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Acceptance of the Howland Award

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I am deeply honored to be a recipient of the John Howland Award, and I am doubly honored to share the 1991 medal with Dr. Roland Scott. He has truly been a pioneer, providing leadership to all of us in academic medicine, and a champion for all children in our nation's capital.

I can well remember my first Howland medal ceremony some 40 years ago at Buck Hill Falls. Over the subsequent decades, I have been privileged to work with the true giants of pediatrics, and I am deeply indebted to them—Powers and Darrow at Yale; Gordon, Wilkins, Taussig, and Harrison at Johns Hopkins—All Howland awardees.

The scores of faculty with whom I have been associated—at Yale, Hopkins, Wisconsin, and Buffalo—have fulfilled my requirement for a good chairman, namely that they all surpassed their chairman in their endeavors. I also must recognize the support of my administrative associates, Gloria Freeman and Fran Davis at Hopkins and Lucy Binkowski at Buffalo.

The people to whom I owe most, however, are my house officers—superior persons, the best of our society—attracted by the splendid institutions where I have worked. Almost without fail, each resident has become a leader in pediatric practice or in academic medicine.

Saul Brusilow, one of those stars, has been uncharacteristically generous in his remarks, and I am deeply grateful to him. He has referred to my public policy accomplishments, and I will allude to them briefly to make clear how easy such accomplishments were in the 1960s and to whom the credits really belong.

The details of the creation of NICHD have been described elsewhere at its 25th anniversary. Briefly, NICHD resulted from our proposal, made while I was a member of the five-person transition task force, chaired by the late Wilbur Cohen, that worked from election day to mid-December 1960 to develop the health and welfare agenda for the next 4 years. My presence on that task force was the doing of Eunice Kennedy Shriver, who hoped for specific recommendations on behalf of children and persons with mental retardation.

NIH research on problems associated with childhood were, at that time, relegated to one study section—human embryology and development—dominated by obstetrics and with a relatively small amount of money to allocate.

The proposal to create a national institute for child health was accepted by President Kennedy with enthusiasm to enhance the youthful image of his administration as a counter to the emphasis on medical care for the elderly, namely medicare.

After personal visits to the two czars of health legislation—Senator Lester Hill of Hill Burton fame and Congressman John Fogarty, the Rhode Island bricklayer—with Eunice Shriver, the Congress approved overwhelmingly the creation of NICHD over the objections of the Director of NIH, Jim Shannon.

Similarly, the creation of the University Affiliated Facilities was accomplished quite easily, again with the support of Eunice Shriver. Their origin has been described at several UAF anniversaries. Clearly, without Eunice Shriver's influence in the White House our creative notion would have had no realization.

As you know, many people have been credited with the creation of Head Start. My role as architect of Head Start, as organizer and chairman of the steering committee that created Head Start, would have meant nothing without the leadership of Sargent Shriver, the Director of the Office of Economic Opportunity. Head Start would still be a pilot program instead of being the most successful social experiment of the 20th century if he had not insisted that we launch a full-scale national effort in the summer of 1965.

Despite the significant accomplishments of NICHD over the past 27 years and the excellent leadership now provided by Duane Alexander, despite the success of the UAPS and Head Start, I must express concern that research on the problems of children has not kept pace with its adult counterpart. When I left Hopkins in 1963, the research budget of the Department of Pediatrics exceeded that of the Department of Medicine, and it was my hope that pediatric departments everywhere would achieve parity with adult medicine. Needless to say, that has not occurred.

In fiscal year 1990, NICHD expended $442 million—a substantial increase from the $24 million allocated in 1964—however, $28 million of that 1990 sum was for AIDS research and $135 million was earmarked for population research, leaving only $279 million for research on the problems of mothers and children.

By contrast, departments of medicine in fiscal year 1990 received $1 billion 39 million for 3953 projects, plus an additional $237 million from the Veterans Administration, while departments of pediatrics received only $196 million for 886 projects—fewer funded projects than departments of pathology! The Veterans Administration departments alone received 25% more funding than pediatrics, plus full support of staff—the second department of medicine and surgery in almost every medical school. In the past decade, funds for research on mothers and children have remained at approximately 3% of the NIH budget, with none of the growth expected for new areas of research and in light of the alleged importance of children in our society.

At the same time, federal service programs for children—Medicaid, MCH, WIC, PL 95-142, and PL 99-457—plus new authorizations and appropriations amounted to $31.7 billion for 1990 and $39.8 billion for 1991. Even more Medicaid dollars will flow in the future as Congress and the states raise, or consider raising, Medicaid eligibility for children to 185% or more of the poverty level as a panacea for child health.

