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COMMUNICABLE DISEASE CONTROL

GOVERNMENT

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HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON

LABOR AND PUBLIC WELFARE

UNITED STATES SENATE

NINETY-FIRST CONGRESS

FIRST SESSION

ON

S. 2264

TO AMEND THE PUBLIC HEALTH SERVICE ACT TO PROVIDE
AUTHORIZATION FOR GRANTS FOR COMMUNICABLE
DISEASE CONTROL

S. 1622

VACCINATION ASSISTANCE ACT OF 1969

JUNE 30, 1969

Printed for the use of the
Committee on Labor and Public Welfare



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COMMUNICABLE DISEASE CONTROL

MONDAY, JUNE 30, 1969

U.S. SENATE,
SUBCOMMITTEE ON HEALTH OF THE
COMMITTEE ON LABOR AND PUBLIC WELFARE,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:30 a.m., in room 4232, New Senate Office Building, Senator Ralph Yarborough (chairman of the subcommittee) presiding.

Present: Senators Yarborough (presiding), Kennedy, Hughes and Dominick.

Committee staff present: John Forsythe, general counsel; James Babin, professional staff member; and Jay Cutler, minority counsel.

The CHAIRMAN. The Subcommittee on Health of the Committee on Labor and Public Welfare will come to order.

I have called a hearing today to consider two bills, the Vaccination Assistance Act of 1969, S. 1622, introduced by Senator Kennedy, and the Communicable Disease Control Amendments of 1969, S. 2264, which I have introduced.

(The text of the bills appears on p. 3.)

The CHAIRMAN. In January of this year, the findings of the National Nutrition Study, which sampled 1,000 preschool children in poverty areas of Texas, reported that: nearly one-half had not completed the DPT series for protection against diphtheria, whooping cough, and tetanus; only 43 percent had been protected against polio; 56 percent had not received smallpox inoculations; 61 percent had not received a measles injection.

I use these figures on Texas because these are the most recent statistics which are available to the committee at this time, and the only State from which we had such a survey. I am not discriminating for or against my own home State. Merely, this is the only one which we could find data from and we welcome it from any other State. I feel that ours is fairly representative of the other States in the Union.

Furthermore, the fact that only one-half of the preschool children in poverty areas are now vaccinated against polio should be evidence enough that much more needs to be done.

German measles is another communicable disease that can be prevented with a vaccine. A vaccine for German measles has just recently been licensed. It is estimated that there are now some 50 million children who need protection. To succeed, we will need a program which is more than of just 1 year or 2 years duration.

Unfortunately, last year the Vaccination Assistance Act was allowed to lapse on the recommendation of the administration. This year the situation will become more serious if the Department of Health, Edu-

cation, and Welfare is successful in its plan to seriously weaken the tuberculosis control program.

Control of tuberculosis has been improving, but it is doubtful that this progress will continue under the 1970 budget amendments pertaining to tuberculosis control submitted by the Department of Health, Education, and Welfare. These budget amendments would eliminate \$18 million in project grants for the control of tuberculosis, venereal diseases, and alcoholism.

Although it can be argued that all States need a certain minimum level of funding for the control of tuberculosis, the wide range in incidence rates for tuberculosis among the States makes it apparent that the Federal investment in combating this communicable disease should not be entirely allocated on the basis of population and financial need. The same principle applies with respect to venereal diseases. That is why the bill that I introduced, the Communicable Disease Control Amendments of 1969, would give recognition to the geographical incidence of communicable diseases in the allocation of funds for their eradication.

In other words, it would permit the placing of more moneys where the danger is greatest.

Medical authorities point that the immunization problem is susceptible to vigorous action. If that action is to be effective, it is essential that we have national leadership and a national commitment to combat those communicable diseases that can be prevented or controlled.

If the Federal financial assistance for vaccinations against polio, diphtheria, measles, and other diseases that can be prevented or controlled is abolished, we can expect needless suffering and death. Furthermore, if the funds for the control of tuberculosis are misallocated, we will further widen the health gap. If we have the medical knowledge to prevent illness, our only responsible course of action is to take the steps that are required to secure its application. In this case, I believe the action that is required is the enactment of the Communicable Disease Control Amendments of 1969.

The CHAIRMAN. Senator Kennedy.

STATEMENT OF HON. EDWARD M. KENNEDY, A U.S. SENATOR FROM THE STATE OF MASSACHUSETTS

Senator KENNEDY. Thank you very much, Mr. Chairman.

Today, the Senate Subcommittee on Health opens hearings on a number of legislative proposals of major importance in our continuing efforts to eradicate infectious disease in America. The Vaccination Assistance Act has proved to be a measure of vital significance in these efforts, and I am hopeful that the Congress will extend its provisions for another 5 years.

In the few brief years of its existence, the act has enabled the Federal Government to join in partnership with State and local governments throughout the Nation in a wide variety of successful immunization programs. The cost of these programs has been modest. Yet, they have already saved millions of dollars in medical expenses that would otherwise have been paid by our citizens and the Nation in providing health care for the victims of a broad range of infectious childhood and other diseases.

In February 1962, when President Kennedy first proposed the

S. 2264

IN THE SENATE OF THE UNITED STATES

MAY 27, 1969

Mr. YARBOROUGH introduced the following bill; which was read twice and referred to the Committee on Labor and Public Welfare

A BILL

To amend the Public Health Service Act to provide authorization for grants for communicable disease control.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That this Act may be cited as the "Communicable Disease
4 Control Amendments of 1969".

5 GRANTS FOR COMMUNICABLE DISEASE CONTROL

6 SEC. 2. Section 361 of the Public Health Service Act
7 (42 U.S.C. 264) is amended by inserting at the end thereof
8 the following new subsection:

9 "(e) (1) There are hereby authorized to be appropri-
10 ated \$60,000,000 for the fiscal year ending June 30, 1970,
11 and \$75,000,000 for the fiscal year ending June 30, 1971,

1 and for each fiscal year thereafter, to enable the Secretary
2 to make grants to States and, with the approval of the State
3 health authority, to political subdivisions or instrumental-
4 ties of the States under this subsection. In the award of
5 such grants the Secretary, in accordance with appropriate
6 regulations, shall give consideration to the relative extent
7 of the communicable disease problems and to the levels of
8 performance in preventing and controlling such diseases.
9 Such grants may be used to pay that portion of the cost of
10 communicable disease control programs which is reasonably
11 attributable to (A) purchase of vaccines or other agents
12 needed to protect those portions of the population determined
13 to be epidemiologically important to the control or preven-
14 tion of communicable diseases and (B) salaries and related
15 expenses of additional State and local health personnel
16 needed for planning, organizational, promotional, and other
17 epidemiologic activities in connection with such programs,
18 including studies to determine the communicable disease con-
19 trol needs of communities and the means of best meeting
20 such needs and personnel and related expenses needed to
21 maintain additional epidemiologic and laboratory surveil-
22 lance occasioned by such programs.

23 “(2) For the purposes of this subsection—

24 “(A) a ‘communicable disease control program’ means
25 a program which is designed and conducted so as to con-

1 tribute to a nationwide effort against tuberculosis, venereal
2 disease, rubella, measles, poliomyelitis, diphtheria, tetanus,
3 whooping cough and other communicable diseases which
4 are transmitted from State to State, are amenable to reduc-
5 tion, and which are determined by the Secretary on the
6 recommendation of the National Advisory Health Council
7 to be of national significance, and

8 “(B) the term ‘State’ includes the Commonwealth of
9 Puerto Rico, Guam, American Samoa, the Trust Territory
10 of the Pacific Islands, the Virgin Islands, and the District
11 of Columbia.

12 “(3) Payments under this subsection may be made
13 in advance on the basis of estimates or by way of reimburse-
14 ment, with necessary adjustments on account of underpay-
15 ments, or overpayments, in such installments and on such
16 terms and conditions as the Secretary finds necessary to
17 carry out the purposes of this subsection.

18 “(4) The Secretary, at the request of a recipient of
19 a grant under this subsection, may reduce the money grant
20 to such recipient by the fair market value of any supplies
21 (including vaccines and other preventive agents), or equip-
22 ment furnished to such recipient and by the amount of the
23 pay, allowances, traveling expenses, and any other costs
24 in connection with the detail of an officer or employee to
25 the recipient when the furnishing of such supplies or equip-

1 ment, or of the detail of such officer or employee (as the
2 case may be), is for the convenience of and at the request
3 of such recipient and for the purpose of carrying out the
4 program with respect to which the grant under this sub-
5 section is made. The amount by which any such grant is
6 so reduced shall be available for payment by the Secretary
7 of the costs incurred in furnishing the supplies, equipment,
8 or personal services on which the reduction of such grant
9 is based, but such amount shall be deemed a part of the
10 grant to such recipient and shall, for the purposes of para-
11 graph (3) of the subsection, be deemed to have been paid
12 to such agency.

13 “(5) Nothing in this subsection shall limit or otherwise
14 restrict the use of funds which are granted to a State or to
15 a political subdivision of a State under other provisions of
16 this Act or other Federal law and which are available for
17 the conduct of communicable disease control programs from
18 being used in connection with programs assisted through
19 grants under this subsection.

20 “(6) Under this subsection, the Secretary shall be re-
21 quired to submit an annual report on performance in pre-
22 venting and controlling communicable diseases.”

S. 1622

IN THE SENATE OF THE UNITED STATES

MARCH 20, 1969

Mr. KENNEDY (for himself and Mr. STEVENS) introduced the following bill;
which was read twice and referred to the Committee on Labor and Public
Welfare

A BILL

Vaccination Assistance Act of 1969.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That this Act may be cited as the "Vaccination Assistance
4 Act of 1969."

5 SEC. 2. Effective July 1, 1969, subsection (a) of sec-
6 tion 317 of the Public Health Service Act is amended to
7 read as follows:

8 “(a) There are hereby authorized to be appropriated
9 \$15,000,000 for the fiscal year ending June 30, 1970, and
10 for each of the next four fiscal years, to enable the Secretary
11 to make grants to the States and, with the approval of the
12 State health authority, to political subdivisions of instrumen-

1 talities of the States under this section. Amounts appropriated
2 pursuant to this section for any fiscal year ending prior to
3 July 1, 1975, shall be available for making such grants dur-
4 ing the fiscal year for which appropriated and the succeeding
5 fiscal year. Such grants may be used to pay that portion of
6 the cost of immunization programs against poliomyelitis
7 diphtheria, whooping cough, tetanus, measles, and rubella
8 which is reasonably attributable to (1) purchase of vaccines
9 needed to protect such groups of children as may be described
10 in regulations of the Secretary upon his finding that they are
11 not normally served by school vaccination programs, and (2)
12 salaries and related expenses of additional State and local
13 health personnel needed for planning, organizational, and
14 promotional activities in connection with such programs,
15 including studies to determine the immunization needs of
16 communities and the means of best meeting such needs, and
17 personnel and related expenses needed to maintain addi-
18 tional epidemiologic and laboratory surveillance occasioned
19 by such programs. Such grants may also be used to pay simi-
20 lar costs in connection with immunization programs against
21 any other disease which the Secretary finds represents a
22 major public health problem in terms of high mortality,
23 morbidity, disability, or epidemic potential and to be sus-
24 ceptible of practical elimination as a public health problem
25 through immunization with vaccines or other preventive
26 agents which may become available in the future."

Vaccination Assistance Act in his special message to the Congress on national health, he said:

"There is no longer any reason why American children should suffer from polio, diphtheria, whooping cough, or tetanus—diseases which can cause death or serious consequences throughout a lifetime, which can be prevented, but which still prevail in too many cases."

