as citizens seeking to join that body we propose not just to change its policies, but even more important, to restore the bonds of trust between the people and their elected representatives.

That is why, in this era of official evasion and posturing, we offer instead a detailed agenda for national renewal, a written commitment with no fine print.

This year's election offers the chance, after four decades of one-party control, to bring to the House a new majority that will transform the way Congress works. That historic change would be the end of government that is too big, too intrusive, and too easy with the public's money. It can be the beginning of a Congress that respects the values and shares the faith of the American family.

Like Lincoln, our first Republican president, we intend to act "with firmness in the right, as God gives us to see the right."

To restore accountability to Congress. To end its cycle of scandal and disgrace. To make us all proud again of the way free people govern themselves.

On the first day of the 104th Congress, the new Republican majority will immediately pass the following major reforms, aimed at restoring the faith and trust of the American people in their government:

FIRST, require all laws that apply to the rest of the country also apply equally to the Congress;

SECOND, select a major, independent auditing firm to conduct a comprehensive audit of Congress for waste, fraud or abuse;

THIRD, cut the number of House committees, and cut committee staff by one-third;

FOURTH, limit the terms of all committee chairs;

FIFTH, ban the casting of proxy votes in committee;

SIXTH, require committee meetings to be open to the public;

SEVENTH, require a three-fifths majority vote to pass a tax increase;

EIGHTH, guarantee an honest accounting of our Federal Budget by implementing zero base-line budgeting.

Thereafter, within the first 100 days of the 104th Congress, we shall bring to the House Floor the following bills, each to be given full and open debate, each to be given a clear and fair vote and each to be immediately available this day for public inspection and scrutiny.

1. THE FISCAL RESPONSIBILITY ACT

A balanced budget/tax limitation amendment and a legislative line-item veto to restore fiscal responsibility to an out-of-control Congress, requiring them to live under the same budget constraints as families and businesses.

2. THE TAKING BACK OUR STREETS ACT

An anti-crime package including stronger truth-in-sentencing, "good faith" exclusionary rule exemptions, effective death penalty provisions, and cuts in social spending from this summer's "crime" bill to fund prison construction and additional law enforcement to keep people secure in their neighborhoods and kids safe in their schools.

3. THE PERSONAL RESPONSIBILITY ACT

Discourage illegitimacy and teen pregnancy by prohibiting welfare to minor mothers and denying increased AFDC for additional children while on welfare, cut spending for welfare programs, and enact a tough two-years-and-out provision with work requirements to promote individual responsibility.

4. THE FAMILY REINFORCEMENT ACT

Child support enforcement, tax incentives for adoption, strengthening rights of parents in their children's education, stronger child pornography laws, and an elderly dependent care tax credit to reinforce the central role of families in American society.

5. THE AMERICAN DREAM RESTORATION ACT

A \$500 per child tax credit, begin repeal of the marriage tax penalty, and creation of American Dream Savings Accounts to provide middle class tax relief.

6. THE NATIONAL SECURITY RESTORATION ACT

No U.S. troops under U.N. command and restoration of the essential parts of our national security funding to strengthen our national defense and maintain our credibility around the world.

7. THE SENIOR CITIZENS FAIRNESS ACT

Raise the Social Security earnings limit which currently forces

seniors out of the work force, repeal the 1993 tax hikes on Social Security benefits and provide tax incentives for private long-term care insurance to let Older Americans keep more of what they have earned over the years.

8. THE JOB CREATION AND WAGE ENHANCEMENT ACT

Small business incentives, capital gains cut and indexation, neutral cost recovery, risk assessment/cost-benefit analysis, strengthening the Regulatory Flexibility Act and unfunded mandate reform to create jobs and raise worker wages.

9. THE COMMON SENSE LEGAL REFORM ACT

"Loser pays" laws, reasonable limits on punitive damages and reform of product liability laws to stem the endless tide of litigation.

10. THE CITIZEN LEGISLATURE ACT

A first-ever vote on term limits to replace career politicians with citizen legislators.

Further, we will instruct the House Budget Committee to report to the floor and we will work to enact additional budget savings, beyond the budget cuts specifically included in the legislation described above, to ensure that the Federal budget deficit will be less than it would have been without the enactment of these bills.

Respecting the judgment of our fellow citizens as we seek their mandate for reform, we hereby pledge our names to this Contract with America.

For more information, call 1-800-742-2662, effective Wednesday, September 28, 1994.