Clearly, I am not opposed to increases in service programs, especially for poor, minority, and handicapped children. It is, however, important to realize that research funding has increased nowhere near as rapidly. As an example, Head Start alone has increased from $40 million to over $1 billion with only modest increases in funds for the study of child development.

Why then has pediatric research not kept pace? What has handicapped child research?

The answer is simple—money! The explanation, however, is more complex than just a shortage of NICHD dollars.

With the regrettable disappearance of the academic full, full-time system, the incomes of the "high rolling," procedure-related, specialty physicians have increased enormously. To keep up even marginally, pediatric dependence on practice income has become greater and greater over the past two decades.

Unfortunately, a large share of that income for pediatrics has come from Medicaid, with its professional fees in many states being only a fraction of professional fees for the same services

from Medicare. Thus, many academic departments of pediatrics have drowned in Medicaid patients, realizing only a fraction of the salaries of the physicians who provide care. At the same time, pediatric subspecialty care has appropriately proliferated as knowledge and technology have exploded. Thus, the resources of departments of pediatrics have been stretched further and further to provide quality clinical services in all necessary areas.

All of these factors have been compounded by a policy of the American boards and accrediting agencies—which I disagree with strongly—namely, that fellowship training in each subspecialty requires a flourishing research program in each subspecialty, thereby creating an even greater dilution of resources. To my mind, the boards exist to protect the public from incompetent practitioners, not to promote creativity. As a result, many departments exist with several one- or two-member divisions, except for a few very large pediatric centers that command most of the pediatric research dollars. These small divisions, burdened by a large service load, provide little competition for research funding to five- to 15-member divisions in the same subspecialty in adult departments.

In addition, the relatively meager supply of practice funds, except in neonatology, and relatively flat university and/or hospital support have limited the recruitment of Ph.D.s in large numbers to participate in pediatric research, except in large centers. In 1990, 34% of all research funds from NIH to clinical departments, especially adult medicine and surgery, went to Ph.D. investigators as contrasted with 20% in 1975. It is not surprising then that the two Mead Johnson awardees, quite deservedly, for 1991 are Ph.D.s from large institutions.

To compound matters further, the pool of potential pediatric researchers is reduced significantly because many of the best and brightest residents prefer motherhood to research careers. Roughly 50–60% of graduating pediatric residents are women, yet female principal investigators make up only 14% of principal investigators supported by NIH—an encouraging increase from 6.7% 10 years ago, but still nowhere near enough. Many of these excellent female residents feel that their male counterparts in research devote 150% effort to research at the expense of their families. My little daughters, Susan and Annie, at my 70th birthday party reminded me that MD stands for "My Daddy" as well as medical doctor. Unfortunately, too many of us males lose sight of that fact, yet we must remain competitive to receive any funding at all!

Is there anything that can be done to correct the problems that I have identified? Limited time permits only limited answers: *1*) To increase the pool of female researchers, a recent conference at NIH concluded that research training for women be extended part time and that better maternity leave be provided. To these measures I would add that subsidized day care for infants of female fellows and junior faculty be made part of institutional overhead as it is in defense contracts. *2*) The boards and accrediting groups in pediatrics should encourage a single departmental basic science fellowship training program for all fellowship training. This would result in an enormous savings of scarce resources and avoidance of unnecessary duplication. The quality of that program would influence approval or disapproval of the individual training programs. *3*) Medicaid fees should be put on a relative value scale comparable to Medicare professional fees. Medicaid's original purpose was to provide equal access to quality care regardless of income. Inadequate professional reimbursement vitiates that goal! *4*) Medical schools should increase the support of Ph.D.s in departments of pediatrics to balance the Veterans Administration support of adult departments. Ph.D.s in clinical departments should receive the same opportunities for promotion to tenure as their M.D. associates. *5*) The most important need by far represents a major public policy change, but one espoused uniformly by capitalist industry—namely, the indexing of research dollars to service dollars not program by program but in the aggregate. In industry, it is abundantly clear that corporations that do not support research and development in relation to production do not remain productive. The child health and child development industry is no exception. *6*) Finally, the dream I have had since the days of the new frontier and the great society is that a super agency for children at the Cabinet or sub-Cabinet level be created so that the power of a Martha Elliott of the old Children's Bureau could truly be felt as it was then in the White House and in Congress.

Who will carry these banners, who will be in the right place, at the right time, with the right ideas and the right friends in power? This is the challenge I leave with you.

And now, I thank you all for this final honor from the bottom of my heart!