When the Vaccination Assistance Act was signed into law in October 1962, the Nation launched a massive immunization campaign against many of the infectious diseases that had plagued the Nation for so long. In the past 6 years, the act has brought immense protection to millions of American children threatened by the suffering, disability, and death brought by these diseases. It has brought continuing protection for children against tetanus, diphtheria, and whooping cough. It has helped to assure the virtual eradication of polio in the Nation, and it has played a major role in the dramatic reduction of the incidence of measles.

In spite of the progress we have made, it is clear that we have not yet accomplished our goals. Therefore, the present hearings on the Vaccination Assistance Act are especially timely. I am convinced that its provisions deserve to be renewed, and I am hopeful that these hearings will help to illuminate the areas where special new efforts must be made.

In my prepared statement, which I am submitting for the record, I have concentrated primarily on the disease of measles in an effort to highlight the long range need for extension of the Vaccination Assistance Act. I would like to make clear, however, that I believe there are numerous other areas where the provisions of the act could be vital in helping to control or eliminate disease. In closing, I would like to discuss briefly two other examples:

First, in the case of Rh hemolytic disease, recent reports indicate that 25 percent of the pregnant women who should be protected are still not being reached by the new antibody vaccine recently developed by medical researchers. Yet we know that the vaccine has been totally effective in preventing the disease wherever it has been used.

Second, in the case of rubella, or German measles, numerous medical experts across the country have stated that we face the prospect of a severe epidemic in 1970 or 1971. Today in the United States, 50 million children and child-bearing women are unprotected against rubella. Unless adequate precautions are taken to prevent the disease, thousands of children will be born blind, deaf, or with heart defects or mental retardation because their mothers contracted this disease during pregnancy. At the recent International Conference on Rubella Immunization, it was estimated that the eventual cost of the epidemic to the U.S. economy would total over \$3 billion.

As in the case of common measles, German measles can be eliminated through an effective immunization campaign of the sort that could be mounted under the Vaccination Assistance Act. Indeed, the imminence of the approaching rubella epidemic offers what I believe may be the strongest immediate argument for extending the act. We simply cannot afford to gamble with the health of millions of our Nation's children by failing to protect them in the most effective pos-

sible way. The Vaccination Assistance Act has demonstrated its value time and again in recent years as a method of providing mass community protection against disease. It is therefore the most obvious available tool to press into service to combat the anticipated rubella epidemic.

Unless the provisions of the Vaccination Assistance Act are carried forward, I do not believe that we will be able to eradicate common measles from America or prevent the epidemic of German measles. Unless the act is extended I do not believe that we will be able to continue the enormous progress we have made against the Rh disease and other diseases in recent years.

Under ideal circumstances, it might be possible for other Federal programs providing comprehensive health care to take over the immunization programs contained in the Vaccination Assistance Act. It appears, however, that priorities have already been established for these other programs. I am skeptical that they are flexible enough to allow inclusion of the immunization programs. The possibility of expanding other Federal programs in this way has been available for some time. Yet, little action has been taken. In many parts of the country, it is the States themselves who refuse to give adequate priority to far-reaching vaccination programs.

Infectious diseases in our society have no geographic boundary. They concern the health and economy of the entire Nation, and it is our obligation to see that every available effort is made to eradicate them. I welcome these hearings as a means of bringing fresh attention to these urgent problems. I commend the chairman for his important efforts in this vital field, and I look forward to early enactment of comprehensive legislation to achieve our goals.

(The complete prepared statement of Senator Kennedy, referred to above, follows:)

PREPARED STATEMENT OF HON. EDWARD M. KENNEDY, A U.S. SENATOR FROM THE STATE OF MASSACHUSETTS

Today, the Senate Subcommittee on Health opens hearings on a number of legislative proposals of major importance in our continuing efforts to eradicate infectious disease in America. The Vaccination Assistance Act has proved to be a measure of vital significance in these efforts, and I am hopeful that the Congress will extend its provisions for another five years.

In the few brief years of its existence, the Act has enabled the Federal Government to join in partnership with State and local governments throughout the nation in a wide variety of successful immunization programs. The cost of these programs has been modest. Yet, they have already saved millions of dollars in medical expenses that would otherwise have been paid by our citizens and the nation in providing health care for the victims of a broad range of infectious childhood and other diseases.

In February, 1962, when President Kennedy first proposed the Vaccination Assistance Act in his special Message to the Congress on National Health, he said:

"There is no longer any reason why American children should suffer from polio, diphtheria, whooping cough, or tetanus—diseases which can cause death or serious consequences throughout a lifetime, which can be prevented, but which still prevail in too many cases."

When the Vaccination Assistance Act was signed into law in October 1962, the nation launched a massive immunization campaign against many of the infectious diseases that had plagued the nation for so long. In the past six years, the Act has brought immense protection to millions of American children threatened by the suffering, disability, and death brought by these diseases. It has brought continuing protection for children against tetanus, diphtheria, and

whooping cough. It has helped to assure the virtual eradication of polio in the nation, and it has played a major role in the dramatic reduction of the incidence of measles.

In spite of the progress we have made, it is clear that we have not yet accomplished our goals. Therefore, the present hearings on the Vaccination Assistance Act are especially timely. I am convinced that its provisions deserve to be renewed, and I am hopeful that these hearings will help to illuminate the areas where special new efforts must be made.

For the purposes of illustration, I would like to place special attention in this statement on our efforts to eradicate measles. Between 1965 and the present time, the use of measles vaccine has brought about the following dramatic results in the United States:

15 million children were spared from infection by measles.

The incidence of the disease dropped from 140 cases per 100,000 population to only 12 cases per 100,000 population.

91,000 children were spared from hospitalization with measles.

15,000 children were spared from encephalitis caused by measles.

5,000 children were spared mental retardation caused by measles.

1,500 children were spared from death.

The American medical profession deserves our highest commendation for this achievement, which has reduced the incidence of measles by over 90% since the vaccine first became available.

Through the efforts of our dedicated private practitioners and public health officers, our progress toward the eradication of measles has been faster than with diphtheria, tetanus, whooping cough, or even polio. I believe that the federal funding of State and local immunization projects through the Communicable Disease Center of the U.S. Public Health Service has made the difference, and has brought about the remarkable decline in the incidence of the disease. Unfortunately, however, the rate of decline halted abruptly at the end of 1968, and has recently begun to show a slight increase in the nation as a whole, with substantial increases in 17 states. To me, it is more than a coincidence that the three-year decline in the incidence of measles came to a halt just as funds for the Vaccination Assistance Act were depleted last year.

We know today that our efforts to eradicate measles have not been completely successful. The figure I have mentioned—12 cases per 100,000 population—translates into 24,000 cases of measles in the United States this year. According to information in the most recently available Morbidity and Mortality Report of the Public Health Service, the number of reported cases of measles for the first half of 1969 is 17,270 cases, or slightly more than for the same period in 1968.

For all practical purposes, diphtheria, tetanus, and polio have been eradicated in the United States, since they now number less than 200 cases per year for each disease. We cannot say the same thing about measles, when 22,500 cases were reported in 1968, and 24,000 cases are anticipated in 1969. The job simply is not finished.

Indeed, on the basis of our past experience, we know that the actual number of cases of measles in the nation is over ten times the number of reported cases. This means that in 1969, about 250,000 children will develop measles. As a result of the disease, in 1969 alone,

1,500 children will be hospitalized for a total of 14,250 hospital days.

250 will develop encephalitis.

80 will be permanently retarded.

25 will die.

In addition, some 375,000 school days will be lost during 1969, because of measles, and the illness will cost our economy more than \$12 million in treating its effects.

In this brief statement, I have concentrated primarily on the disease of measles in an effort to highlight the long-range need for extension of the Vaccination Assistance Act. I would like to make clear, however, that I believe there are numerous other areas where the provisions of the Act could be vital in helping to control or eliminate disease. In closing I would like to discuss briefly two other examples:

First, in the case of Rh hemolytic disease, recent reports indicate that 25% of the pregnant women who should be protected are still not being reached by the new antibody vaccine recently developed by medical researchers. Yet we know that the vaccine has been totally effective in preventing the disease wherever it has been used.

Second, in the case of rubella, or German measles, numerous medical experts across the country have stated that we face the prospect of a severe epidemic in 1970 or 1971. Today in the United States, 50 million children and child-bearing women are unprotected against rubella. Unless adequate precautions are taken to prevent the disease, thousands of children will be born blind, deaf, or with heart defects or mental retardation because their mothers contracted this disease during pregnancy. At the recent International Conference on Rubella Immunization, it was estimated that the eventual cost of the epidemic to the United States economy would total over three billion dollars.

As in the case of common measles, German measles can be eliminated through an effective immunization campaign of the sort that could be mounted under the Vaccination Assistance Act. Indeed, the imminence of the approaching rubella epidemic offers what I believe may be the strongest immediate argument for extending the Act. We simply cannot afford to gamble with the health of millions of our nation's children by failing to protect them in the most effective possible way. The Vaccination Assistance Act has demonstrated its value time and again in recent years as a method of providing mass community protection against disease. It is therefore the most obvious available tool to press into service to combat the anticipated rubella epidemic.

Unless the provisions of the Vaccination Assistance Act are carried forward, I do not believe we will be able to eradicate common measles from America or prevent the epidemic of German measles. Unless the Act is extended I do not believe we will be able to continue the enormous progress we have made against the Rh disease and other diseases in recent years.

Under ideal circumstances, it might be possible for other federal programs providing comprehensive health care to take over the immunization programs contained in the Vaccination Assistance Act. It appears, however, that priorities have already been established for these other programs, I am skeptical that they are flexible enough to allow inclusion of the immunization programs. The possibility of expanding other federal programs in this way has been available for some time. Yet, little action has been taken. In many parts of the country, it is the States themselves who refuse to give adequate priority to far-reaching vaccination programs.

Infectious diseases in our society have no geographic boundary. They concern the health and economy of the entire nation, and it is our obligation to see that every available effort is made to eradicate them. I therefore welcome these hearings as a means of bringing fresh attention to these urgent problems. I commend the Chairman for his important efforts in this vital field, and I look forward to early enactment of comprehensive legislation to achieve our goals.

The CHAIRMAN. Thank you, Senator Kennedy, for that very perceptive and forceful statement. It is very well documented. It will be of great help to us in these hearings. We know of your great interest in this subject of health. You have been diligent in attendance of the health hearings.

The staff, without having made any hideous comparisons, tells me that you have attended more hearings than any other Senator except the chairman, whose duty it is to be here. We are grateful for that. And we appreciate your strong leadership and strong, very effective work in these fields.

Senator Dominick.

Senator DOMINICK. Thank you, Mr. Chairman. You and Senator Kennedy have proposed bills relating to areas of concern to the entire health community. I am interested in listening to these hearings. One of the things we are facing is the question of whether we should proceed on a categorical grant basis or whether we should proceed on a block grant basis. From the indication given in your opening statement, I take it we only have information on one State as to what it has or has not done in the way of immunization programs. If this is true, and we go ahead on the basis of taking care of those States which have not opted to do the immunization program, then are we not in fact reward-

ing those who have not gone forward and penalizing these who have. This is one factor that I think we are going to have to take a look at in the process of the hearing.

I obviously share your desire and that of Senator Kennedy to provide the best medical care we can, and I will continue to advocate whatever aid and assistance is necessary to achieve sound programs.

The CHAIRMAN. Senator Dominick, I am advised that the Public Health Service has made surveys in some other areas, but this one I read from my own State is the only one released. And before the hearings are completed, before the record is closed, I hope that we can get whatever data they have for all parts of the country or whatever parts have been completed and released.

Thank you very much.

Senator Hughes.

Senator HUGHES. No statement to make, Senator.

The CHAIRMAN. The first witness this morning is Dr. William Stewart, Acting Assistant Secretary of Health, Education, and Welfare for Health and Surgeon General. We welcome you back, Dr. Stewart. You have testified very effectively before this committee many times, and your testimony has aided us in pushing the cause of health for the American people. We welcome you here. Will you introduce those accompanying you, please.

STATEMENT OF DR. WILLIAM STEWART, ACTING ASSISTANT SECRETARY, HEW, FOR HEALTH, SURGEON GENERAL; ACCOMPANIED BY IRVING LEWIS, ADMINISTRATOR, HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION, AND DR. DAVID SENCER, DIRECTOR, NATIONAL COMMUNICABLE DISEASE CENTER

Dr. STEWART. Thank you, Mr. Chairman. On my left is Mr. Irving Lewis, the Deputy Administrator of the Health Services and Mental Health Administration of the Public Health Service, and on my right is Dr. David Sencer, the Director of the National Communicable Disease Center of the Public Health Service.

The CHAIRMAN. Dr. Stewart, you are very knowledgeable in proceedings here and in testimony, so we invite you to proceed in your own way.

Dr. STEWART. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, I am happy to appear before you this morning to present the views of our Department on the objective and provisions of two related bills—S. 1622 and S. 2264—which would authorize Federal project grants to assist States and communities in financing certain communicable disease control activities.

S. 1622, the Vaccination Assistance Act of 1969, would extend, with minor changes, the provisions of section 317 of the Public Health Service Act, which until recently provided the special authority for project grants to States and communities for intensive immunization programs against such communicable diseases as poliomyelitis and measles. The proposed extension would be for a 5-year period, fiscal years 1970 through 1974, with appropriations of \$15 million authorized

for each year. The only other proposed changes in section 317 would be the specific mention of rubella and the deletion of certain limitations on the age groups of children eligible for vaccines purchased with Federal grant funds.

S. 2264, the Communicable Disease Control Amendments of 1969, would add a new subsection to section 361 of the Public Health Service Act to authorize project grants to States and local agencies for the support of various communicable disease control programs. The grant authority contained in this new subsection would embrace all of the purposes covered by the provision of S. 1622, and in most respects the language of this proposed authority parallels the present language of section 317. It differs from section 317 in two major respects, however. First, it would not be limited to grants for immunization programs, but would also authorize grants for communicable disease programs—such as tuberculosis and venereal disease control—for which measures other than immunization are employed. Second, the proposed grant authorization would be a continuing one, with appropriations of \$60 million for fiscal 1970 and \$75 million for fiscal 1971 and for each fiscal year thereafter. In addition, while the provisions of the bill are not explicit on this point, S. 2264 apparently contemplates that most Federal aid under the PHS Act for State and local communicable disease control activities would be in the form of project grants awarded on the basis of the relative extent of communicable disease problems and of "level of performance," rather than formula grants allotted among the States on the basis of population and relative financial need.

We believe that our present grant authorities in section 314 of the PHS Act—commonly known as the partnership for health grants—are adequate to cover all of the purposes for which grants would be authorized under either S. 1622 or S. 2264. We further believe it would be most unwise to initiate any new categorical grant authorizations for purposes which are now covered by existing formula and project grant authorizations.

In view of the recent legislative histories of the acts which achieved and extended this consolidation of many separate categorical grant authorities—particularly Public Law 89-174—I shall not attempt at this time any restatement of the case for consolidated grant authorities or any review of the complication of Federal, State, and local budget and accounting procedures which result from the proliferation of categorical grant programs. The reports of your own committee on these legislative amendments, it should be noted, included excellent statements regarding the need for grant consolidation and simplification. I would like, however, to emphasize the importance of the comprehensive health planning features built into the section 314 authorizations, and to caution against the weakening of such planning provisions which would result from the enactment of new categorical grant authorizations outside the framework of section 314. This section you will recall not only authorizes special grant assistance for statewide and areawide planning agencies, but it also includes provisions requiring that health services aided by formula or project grants under subsections (d) and (e) must be in accord with plans developed by these State planning agencies.

Neither S. 1622 nor S. 2264, it should be noted, includes any reference to these planning provisions of section 314, even though both bills provide grant authorizations which substantially overlap or duplicate the purposes for which grants may now be made under section 314. Both bills specifically state in fact that nothing in their provisions shall restrict the use of grant funds under other provisions of the act, or other Federal laws, for communicable disease control purposes. However, even the inclusion of provisions requiring conformity with health plans developed pursuant to the provisions of section 314, would not overcome the basic defects of the proposed bills. The result of the enactment of these bills would be overlapping and duplicatory grant authorizations and an impairment of effective health planning. In addition to these basic objections, we are particularly concerned about the apparent purpose of S. 2264 to assure that Federal grant support for communicable disease control programs would be provided primarily through project grants. This purpose was explicitly related—in the statement accompanying the introduction of the bill—to the proposed shift in funding outlined in President Nixon's revised budget proposals for fiscal 1970. A brief explanation of the objectives and provisions of this budgeting proposal may, therefore, be helpful in explaining our reservation on this feature of the S. 2264 proposal.

Under the provisions of section 314(d), the States are able to distribute their formula grant funds among various health programs according to their own judgments as to relative needs and priorities, without regard to the former categorical restrictions. Under section 314(e), project grants are also available to help support a wide range of State and local health services, including the control of communicable diseases, where such services are part of new or innovative programs or constitute activities of special regional or national significance. From the inception of the new grant legislation it was envisioned that certain categorical programs such as tuberculosis, cancer, and venereal disease control would, over time, be shifted over from project grant to formula grant support as they matured and became widely accepted in practice. Such a shift would serve not only to correct certain rigidities in the Federal grant structure carried over, in part, from previous categorical grant authorizations, but also to support the partnership for health concept that Federal aid should strengthen rather than inhibit the authority of State and local health agencies in the planning and control of their various health programs and activities.

President Nixon's recently announced amendment to the fiscal year 1970 budget represents the first significant attempt to translate this concept into reality. That is, the President has proposed to amend the budget submitted to the Congress last January by the outgoing administration by transferring \$18 million from project to formula grants. Tuberculosis control has generally been identified as the program area which will be most directly affected by this change in funding mechanisms.

To assure that this shift in funding mechanisms will not precipitously terminate any tuberculosis project, the Health Services and Mental Health Administration of this Department will provide transitional support with section 314(e) project grant funds during the coming fiscal year. This will give the States an effective changeover

in the sources of funding with the least adverse impact on tuberculosis control programs.

Additionally, let me emphasize that tuberculosis as well as other disease or health projects which have been developed to meet demonstrated special needs and which have been approved by the State health planning agency will continue to be eligible to compete for section 314(e) funds as they have in the past.

We believe, however, that the general approach is a sound one and is consistent with the basic objectives of the partnership for health legislation—a simpler and more flexible grant structure, a broader area of program discretion at the State and local level, and more effective health planning.

In summary, Mr. Chairman, we strongly support the concepts and objectives underlying the grant consolidation represented by section 314 of the Public Health Service Act. We, therefore, believe that the appraisal of any new health grant proposals should include consideration of their relationship to the provisions and objectives of this existing authority. In our opinion, neither S. 1622 nor S. 2264 would broaden the scope of our present grant authority, and the enactment of either bill would tend to weaken and complicate the administration of our present grant structure. And we, therefore, recommend against enactment of either of these legislative proposals.

That concludes my statement. Mr. Chairman, I will be glad to answer any questions.

The CHAIRMAN. Senator Kennedy.

Senator KENNEDY. First of all, I would like to say a word of welcome to the Surgeon General, Dr. Stewart. I have had a chance in recent years to work with him on a number of different kinds of programs, and to attend a major international conference with him. I know how diligent and industrious and compassionate an individual he is. And I want to say that his testimony before this committee of any of the questions dealing with public health is extremely weighty, and that I very much appreciate his appearance here today.

What I would like to ask, Mr. Surgeon General, is whether you can give us the views of the National Communicable Disease Center concerning the effectiveness of the Vaccination Assistance Act? Can you give us some insight into their views of the Vaccination Assistance Act?

Dr. STEWART. Well, I think, Senator Kennedy, I can answer by saying in the past when the Vaccination Assistance Act was still in effect that it was a very effective measure, and similarly effective for immunization programs particularly when they related to the utilization of new vaccines, such as measles vaccines and earlier, the polio vaccine. Here it served a very useful purpose.

I think more important than that, though, it served the purpose of creating a surveillance mechanism for following these new vaccines, too. Of course, this existed before the Partnership for Health Act was in effect. I think that the mechanisms we now have are equally effective in carrying out the purposes that were formerly carried out under the Vaccination Assistance Act.

Senator KENNEDY. Of course, the Vaccination Assistance Act was a rifle shot approach, was it not, which you lose to some extent under the Partnership for Health approach?

Dr. STEWART. Yes. Earlier it specified specifically the disease; in fact, when the act was renewed the disease "measles" was specified, so that one could describe it as a rifle shot; that is correct.

Senator KENNEDY. As I understand it, the original Vaccination Assistance Act, as well as the legislation I have introduced and the legislation the Chairman has introduced, is really moving against recognized targets. It is attempting to move with some precision into what I think are really areas of great concern, particularly the area of German measles. The anticipated rubella epidemic in 1970 or 1971 is likely to wreak serious ravages upon the population of this country, and we must be sure that the precautions we take are adequate. Only last week, for example, I received a telegram from Dr. Jacob H. Fine, president of the Massachusetts Medical Society, telling me that the Vaccination Assistance Act program has been highly successful, and urging that the program be extended.

In light of this urgency, can you give us any information on how many States are presently at the point where they are able to carry on effective immunization programs under the Partnership for Health appropriations?

Dr. STEWART. No, I cannot give you any specific figures.

Dr. Sencer, do you have anything on that?

Dr. SENCER. We have the proposed project in the supplemental.

Dr. STEWART. I can say that at the present time we have 68 projects in the rubella vaccination program ready to go, and we are ready anytime the supplemental appropriation is passed. It has passed both Houses and is now in conference.

Senator KENNEDY. How many different States would participate in such projects?

Dr. STEWART. Dr. Sencer says it is in all States except one. I can give you a list if you wish, Senator Kennedy.

Senator KENNEDY. Would you supply that, please?

Can that be made a part of the record?

The CHAIRMAN. Yes. That is ordered printed as part of the record.

Senator KENNEDY. Thank you.

(The information referred to follows:)

LIST OF 68 APPROVED RUBELLA PROJECTS

Vermont State Department of Health, 115 Colchesler Avenue, Burlington, Vermont.

Connecticut State Department of Health, 79 Elm Street, Hartford, Connecticut.
Commonwealth of Massachusetts, Department of Public Health, State House, Boston, Massachusetts.

Maine Department of Health and Welfare, State House, Augusta, Maine.

New Hampshire Division of Public Health Service, Bureau of Communicable Disease Control, Concord, New Hampshire.

Rhode Island Department of Health, 40 Fountain Street—6th Floor, Providence, Rhode Island.

New Jersey State Department of Health, P.O. Box 1540, Trenton, New Jersey 08625.

Philadelphia Department of Public Health, Municipal Services Building, Room 540, 15th and John F. Kennedy Blvd., Philadelphia, Pennsylvania 19107.

City of New York, Department of Health, 125 Worth Street, New York, New York 10013.

Delaware State Board of Health, Dover, Delaware 19901.

New York State Department of Health, 84 Holland Avenue, Albany, New York 12208.

- Pennsylvania Department of Health, P.O. Box 90, Harrisburg, Pennsylvania 17120.
- Allegheny County Health Department, 620 City-County Building, Pittsburgh, Pennsylvania 15219.
- Maryland State Department of Health, 301 West Preston Street, Baltimore, Maryland.
- Virginia State Department of Health, James Madison Building, Richmond, Virginia.
- D.C. Department of Public Health, 1875 Connecticut Avenue, N.W., Washington, D.C.
- Virgin Islands Department of Health, Box 1442, St. Thomas, U.S. Virgin Islands.
- State of West Virginia Department of Health, 1800 Washington Street, East Charleston, West Virginia.
- Puerto Rico Department of Health Programs of Preventive Medicine, Ponce de Leon Avenue, Stop 18½, Santurce, Puerto Rico.
- North Carolina State Board of Health, P.O. Box 2091, Raleigh, North Carolina.
- Kentucky Department of Health, 275 East Main Street, Frankfort, Kentucky 40601.
- Mississippi State Board of Health, P.O. Box 1700, Jackson, Mississippi.
- South Carolina State Board of Health, J. Marion Sims Building, Columbia, South Carolina.
- Chattanooga—Hamilton County Health Department, Third and Hampton Streets, Chattanooga, Tennessee.
- Knox County Health Department, Cleveland Place, Knoxville, Tennessee.
- Memphis and Shelby County Health Department, 814 Jefferson Avenue, Memphis, Tennessee.
- Metropolitan Health Department, 311-23rd Avenue, Nashville, Tennessee.
- Alabama Department of Public Health, State Office Building, Montgomery, Alabama.
- Florida State Board of Health, 1217 Pearl Street, Jacksonville, Florida.
- Georgia Department of Public Health, 47 Trinity Avenue, S.W., Atlanta, Georgia.
- Chicago Board of Health, Chicago Civic Center, Chicago, Illinois.
- Illinois Department of Public Health, New State Office Building, Springfield, Illinois 62706.
- Division of Public Health of The Health and Hospital Corporation of Marion County, 1841 City-County Building, Indianapolis, Indiana 46204.
- Berrien County Health Department, Courthouse, St. Joseph, Michigan 49085.
- Detroit Department of Health, City-County Building, 2 Woodward Avenue, Detroit, Michigan 48226.
- Saginaw City Health Department, 1581 S. Washington, Saginaw, Michigan 48601.
- Ohio Department of Health, 450 East Town Street, Columbus, Ohio 43216.
- Department of Health and Social Services, Wisconsin Division of Health, Bureau of Preventable Diseases, Section of Communicable Disease Control, P.O. Box 309, Madison, Wisconsin 53701.
- City of Milwaukee Health Department, Room 112, Municipal Building, 841 North Broadway, Milwaukee, Wisconsin 53202.
- Kansas State Department of Health, State Office Building, Topeka, Kansas.
- Iowa State Department of Health, Lucas State Office Building, Des Moines, Iowa.
- Minnesota Department of Health, 717 Delaware Street, S.E., Minneapolis, Minnesota.
- South Dakota State Department of Health, Pierre, South Dakota.
- Missouri Division of Health, State Office Building, Jefferson City, Missouri.
- St. Louis Division of Health, Room 3, Municipal Courts Building, 1320 Market Street, St. Louis, Missouri 63103.
- Nebraska State Department of Health, State Capitol, Box 94757, Lincoln, Nebraska 68509.
- Kansas City Health Department, 414 East 12th Street, Kansas City, Missouri.
- State Department of Health, State Capital, Bismarck, North Dakota.
- San Antonio Metropolitan Health District, 131 West Nueva, San Antonio, Texas.
- Arkansas State Health Department, Little Rock, Arkansas.
- Texas State Department of Health, 1100 W. 49th, Austin, Texas.
- Louisiana State Department of Health, 325 Loyola Avenue, New Orleans, Louisiana.
- Oklahoma State Health Department, 3400 North Eastern, Oklahoma City, Oklahoma.
- New Mexico Department of Health and Social Services, P.O. Box 2348, Santa Fe, New Mexico.

City of Houston Health Department, 1115 N. MacGregor, Houston, Texas.

Idaho Department of Health, Statehouse, Boise, Idaho.

Montana State Department of Health, Cogswell Building, Helena, Montana.

Colorado Department of Health, 4210 East 11th Avenue, Denver, Colorado.

Utah State Department of Health and Welfare, Utah State Division of Health, 44 Medical Drive, Salt Lake City, Utah.

Wyoming Department of Public Health, State Office Building, Cheyenne, Wyoming.

Pima County Health Department, 151 W. Congress Street, Tucson, Arizona.

City-County District Health (Reno-Sparks-Washoe County), 10 Kirman Avenue, Reno, Nevada.

Oregon State Board of Health, P.O. Box 231, Portland, Oregon.

Arizona State Department of Health, 1624 West Adams, Phoenix, Arizona.

District Health Department, P.O. Box 4426, 625 Shadow Lane, Las Vegas, Nevada.

California State Department of Public Health, 2151 Berkeley Way, Berkeley, California.

State of Hawaii, Department of Health, P.O. Box 3378, Honolulu, Hawaii.

Alaska Department of Health and Welfare, Division of Public Health, Pouch H, Juneau, Alaska.

Senator KENNEDY. How many of the States would give top priority for the immunization of children under the partnership program?

Dr. STEWART. I think if one is talking about rubella and the concern that we have about the timing of the possible next epidemic and its results, that all the State health offices in the country are terribly concerned about rubella and will put high priority on it. I do not think there is any question about it. In some States they may not put emphasis at this time—and I do not mean it is less important—on polio because it has been taken care of within the normal mechanism of the well-baby clinics and the private areas. So it varies in time. I cannot conceive of a State health officer or board of health not considering this a terribly important, high priority project.

Senator KENNEDY. Of course, I imagine the States must have many other priorities as well. They have many different responsibilities as public health officials and, like all of us, they are aware of the pressing demands that exist in the States. Many different demands are placed upon State budgets. And, of course, the question which is immediately raised is whether by using block grants, you are going to do as effective a job as you would by the rifle shot approach.

Dr. STEWART. Under section 314(e), Senator Kennedy, these are project grants. In form and shape it is very similar to what would be provided under the Vaccination Assistance Act, and we, in fact, have received 68 applications. We have turned down none. Under the Vaccination Assistance Act, there would still have to be the application procedure. The only real difference between the two approaches is that if the authorization proposed in your bill were to be enacted, it would specifically state it is for that purpose, whereas under 314(e) it is a flexible open group of grant monies. Under 314(e) the priorities can be changed rapidly, the program can be made rifle or less rifle, or the priorities can vary by sections of the country depending on what problem one is addressing oneself to. And there is only one application form for this. And there is only one set of procedures.

I wish to emphasize, Senator Kennedy, I am not arguing against rubella control or disease control.

Senator KENNEDY. No, I understand.

Dr. STEWART. If I felt the mechanism of the specific category would enhance our ability to control rubella, I would be talking differently. But I believe in the mechanism that we have developed. I was involved in the consolidation of all of the various approaches we had previously where we had so many specific categories that the system was inflexible. And we consolidated. It depends a bit upon our own interests in developing priorities as to whether we aim ourselves at the right priorities. I believe this is the concern that you have.

Senator KENNEDY. Does the Communicable Disease Center have a separate view on this? Are they pretty much in agreement with the view you have stated? I know that you are speaking in terms of the policy of the Department, but I am interested in whether, in view of the immunization programs of recent years, the Communicable Disease Center itself feels that the job of immunization can be done as effectively under the partnership for health approach as it can be done under the Vaccination Assistance Act. Does the Center consider the rifle-shot approach? Has it expressed itself on this matter? I would think from the point of view of the responsibility for the success of the programs under the Vaccination Assistance Act they have probably had about as much to do with the effectiveness of these programs as any other group. Have they communicated with you what their views or their attitudes would be?

Dr. STEWART. Yes, they have, Senator Kennedy. Let me give you what I interpret was the reply, and then we can ask Dr. Sencer what he thinks.

I think that the Communicable Disease Center has told us that they can administer an immunization program very effectively and very well under the present partnership for health program. If they had their druthers they would prefer that it was as a specific categorical program because they feel they would have more control on it that way than they do under the 314. However, I believe that they sincerely believe they can administer it under 314. My own feeling is they can, too; if they give it a trial it will work very well, and they will eventually come around to enjoying the flexibility of it.

Now, that is my interpretation of what Dr. Sencer is saying. Let us see if I am right.

Dr. SENCER. Yes, sir.

Senator KENNEDY. That gives you a little guidance. [Laughter.]

Dr. SENCER. Senator Kennedy, the grants that have been submitted for funding under the supplemental appropriation as have been approved by both House and Senate have been approved for funding and will provide a good basis of continuing the work that has been started and continued under the Vaccination Assistance Act. As Dr. Stewart said, we have 68 grants in hand that are targeted toward the problems of rubella. We are ready to approve these grants, and we would hope that the work in the State and local health departments would continue at the same level that it has been under the Vaccination Assistance Act.

Senator KENNEDY. Thank you, Dr. Sencer. I think Dr. Stewart is very fair in indicating that as far as the center itself is concerned, it would prefer the rifle shot approach. I understand the position of the Public Health Service, but I wonder whether you would tell us how it was reached.

Dr. SENCER. Well, we have had discussions with Dr. Stewart and his staff. As he said, we have presented our views, and we, I suppose, like any bureaucrat would prefer to have control of the funds. We feel that the program is the important thing, to get people immunized, and if the mechanism of 314(e) can work for immunization of children, not only the susceptibles of today, but also the new entrants into our population who are not getting all the preventive services they need, then we will certainly work with 314(e).

Senator KENNEDY. I have more confidence in you than the mere fact that you only wanted the program because you are bureaucrats or because you are just interested in maintaining control over a program. I suppose that to some extent, your views are upon the experience of the Center over recent years, are they not?

Dr. SENCER. I think one difference that we would have is that it is easier to coordinate a program on a national basis outside of the 314(e) mechanism. But other than that, so far the 314(e) mechanism has provided funds, and we do have review and approval procedures that assure that appropriate action is taken.

Senator KENNEDY. Dr. Stewart, would you give us your assessment of the threat of rubella in the country within the next couple of years?

Dr. STEWART. Yes, sir; Senator Kennedy.

As you are aware, the epidemics of rubella occur every 6 or 7 years on the average. We had our last epidemic in 1964, as I recall. We are anticipating that cycle to occur in 1970, 1971, 1972, in that period of time. Rubella is a mild disease in children but our real concern about rubella is when it affects women who are pregnant. In early pregnancy those who acquire rubella will pass the disease to the child and the child will have congenital defects, mental retardation, blindness, deafness, a conglomerate of congenital defects. Therefore, if we can prevent rubella in pregnant women, we can prevent many real tragedies that occur from this disease. Our whole vaccination program is geared around building a wall of immunity around the mothers because there are some problems of giving it to the women, the adult women themselves. It is a terribly important problem. It is the first, not the first but the first really significant preventive that has come along in the last 3, or 4, or 5 years which gives us some great hope of preventing real tragedies. It is very important that it be limited to the nonchild-bearing age groups—

Senator DOMINICK. Would the gentleman yield for clarification of the record.

Senator KENNEDY. Yes.

Senator DOMINICK. Rubella is commonly known as German measles; is it not?

Dr. STEWART. Yes.

Senator DOMINICK. Thank you.

Senator KENNEDY. I would just like to make two final comments.

The Center for Communicable Diseases has, I think, an outstanding record. It has been an area of governmental service that has made an extraordinary and important contribution in the health field, and that is why we are so interested in its views. I certainly commend the Center for what it has done in the past. If the decision is to move in the partnership direction, I am hopeful that it can work equally as effectively as under the Vaccination Assistance Act.

Finally, Dr. Stewart, when I had the chance to go to Alaska several months ago, I saw the marvelous people that you have in the Public Health Service in some of the most remote and difficult circumstances. I saw the extraordinary work they are doing and the dedication and compassion they show in training health aides in these very small communities. In so many instances, training in preventive medicine makes an extraordinary degree of difference, for all the reasons that are familiar to all of us. They are some of the most dedicated people that I have ever seen in any service. And I know that you are proud of them and I wanted to mention that to you this morning.

Dr. STEWART. Thank you very much, Senator.

Senator KENNEDY. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Dominick.

Senator DOMINICK. Thank you, Mr. Chairman.

Dr. Stewart, just for the record I would like to go over some background information. Prior to 1966, it is my understanding that we could use project grants only for 16 specific health programs; is that correct?

Dr. STEWART. That is correct.

Senator DOMINICK. And we started consolidating these programs in 1966, in a 2-year extension of authority?

Dr. STEWART. That is correct.

Senator DOMINICK. And then, under the last administration, the 90th Congress passed the Partnership for Health Act which further consolidated these programs.

Dr. STEWART. Actually the first act was passed in the 89th Congress and was called the Partnership for Health Act. The 90th extended this act and modified it a little.

Senator DOMINICK. And it is your feeling at this time that by the consolidation you have provided for flexibility to meet more readily the problems that face the various States; is that correct?

Dr. STEWART. That is correct.

Senator DOMINICK. Now, in Senator Yarborough's opening statement two items concern me. One of them is, and I quote, "This year the situation will become more serious if the Department of HEW is successful in its plan to seriously weaken the tuberculosis control program." Do you have any knowledge of a plan to weaken the tuberculosis program?

Dr. STEWART. Well, certainly we have no intention at all of weakening the tuberculosis program. In the review of the last administration's budget by the present administration there was proposed a transfer of \$18 million from the project grant area to the formula grant area, principally in the tuberculosis area. The State that got an increase in the formula grant could use this increase for tuberculosis or any other purpose in the Partnership for Health. While some have read it that way, it was not implied that they could not in the future apply for a tuberculosis control project grant under 314(e).

What we were trying to do was to implement a policy related to project grants. It was our feeling that project grants are for innovation, to start things, to demonstrate things, which would have a time

limit to them. That is, when the program has been developed to the point where it needs to be ongoing, then ongoing mechanisms including the formula grants or other ongoing mechanisms such as Medicaid or other programs should pick it up into the normal stream of things freeing up the project grant money for more innovation and starting up of other programs.

It was felt that there have been project grants in tuberculosis and some in venereal disease, in fact, that have been in being for some time and could be moved into these ongoing mechanisms. It was not implied that future projects for innovation or starting up new kinds of programs could not include control of tuberculosis.

So this was not intended at all to weaken the tuberculosis program. It was an attempt to move to another mechanism of financing a continuing program in tuberculosis control.

Senator DOMINICK. The second quote that I was concerned about from the chairman's opening statement is in the last paragraph, the first sentence, and I quote again, "If Federal financial assistance for vaccinations against polio, diphtheria, measles, and other diseases that can be prevented or controlled is abolished, we can expect needless suffering and death."

Well, I am sure that we would all agree that is probably true, if it is abolished. But there is no intention to abolish Federal assistance for these programs as far as I know. Is there?

Dr. STEWART. No, sir. I think I mentioned when talking to Senator Kennedy that as far as the purpose of all of these proposals, we think they are terribly important, there should be immunization, there should be prevention, there should be tuberculosis control. We are really arguing over whether one mechanism is a better way of administering such programs than another mechanism.

If what is proposed in fact were a decline in vaccination or would not permit the development of a rubella program, then there would be unnecessary suffering.

But I do not think that is true at all. I think that under the present authorizations we have we will be able to do a very good job in the immunization programs in the country.

Senator DOMINICK. When we had hearings on the Hill-Burton extension, we had statements from some of the public health officers of the various States, including one from mine, indicating they were more or less in favor of categorical grants. However, they were frank enough to admit the reason for their position was that they thought they could get the groups who are interested in a particular disease to put more pressure on the appropriations committee and, therefore, get more funding. In general, their theory was this would be easier under a categorical grant than it would be under a block grant. I can see that when we are dealing with health matters, anyone who is interested in a particular area obviously is going to try their best to get as much funding as they can to solve the problem.

In fact, however, it is not true that we have a large authorization under existing law for block grants which will give us pretty good funding if we can get it through the appropriations committee? Is that not true?

Dr. STEWART. This is true.

Senator DOMINICK. I wonder, can you give us any comparisons on that? We do not want to have a record which is inadequate.

Dr. STEWART. I can give you the 1970 budget request for the formula grant. It was \$90 million. The authorization is \$100 million. Under the project grant, the request is \$80 million, and the authorization is \$80 million.

Is that satisfactory, Senator Dominick?

Senator DOMINICK. Yes, that is helpful.

Now, do we have any breakdown on a State-by-State basis as to a comparison of funding to be distributed pursuant to section 314(d) as it is now written, or as the Public Health Service Act would be changed under Senator Yarborough's proposal? Do we have a breakdown of that on a State-by-State basis?

Dr. STEWART. Well, I was with you to the last phrase. I do not think Senator Yarborough's proposal would change funding at all.

Senator DOMINICK. Well, under S. 2264, as I understand it—and maybe I am wrong, Mr. Chairman, and you correct me if I am—it is my understanding that in addition to the allocation under the formula that we now have the bill would authorize \$60 million one year and \$75 million the next for project grants, then it injects the idea of making payments in advance on the basis of estimates, adjustments for underpayments and overpayments, the Secretary can do much as he desires in order to carry out the purposes of this subsection, and it varies the formula on the basis of the incidence of disease.

Dr. STEWART. Senator Dominick, I think what Senator Yarborough's bill does is add authorizations over and above what is authorized now under the Partnership for Health Act. It is a new authorization for the purposes listed. The language about overpayment, underpayment is standard language that occurs in all bills that relate to a formula grant or a project grant.

And it would be a project grant, rather than a formula grant so the decision of who would get the money would depend on a review of the project proposed, which review would be based on the extent of illness, extent of disease, rather than some formula based on population, financial need, or any other kind of formula that would be constructed.

Senator DOMINICK. I think it would be helpful if you could give us the State-by-State figures for the 314(d) allocations.

Dr. STEWART. Yes, sir; we can give you that.

Senator DOMINICK. If you could furnish that for the record.

Dr. STEWART. Yes, sir.

(The information subsequently supplied follows:)

COMPREHENSIVE HEALTH PLANNING AND SERVICES, ALLOCATIONS OF GRANTS FOR COMPREHENSIVE PUBLIC HEALTH SERVICES

	1968 actual	1969 estimate	1970	
			Original estimate	Revised estimate
Alabama.....	\$1,279,400	\$1,334,700	\$1,469,800	\$1,850,000
Alaska.....	378,500	371,800	371,800	382,800
Arizona.....	590,500	735,500	781,600	940,300
Arkansas.....	847,500	884,300	971,300	1,191,000
California.....	4,118,800	4,598,700	5,099,100	6,647,700
Colorado.....	631,500	779,000	849,500	1,030,100
Connecticut.....	694,200	936,300	1,012,200	1,245,100
Delaware.....	377,600	415,000	432,600	479,000
District of Columbia.....	413,500	470,000	490,700	555,800
Florida.....	1,855,500	1,840,200	2,035,800	2,598,200
Georgia.....	1,411,200	1,518,200	1,674,400	2,120,500
Hawaii.....	411,300	473,000	502,000	570,700
Idaho.....	439,100	484,900	508,700	579,600
Illinois.....	2,547,200	2,719,800	3,011,400	3,887,900
Indiana.....	1,348,100	1,483,200	1,648,500	2,086,200
Iowa.....	884,800	959,800	1,040,800	1,282,900
Kansas.....	731,100	857,200	925,600	1,130,600
Kentucky.....	1,169,400	1,189,200	1,292,000	1,615,000
Louisiana.....	1,195,000	1,312,300	1,438,900	1,809,100
Maine.....	484,600	556,000	585,400	680,900
Maryland.....	893,300	1,155,100	1,267,500	1,582,500
Massachusetts.....	1,385,800	1,546,400	1,678,300	2,125,600
Michigan.....	2,086,500	2,274,900	2,560,000	3,291,100
Minnesota.....	1,078,000	1,171,600	1,282,200	1,601,900
Mississippi.....	1,028,800	1,050,700	1,131,200	1,402,300
Missouri.....	1,313,900	1,438,100	1,572,000	1,985,200
Montana.....	429,500	478,600	497,500	564,600
Nebraska.....	562,000	648,400	688,600	817,400
Nevada.....	390,200	397,800	413,200	453,200
New Hampshire.....	409,200	468,500	490,100	554,900
New Jersey.....	1,614,400	1,872,800	2,065,900	2,638,000
New Mexico.....	490,700	569,500	607,500	710,100
New York.....	4,253,900	4,391,700	4,771,200	6,214,000
North Carolina.....	1,588,300	1,690,900	1,873,500	2,383,600
North Dakota.....	426,600	471,300	488,500	552,800
Ohio.....	2,628,600	2,785,500	3,112,500	4,021,500
Oklahoma.....	865,300	961,100	1,037,900	1,279,100
Oregon.....	632,500	785,500	845,000	1,024,100
Pennsylvania.....	3,143,200	3,101,700	3,422,700	4,431,600
Rhode Island.....	428,200	513,200	537,400	617,400
South Carolina.....	938,500	1,063,500	1,171,100	1,455,200
South Dakota.....	434,300	479,200	493,800	559,900
Tennessee.....	1,371,300	1,388,900	1,530,800	1,930,700
Texas.....	3,012,800	3,135,400	3,455,900	4,475,500
Utah.....	469,400	568,500	604,800	706,600
Vermont.....	388,100	406,100	418,500	460,200
Virginia.....	1,307,700	1,466,200	1,606,700	2,031,000
Washington.....	847,100	1,014,700	1,132,200	1,403,700
West Virginia.....	694,900	809,500	866,200	1,052,100
Wisconsin.....	1,192,300	1,307,600	1,427,900	1,794,600
Wyoming.....	381,500	377,800	385,400	416,600
Guam.....	306,200	310,900	314,300	328,200
Puerto Rico.....	1,092,700	1,162,400	1,266,500	1,581,300
Virgin Islands.....	266,800	265,700	265,700	268,400
American Samoa.....	88,700	265,700	265,700	268,400
Trust Territory of the Pacific Islands.....		317,500	3091700	323,300
Total.....	60,250,000	66,032,000	72,000,000	90,000,000

Senator DOMINICK. As you know, Colorado has a number of institutions involved in areas of concern to us this morning. These include the American Medical Center, CARIH (the Children's Asthma Research Institute and Hospital), the National Jewish Hospital, and others. I wonder if you could give me some idea of what kind of transitional support you are talking about during the shift in the funding

mechanisms from the categorical project grant for tuberculosis to block grant for tuberculosis, venereal disease, and alcoholism?

Dr. STEWART. Senator Dominick—

Senator DOMINICK. You said, I think, that you were going to give transitional support to this process.

Dr. STEWART. Right. We will continue to use 314(e) money to act as a transition until such time as a State can pick a program up on the formula money. In some instances we may continue a program as a project grant because it is a new kind of program, or just getting started, or project grant support is necessary for a while. If I might call on Mr. Lewis who is administering that transitional grant program to give further detail—

Senator DOMINICK. Before you do, I wonder if you could give me some idea of the progress that we have made in controlling tuberculosis, let us say, over the last 10 years. Has it been substantial?

Dr. STEWART. Oh, yes, there has been substantial improvement. Much of our problem relates to two factors. One, we have a few areas in the country where transmission is still occurring from one person to another. It is well known, where these areas are. The other is the residual breakdown of adults who acquired tuberculosis, 50, 60 years ago and as our population ages over time that group will gradually disappear. Our whole problem is to spot those cases so they do not transmit to somebody else and get them under chemotherapy. You use an indicator of the spread. The tuberculin test, for example, is an indicator of spread. We have very few areas in the country where any spread is going on. These areas are tremendously important and we should concentrate there. So there has been great progress made in tuberculosis control.

Senator DOMINICK. In the first group of incidences that you are talking about, I gather that project grants would still go forward, is that correct?

Dr. STEWART. The method of funding is going to depend on how they can operate this rather than whether it is a kind of a disease problem or not. In some instances States will be getting more money under the formula grant than they were under the project grant. They may want to expand their tuberculosis control. They may want to contract it and use the money for a different kind of problem because they are one of the areas where there is very little tuberculosis remaining. In some instances we may want to continue the project because it is a terribly important area and a program is just getting started or implemented.

Senator DOMINICK. Thank you very much, Doctor. I think you have made a fine statement.

The CHAIRMAN. Senator Hughes.

Senator HUGHES. Mr. Chairman, I just have a couple of questions which may have been answered. If they have, I hope, Dr. Stewart, you will just simply indicate they have in the record and I can pick it up there.

I am assuming that somewhere in all the testimony we have had in the various hearings that it is widely known how many States have adequate planning agencies. When I say "adequate," I am throwing in an adjective that may be hard to describe. But how many of them do have adequate planning agencies, if you have any idea?

Dr. STEWART. Well, I can tell you all of them do.

Senator HUGHES. All of them have one?

Dr. STEWART. "Adequate" throws me a little bit, Senator Hughes. I am sure that if I said there are a few that I think, myself, are adequate, I would have left out some who consider themselves adequate. But in general, they are just starting. And if you mean operational, functional, and doing the kind of job we hope to see, very few of them have reached that point. Then I guess that is what you mean by "adequate."

Senator HUGHES. That is what I am trying to identify. It has been my experience that only in the last 3 or 4 years have we really moved into planning agencies to the point of adequacy, or, to use the popular term, sufficiency.

Dr. STEWART. This is quite true, Senator Hughes. We spent the first year and a half on this program really deciding who was going to do it in the State and who the advisers were going to be, and all the powers that needed to be involved had to get themselves arranged so they could do it. So it is just beginning to emerge as an operational effort.

Senator HUGHES. Do you find in the States many interdepartmental jealousies that have impeded this planning program, or help the planning efforts?

Dr. STEWART. Well, I do not know about the word "many," but there have been States where in implementing the development of the State planning effort there were jurisdictional battles between several departments, which is rather common in any organization.

Senator HUGHES. Well, I found them to be pretty violent in my State at times with between three or four different jurisdictions trying to get themselves into the planning. I am wondering if these are being resolved rapidly enough to really administer these programs on a block-grant basis.

Dr. STEWART. Well, they are being resolved, and while one could wish they were being resolved more rapidly, I think that we are seeing the emergence of a major new agency in the country, the State planning agency, which is going to have enough strength virtually to begin to do some of these things.

Senator HUGHES. Now will you recognize the State planning agency, if it exists, in addition to a health planning agency?

Dr. STEWART. If the Governor has selected his planning agency as the State health planning agency, that is the one we accept as the health planning agency. Many Governors have done this.

Senator HUGHES. And you exercise no control or directional guidance to a State on this?

Dr. STEWART. No; we do not at all. The only guidance we require is that they have consumers on their advisory council, plus a few other requirements which are in the law. But other than that, the Governor chooses where the State agency goes.

Senator HUGHES. Then the legislation as passed places it in the hands of the 50 State Governors to make a determination of the actual planning which will affect the total operation of the block-grant program?

Dr. STEWART. This is true.

Senator HUGHES. Do you find in this any regional problems that may develop as far as the effectiveness of the programs that you are able to identify, as separate from another region of the country?

Dr. STEWART. There have been some regional problems and there will be more, Senator Hughes, not so much at the State level as at the local level.

There were areawide health planning agencies in existence before this law came into being, and in some instances the arrangements regions were trying to make after the Partnership for Health Act was passed were different than what had grown up voluntarily, and there were problems along that line. Other problems arose where States had not been divided into areas before. And there are always arguments when one tries to regionalize a geographic area.

But, in general, we have seen the doubling of areawide planning agencies in the last 2 years.

Senator HUGHES. Is regional planning a requirement of the program itself?

Dr. STEWART. No; regional planning may occur in an area of a city, a metropolitan area which is supposed to be the feed-in to the development of the State planning agency.

Now the project grant under 314(e) must be consistent with the State plan that is developed by the State's planning agency. So there is a relationship between them.

Senator HUGHES. And do you have, actually, on file evidence of the 50 States having a State plan which in itself encompasses regional plans within the State?

Dr. STEWART. At the moment, I think it would be better to say that there is a State planning agency which has a partial State plan under that area.

There are two State plans, Senator Hughes. There is a State plan for the expenditure of the formula grant money—

Senator HUGHES. That is what I am trying to get at, to identify.

Dr. STEWART. All right. There are two State planning efforts. There is a plan, a State plan, for the expenditure of the formula grant under section 314(d). They can select what they want to do, but there has to be a plan. That plan must be approved by our regional office.

Senator HUGHES. Is it ultimately approved by you?

Dr. STEWART. Well, it is, in behalf of the HEW as approved in the regional office.

Senator HUGHES. That is an allocation of authority?

Dr. STEWART. Correct. Now the State planning agency, though, is a planning process. It does not produce a document that says, "Here is the State plan for all of health, private and public, in our State." But it is a process of planning which is supposedly, to assist the legislature, the Governor, the Blue Cross, any other group, in what priorities should be emphasized. It is more in the line of economic planning in that it relates to how much investment we want to make in this area over the next 10 years.

Senator HUGHES. That is my very point. Most State planning agencies do not get into the effectiveness of including health in their State planning programs.

Dr. STEWART. We hope this will be the mechanism to do that.

Senator HUGHES. In these bills, then, I noticed you voice some concern about the method recommended. We get into the area, if I might speak to it for a moment, of venereal disease control. And, again, it is not encompassed in the bill with which we are concerned. I think the statistics indicate a rather rapid rise in venereal disease in the country, do they not?

Dr. STEWART. Primary and secondary syphilis has been going down for some years. Gonorrhea has gone up tremendously in the country.

Senator HUGHES. Gonorrhea has been going up rapidly.

Dr. STEWART. Correct.

Senator HUGHES. There are some indications that some of this—this, again, is probably a matter of State jurisdiction. I am not entirely sure, but I would at least like to know, that much of this is due to the fact that people do not seek treatment, particularly the underaged person, because of the open information about treatment being given; doctors must notify parents, and so on.

Dr. STEWART. Some of it is caused by not seeking that treatment. Some of it is, in fact much of the treatment is, now given by private physicians who are then reluctant to report this to any public agency. So we have underreporting.

Senator HUGHES. Our statistics are undoubtedly way low.

Dr. STEWART. We do studies to try to determine how much underreporting there actually is.

One other thing, though. I do not want to imply that it is all administrative problems. In the case of gonorrhea, we have a problem of science and technology here, too. The diagnosis of gonorrhea in the female is very difficult and uncertain, and does not lend itself to mass control methods. And there is some problem with the dose of penicillin. So there are technical problems as well as administrative problems.

Senator HUGHES. Well, is there any effort being made to reach into these areas? I think we found in evidence before the subcommittee in particularly very low-income areas, poverty-stricken areas, there is a great deal of evidence of this thing almost running rampant, particularly in teenagers and others in their early twenties.

Dr. STEWART. As far as syphilis goes, we have developed what we call the epidemiological method of case contact detection and have financed under the Communicable Disease Center at the present time many programs in areas such as you are describing, which are aimed at detecting and breaking the chain of the spreading of syphilis.

As far as gonorrhea goes, it is a little different problem; you cannot detect it well enough to break the chain. You can treat cases. And it extends to a broader population. It is a more difficult area to handle. Obviously, it is also involved in the problem, but at the moment the rate of gonorrhea is increasing very rapidly, and I think that Dr. Sencar has talked about it as being an epidemic.

Senator Hughes. I think there are many instances and many cases that indicate that the doctor is right in certain areas of the country.

Under the type of program that you are apparently advocating, do we have the capability of really getting out and doing something about it, or are we restricted for scientific reasons, State laws, or what is it?

I am assuming, Mr. Chairman, it is all right to go into this at the moment.

The CHAIRMAN. Surely.

Dr. STEWART. At the present time, Senator Hughes, the Federal participation in venereal disease programs can be financed under the Partnership for Health Act within localities and States. There also are direct operations of the Communicable Disease Center in venereal disease control. I think that S. 2264 would also authorize funds to be used for venereal disease control. I think it authorizes what we already have the authority to do.

Now, I think anyone would tell you we can do more in venereal disease control. We could have a better effort. But the problem is not authorization as much as it is the amount of effort and the amount of trained people that we have in the country who know how to do these things.

Finally, we need more research in mass approaches, particularly in the case of gonorrhea.

Senator HUGHES. Do you find the States are concerned enough about this? I am sure they are concerned. I, again, suffer from a lack of a choice of words. But I mean, in making the choices and priorities—we have to make priorities—do we have adequate funding to really get into this and to direct our attention to it? Again, it is still one of the untouchable areas as far as public discussion.

Dr. STEWART. Senator, it is that old problem that if you look at it as a program person or professional, trying to do something about it, then there is never really enough effort, but if you also put it in perspective with all the priorities and pressures at the State level, or any other level, then it has to have some kind of priority attached to it, and we try to insure these factors are properly balanced.

I think we have expressed our concern about the venereal disease problem several times in hearings, in appropriations, and here. And we have a program that is well on its way, but we need to do a lot more.

I have been meeting with the American Public Health Association to try to develop a new look at our approach to venereal disease. They have called a meeting of all the professional societies, who are the doctors who are taking care of these patients, to see what we can do and how we are trying to go from there.

Senator HUGHES. Well, if I could just speak for a moment about gonorrhea, as you mentioned yourself, there has developed a resistance to the normal treatment patterns in years past.

Dr. STEWART. It takes more penicillin to cure the case, but this resistance is not a real impediment. The real impediment is the difficulty of diagnosis in gonorrhea in the female.

Senator HUGHES. The diagnosis. You do feel there is adequate leeway in existing programs to go ahead and conduct whatever you have the capacity of doing at present?

Dr. STEWART. We think that we have adequate authority to carry out our programs; yes.

Senator HUGHES. I think that is all, Mr. Chairman.

Thank you, Mr. Chairman.

Senator DOMINICK. Mr. Chairman, if I may, just for the record, Dr. Stewart asked Dr.—

Dr. STEWART. Mr. Lewis.

Senator DOMINICK. To give some examples of the transitional support on tuberculosis controls, and we did not get it in the record. I asked him to wait a minute and then we went on before we got it in the record. I wonder if we could follow up on that.

Mr. LEWIS. Some of these arrangements are still in the process of being worked out, Senator, but what we are doing is that while we are awaiting firm knowledge of what the budgetary results will be, which is actually necessary in order for our plans to be final, we have kept all the current tuberculosis control project programs on a funding status for the first quarter of fiscal year 1970.

We are planning program funds both out of the funds in fiscal year 1969 and out of the funds in 1970 to insure that those States which fall substantially short of the TB project amount which we now are programming and the amount they would get under 314(d) and those States which wish to continue these projects but for various reasons have difficulty finding resources, can continue the projects with assurance of funding anywhere from 3 months through the balance of the year.

Now, at the Surgeon General's direction, we are also working on a set of criteria, which we have not yet developed but which we will complete in the next several weeks, for the continued funding of tuberculosis projects under 314(e), which is the project grant proposal.

It is our view, assuming that the budget proposals are enacted, that there would be enough resources in both 314(e) project grant funds and 314(d) block grant funds to permit us to make an adequate transition for the States during 1970, but the range of support will vary anywhere from 3 months to a year depending on the variance between the project grant and the formula grant in a State.

Senator DOMINICK. Under date of June 18, Mr. Ravell, assistant director of the community health service wrote Senator Prouty. He said:

In those States where the formula distribution of 314(d) funds is less than was funded for tuberculosis in fiscal 1969 from 314(e) funds, the amount of the shortage will be funded in fiscal 1970 from 314(e) moneys.

Mr. LEWIS. That is what I had in mind.

Senator DOMINICK. That is part of the transitional support?

Mr. LEWIS. That is right.

Senator DOMINICK. Thank you.

Senator KENNEDY. Mr. Chairman.

The CHAIRMAN. Senator Kennedy.

Senator KENNEDY. On behalf of Senator Eagleton, I would like to ask the Surgeon General two additional questions. You may respond now, or you may provide the answers later for the record.

In the order of their greatest incidence, would you give us the causes of infant mortality in the United States, for, say, children of the age of 4 and under, or for whatever age group to which your figures apply?

Would you like to submit that later on?

Dr. STEWART. I think we will submit it later on; yes, sir.

Senator KENNEDY. And then, would you tell us whether the order of incidence is the same for black children as for white children?

Would you please list the order of incidence for both black and white children? Those are the two questions for Senator Eagleton.

(The information, subsequently supplied, follows:)

LEADING CAUSES OF INFANT MORTALITY, BY COLOR: UNITED STATES, 1957

TOTAL

Rank	Cause of death	Number
1.0	Postnatal asphyxia and atelectasis.....	12,783
2.0	Immaturity, unqualified.....	11,909
3.0	Congenital malformations.....	11,632
4.0	Birth injuries.....	6,561
5.0	Influenza and pneumonia, except pneumonia of newborn.....	5,716
6.0	Accidents.....	2,751
7.0	Pneumonia of newborn.....	2,219
8.0	Immaturity with mention of any other subsidiary condition.....	1,271
9.0	Hemolytic disease of newborn (erythroblastosis).....	1,191
10.0	Gastritis, duodenitis, enteritis and colitis, except diarrhea of newborn.....	1,013
11.0	Hernia and intestinal obstruction.....	685
12.0	Meningitis, except meningococcal and tuberculous.....	679
13.0	Neonatal disorders arising from certain diseases of mother during pregnancy.....	557
14.0	Hemorrhagic disease of newborn.....	519
15.0	Bronchitis.....	314
16.0	Acute upper respiratory infections.....	293
17.0	Septicemia and pyemia.....	282
18.0	Homicide.....	226
19.0	Diarrhea of newborn.....	225
20.0	Malignant neoplasms, including neoplasms of lymphatic and hematopoietic tissues.....	196
21.0	Meningococcal infections.....	167
22.0	Benign neoplasms and neoplasms of unspecified nature.....	97
23.0	Diseases of thymus gland.....	35
24.0	Dysentery, all forms.....	32
25.0	Whooping cough.....	29
26.0	Tetanus.....	25

WHITE

1.0	Congenital malformations.....	9,852
2.0	Postnatal asphyxia and atelectasis.....	9,525
3.0	Immaturity, unqualified.....	8,173
4.0	Birth injuries.....	5,198
5.0	Influenza and pneumonia, except pneumonia of newborn.....	3,374
6.0	Accidents.....	1,870
7.0	Pneumonia of newborn.....	1,510
8.0	Hemolytic disease of newborn (erythroblastosis).....	1,105
9.0	Immaturity with mention of any other subsidiary condition.....	893
10.0	Hernia and intestinal obstruction.....	567
11.0	Gastritis, duodenitis, enteritis, and colitis, except diarrhea of newborn.....	504
12.0	Meningitis, except meningococcal and tuberculous.....	455
13.0	Neonatal disorders arising from certain diseases of mother during pregnancy.....	434
14.0	Hemorrhagic disease of newborn.....	371
15.0	Bronchitis.....	204
16.0	Acute upper respiratory infections.....	185
17.0	Septicemia and pyemia.....	171
18.0	Malignant neoplasms, including neoplasms of lymphatic and hematopoietic tissues.....	165
19.0	Homicide.....	151
20.0	Meningococcal infections.....	144
21.0	Diarrhea of newborn.....	95
22.0	Benign neoplasms and neoplasms of unspecified nature.....	79
23.0	Diseases of thymus gland.....	32
24.0	Dysentery, all forms.....	11
25.0	Whooping cough.....	9
26.0	Tetanus.....	5

NONWHITE

1.0	Immaturity, unqualified.....	3,736
2.0	Postnatal asphyxia and atelectasis.....	3,258
3.0	Influenza and pneumonia, except pneumonia of newborn.....	2,342
4.0	Congenital malformations.....	1,780
5.0	Birth injuries.....	1,363
6.0	Accidents.....	881
7.0	Pneumonia of newborn.....	709
8.0	Gastritis, duodenitis, enteritis, and colitis, except diarrhea of newborn.....	527
9.0	Immaturity with mention of any other subsidiary condition.....	378
10.0	Meningitis, except meningococcal and tuberculous.....	224
11.0	Hemorrhagic disease of newborn.....	148
12.0	Diarrhea of newborn.....	130
13.0	Neonatal disorders arising from certain diseases of mother during pregnancy.....	123
14.0	Hernia and intestinal obstruction.....	118
15.0	Septicemia and pyemia.....	111
16.0	Bronchitis.....	110

See footnote at end of table, p. 33.

LEADING CAUSES OF INFANT MORTALITY, BY COLOR; UNITED STATES, 1957—Continued

TOTAL		
Rank	Cause of death	Number
NONWHITE		
17.0	Acute upper respiratory infections.....	108
18.0	Hemolytic disease of newborn (erythroblastosis).....	86
19.0	Homicide.....	75
20.0	Malignant neoplasms, including neoplasms of lymphatic and hematopoietic tissues.....	31
21.0	Meningococcal infections.....	23
22.0	Dysentery, all forms.....	21
23.5	Whooping cough.....	20
23.5	Tetanus.....	20
25.0	Benign neoplasm of unspecified nature.....	18
26.0	Diseases of thymus gland.....	3

Source: Health Services and Mental Health Administration, Public Health Service, U.S. Department of Health, Education, and Welfare, July 9, 1969.

Let me just ask briefly, in connection with the rubella vaccination program, do you plan to immunize children only, or will the vaccine be made available to women of childbearing age as well?

Dr. STEWART. In the rubella vaccine, we only intend to immunize children.

Senator KENNEDY. Not women?

Dr. STEWART. No.

Senator KENNEDY. Is there still some danger in using the vaccine for childbearing women?

Dr. Stewart. We think immunization of women of childbearing age is a potential danger that the method of immunizing we propose, in effect, builds a wall around the mothers, and eventually, of course, when the age group immunized now will grow older, we will have immunized adult women as well.

Senator KENNEDY. But you are continuing research in that area?

Dr. STEWART. Very much so, and it will be under constant surveillance and review by our expert committee.

Senator KENNEDY. Also, with respect to the Rh disease, the hemolytic disease of the newborn, I understand that there is an effective vaccine that has been developed, but that it is not yet being as widely used as it should be. Can you give us any information on that?

Dr. STEWART. Not at this time, Senator Kennedy. I can supply you with it. We do not at the present time have any assistance for vaccination in this area.

Senator KENNEDY. Would you please take a look at this problem?

Dr. STEWART. I certainly will.

Senator KENNEDY. And give us whatever information and judgments you have?

Dr. STEWART. I certainly will.

Senator KENNEDY. Thank you very much, Mr. Chairman.

The CHAIRMAN. Dr. Stewart, it is my information that the data that I gave in my opening statement about the incidence of preventive vaccination for polio or measles was obtained under the National Nutritional Survey. Texas is the only State for which figures have been released. Have they been released for any other State yet?

Dr. STEWART. Not under the National Nutrition Survey; no.

The CHAIRMAN. Do you have that data for other States?

Dr. STEWART. We have it for the rest of the country in a publication called, "U.S. Immunization Survey—1967-68."

The CHAIRMAN. Well, I order that filed for the record. Let me look at it, please. Is that the latest you have?

Dr. STEWART. Yes, sir; 1967-68. This is the latest. This is a continuing survey. We publish this every year, year and a half. It is published every year, Senator Yarborough.

The CHAIRMAN. Well, due to the length of it, I will direct that it be filed with the committee for information rather than published in full, and would you please send us enough copies for each member of the full committee, as well as the subcommittee?

Dr. STEWART. Yes.

The CHAIRMAN. Now, do you have any data unpublished, State-by-State—

Dr. STEWART. No, sir.

The CHAIRMAN. Such as I gave for Texas?

Dr. STEWART. No, sir. But you could break this down by—I do not know you could.

The CHAIRMAN. This came from the national nutritional study. Did they make that for one State only?

Dr. STEWART. Well, I do not know about the national nutrition survey, but as far as the Communicable Disease Center, they could give it to you community-by-community if you wish. Their data are by standard metropolitan statistical areas.

The CHAIRMAN. But do they give it State-by-State?

Dr. SENCER. Yes, sir.

The CHAIRMAN. Will you then furnish that information to the committee, State-by-State?

Dr. STEWART. Yes.

The CHAIRMAN. This is ordered filed with the record and incorporated by reference.

(The material above-referred to will be found in the files of the subcommittee, and incorporated in the record by reference.)

The CHAIRMAN. Now, Dr. Stewart, dealing with the formula grants under 314(d), you have discussed those a good bit. Do you know or have information how the States and where the States will spend their moneys granted under that section?

Dr. STEWART. Well, of course under a State plan we have a record of all 314(d) spending. Of course, this is reviewed—

The CHAIRMAN. In what areas will the States spend it?

Dr. STEWART. I have it State-by-State in the regional offices under their State plan.

The CHAIRMAN. You do not have that with you here?

Dr. STEWART. No, sir; I do not.

The CHAIRMAN. I would ask you to file that with the committee.

Dr. STEWART. Yes. Well, you are talking about an enormous amount of material, Senator Yarborough. These are joint State plans—

The CHAIRMAN. Don't you have a digest of it where you can show in not over half a page what the States want the money for, what they are going to do with it? I do not mean for you to offer the whole works.

Dr. STEWART. I think we can give you an abstract of some of the State plans on where the money is going at the present time, Senator Yarborough. And we will try to get it for such States as we possibly can.

(The information, subsequently supplied, follows:)

FEDERAL, STATE AND LOCAL, PUBLIC AND PRIVATE FUNDS BUDGETED IN FISCAL YEAR 1969 STATE PLANS RELATING TO SECTION 314(d), PHS ACT

The following estimates include amounts initially budgeted and reported by all 56 State Health and Mental Health Authorities in their 1969 State Plans under Section 314(d) of the PHS Act. The amounts estimated do not reflect subsequent budget revisions nor the amounts finally expended for the designated health programs. However, the reported allocations seem sufficiently complete to present a fairly accurate overall picture of State plans.

The total Federal funds available to States under 314(d) in 1969 amounted to \$66,032,000 or about 19% of the total amount reported in the following breakdown. The remainder of the funds come from other public or private sources.

	<i>Amount</i>
1. Chronic disease programs.....	\$25, 372, 574
2. Communicable disease programs.....	28, 143, 156
3. Environmental health programs.....	32, 744, 561
4. Mental health programs.....	88, 658, 986
5. Traditional public health services, such as clinics, nursing, health education, and dental.....	146, 977, 834
6. Administration and management services.....	29, 590, 297
Total	351, 487, 408

The CHAIRMAN. In other words, you offer formula grants as the reason why these bills should not pass. I want to get the facts as to what these formula grants provide.

Now, my information is that these State planning agencies have not yet been set up to the point that they are operable. It will be 2 or 3 years before they will be able to function efficiently, and we are asking for grants now.

Senator HUGHES. Will the chairman yield?

Dr. STEWART. Well, Senator Yarborough—

The CHAIRMAN. I yield to the Senator. Here is a knowledgeable Senator who has just left the Governor's office, and I will yield to him at this point.

Senator HUGHES. Mr. Chairman, I appreciate you yielding just for a second. I do not want to add to the bulk of the material, either, but I am wondering, again, if you have any evidence of the performance at the county level under these plans.

Dr. STEWART. Well, if you are talking about the State health plan that relates to section 314(d)—

Senator HUGHES. I am talking about vaccination, and about the inoculation vaccination plan.

Dr. STEWART. Yes, we can have that.

Senator HUGHES. The reason I ask is that some local county health committees and local county health officers will not allow the plan to be initiated or carried out.

Dr. STEWART. This may be in relation to a mass immunization program, you mean?

Senator HUGHES. Yes.

Dr. STEWART. This could happen; yes.

One of the things I am afraid we are getting confused in not recognizing that State health planning——

Senator HUGHES. I am the only one confused.

Dr. STEWART (continuing). And the State health plan are two separate things. The State health plan relates to the expenditure of funds under 314(d). It also includes the Children's Bureau's funds, too. It is a joint plan. It is developed for the formula grants that go to the States.

Senator HUGHES. That does not include the immunization fund; does it?

Dr. STEWART. Does not.

Senator HUGHES. Thank you, Mr. Chairman.

What I really want to know is, do we get the job done.

Dr. STEWART. Well, I think that it is difficult to follow the Federal formula grant dollar to the county where it is spent. However; our immunization surveys indicate how well we are doing, both privately and publicly.

Senator HUGHES. Well, it is difficult at every level to find out how we are spending our dollar. In three terms as Governor, I could not even find out how much Federal money we were getting in my State, let alone how it was being spent.

Dr. STEWART. Yes, sir.

Senator HUGHES. And for that reason I think we should get to the point of what we are trying to do and how effectively we can do it. If you can help the subcommittee obtain the information it would be helpful to us.

Dr. STEWART. We certainly will. We will provide it for you.

The CHAIRMAN. Did I correctly understand you, Dr. Stewart, that these State plans do not show how the immunization money would be divided, or spent at the State level?

Dr. STEWART. The State plan is the State's plan for expenditure of the formula money under 314(d) and other formula grants such as the material and child health, crippled children, and others.

The CHAIRMAN. Yes.

Dr. STEWART. It says we are going to implement some kind of program and we intend to hire three people to do this. It is this sort of thing.

The CHAIRMAN. If I understand you, that State plan does not show categorically how they are going to spend the immunization money.

Dr. STEWART. If the State were running their immunization program purely with State and local dollars, it would not show at all.

The CHAIRMAN. It would not show?

Dr. STEWART. That is right.

The CHAIRMAN. Well, if it does not show what their immunization plans are, you cannot tell from that what immunization plan is being carried out in a State, can you?

Dr. STEWART. No; you can probably tell how many infants visited the well baby clinics that are supported under maternal and child health. We know how many children are immunized in those clinics. There are some estimates one could make of the amount of vaccination that is going on in the programs.

The CHAIRMAN. Now, Senator Dominick asked you a question about this sentence in my opening statement where I said, "This year the

situation will become more serious"—speaking now of tuberculosis—"if the Department of Health, Education, and Welfare is successful in its plan to seriously weaken the tuberculosis control program."

Well, if you had \$18 million that had previously been allocated for tuberculosis control under a project grant, changed it into an \$18-million formula grant which they are encouraged to use for the control of tuberculosis, venereal, and alcoholism, doesn't that absolutely and inevitably weaken what the Federal Government is doing with the \$18 million project grant?

Dr. STEWART. No, I do not think so, Mr. Chairman. The intention here—

The CHAIRMAN. \$18 million less on tuberculosis control is not weakening the program?

Dr. STEWART. No, I am saying that the State receiving this money under the formula grant can spend it for tuberculosis control and other States can come back—

The CHAIRMAN. But you would not want them to use it for other purposes.

Dr. STEWART. If their tuberculosis problem is one that can be handled by other means, then they might be able to free-up this money for important problems like alcoholism—

The CHAIRMAN. You would expect the State to use these funds for ongoing programs and then move over into more innovative fields. You think that by now they ought to be doing this. That was the substance, as I understood you, of your answer to Senator Dominick.

In other words, you would expect them to take part of the \$18 million and move over into an innovative field, would you not?

Dr. STEWART. No, sir. We expect them to use the \$18 million for ongoing kinds of programs. We expect the States to continue to use 314(e) as the sort of project money for innovation and the development of new programs.

The CHAIRMAN. You would expect them to use the full \$18 million for tuberculosis control?

Dr. STEWART. No, I did not say that. I said they could use it for tuberculosis control if it fits within their priorities.

The CHAIRMAN. But don't you encourage them to use it for other things, too?

Dr. STEWART. We encourage them to use it for what they think are the priorities within their State.

The CHAIRMAN. In other words, you pull down the \$18 million the Federal Government would put into tuberculosis control?

Dr. STEWART. No, we think that the State is in a better position to determine the priorities within their State under the formula grant money, and we say if tuberculosis is a real problem in your State use the formula money for that. But it is their decision, not our decision.

The CHAIRMAN. Well, when you have a project grant and if there is no tuberculosis in the State or city, you do not use money for that anyway, do you?

Dr. STEWART. No; they may choose then to use it for something else.

The CHAIRMAN. You said, the areas were well known where there is a heavy incidence of tuberculosis. Where are those areas?

Dr. STEWART. I can provide that for you, Senator Yarborough.

The CHAIRMAN. Generally, it is serious in ghetto areas, is it not?

Dr. STEWART. Along the Mexican border—

The CHAIRMAN. People with low incomes low amounts of money for health and food often have tuberculosis.

Dr. STEWART. It is mostly where the Negroes from the South have migrated north or the Puerto Ricans have moved from Puerto Rico—

The CHAIRMAN. Now, Senator Dominick asked you about what I had said earlier. If this money is turned over to the States, how do you know that certain programs will not be abolished? You say they would decide whether polio is serious, or measles is serious. How do you know that they won't abolish programs that you, the Surgeon General and the Assistant Secretary of Health, Education, and Welfare for the health of the Nation think important because of data you have assembled, that they won't have?

Dr. STEWART. Under the formula grant, 314(d), we do not know that until they tell us what their State plan is, and they in setting their priorities within the State may have decided that something else is of higher priority, or they may not, or there may be other mechanisms of funding it rather than 314(d). The 314(d) money is a very small amount of money compared to all of the health money going into a State.

The CHAIRMAN. Oh, I realize that. And that is the reason I regret so much to see this proposal abolished. You are right, \$18 million is a small amount of money for the control of tuberculosis. That is about \$9 per hundred people. That is 11 cents a person in the United States for tuberculosis control.

Do you think that 11 cents a person is an overexpenditure by the Federal Government of programs to eliminate tuberculosis?

Dr. STEWART. I think that I would have to see that in the context of what all is spent on tuberculosis control.

The CHAIRMAN. You have constant cases, don't you, of people with active cases of tuberculosis being found working in restaurants?

Dr. STEWART. This is true, but the treatment of this has changed considerably.

The CHAIRMAN. It is not rare or unusual over the country, is it, where tuberculosis—

Dr. STEWART. It is a declining number. It is a large number at the present time, but the treatment of tuberculosis has changed extensively in the last 10 years so that it is cheaper than it used to be as far as treatment goes.

The CHAIRMAN. Well, but it is not rare or unusual for a person with an active case of tuberculosis to be working in a restaurant or a place that serves food?

Dr. STEWART. No; I do not think you would find anyone with active tuberculosis working in a restaurant.

The CHAIRMAN. You do not think you would find that?

Dr. STEWART. Not if the local public health agency has been doing what it should.

The CHAIRMAN. Well, I think there are a lot of people who are knowledgeable in the field who are going to disagree with you, Mr. Secretary, but we will not belabor that point.

The hour is late and I am forced to leave, to my deep regret, even before my fellow Texan, Dr. Pigford, gets to testify. I am chairman

of the Appropriations Subcommittee in charge of the appropriations for the Treasury and Post Office and Executive Offices of the President. That is the first bill up, and I am required to leave to manage it on the floor.

It is with great regret that I turn the hearing over to Senator Hughes, who has agreed to stay and conduct the hearing.

Will you take charge, Senator Hughes?

Dr. STEWART. Thank you, Mr. Chairman.

The CHAIRMAN. I regret that I am forced to leave at this time.

Senator HUGHES (presiding pro tempore). Doctor, I want to say I regret the chairman had to leave because it is going to appear funny that in my own State, as you are well aware, tuberculosis has been on the decline for many, many years. We have been down to where we have had six or eight patients in a very large facility, and we have been trying to convert that facility to other usage over the years and fighting to try and do it.

And one of the difficulties, of course, is the fact that we established a ward for research in the field of alcoholism which has been a very successful operation, in my opinion, in the limited time we have had it. We are still trying to convert much of it as sensibly as we can.

I am concerned about tuberculosis in the country. I also want you to know that I am aware of the fact that we have to alter these facilities and approaches as we go along, particularly in States like mine where this is not a major problem any more, other than early detection. This is really what we are trying to do in the direction of our funds.

I do not want it to appear that I do not think change isn't necessary. It is necessary. As a Governor who has supported block grants for all the years he was in the Governor's office, I do not want my statement to be interpreted that I am against block grants as systems. I certainly have some fear and concern about these block grants for reasons which I am sure we all share. But I am of the opinion that we need to be experimenting as much as we can while at the same time we are pinpointing with a rifle approach specific questions which we are unable to penetrate through this system, as Senators Kennedy and Yarborough said.

Dr. STEWART. I think you are quite right there, Mr. Chairman.

Senator HUGHES. So if I seemed a little downgrading on the others, I am on your side on some of this. The reason I asked questions about regions is that you now seem to be developing a regional question on some of this. I am not talking about regions in the State, but in the country.

Dr. STEWART. Yes, I think this is true. I think we are moving in that direction, particularly as it relates to, oh, sort of surveillance and development of these programs in concert with the States. There is a great deal of difference in the HEW region in which your State is located, Senator Hughes, and region 2, which is New York and Pennsylvania. It is a different kind of arrangement problem. Your State is a very good example, Senator Hughes, of what has happened with tuberculosis where it has been controlled. The five or six cases diagnosed are usually cases that were not indigenous to Iowa.

And so the problem is a kind of a surveillance problem of any cases that might break out. But you were receiving project grants of \$65,000,

with the shift we propose, the formula grant would increase substantially—about \$263—the choice would be the State's as to whether you use this increase in tuberculosis or alcoholism or anything else, realizing that you have to maintain some kind of a surveillance for tuberculosis, too.

So you may end up spending the same amount of money. Iowa is an example of a State where funds supporting project grants for tuberculosis control could be better utilized in another health program.

On the other hand, there are areas where it is still terribly important that there be active serious casefinding, followup, and treatment.

Senator HUGHES. Well, we have a terribly expensive area of land, facilities, and buildings, and everything else that sat for many years without proper utilization, usage, development, or anything else, for lack of funds, and this is a terrible waste of resource. We have to be directed in this direction.

I have no further questions, gentlemen.

Do you have any, Senator Dominick?

Senator DOMINICK. No, I do not, Mr. Chairman. I think the comments you have made are tremendous, and I hope we can—

**STATEMENT OF DR. ROBERT J. ANDERSON, MEDICAL DIRECTOR,
AMERICAN THORACIC SOCIETY, NATIONAL TUBERCULOSIS &
RESPIRATORY DISEASE ASSOCIATION, NEW YORK**

Dr. ANDERSON. Mr. Chairman and members of the committee, the National Tuberculosis & Respiratory Disease Association, along with its State and local associations, has as its primary goal the eradication of tuberculosis and the control of respiratory diseases in the United States. Programs for these ends are carried out in the framework of the health system of the country. Therefore, we are concerned that this system be strong and effective.

This concern led us to support the Comprehensive Health Planning and Public Health Services Amendments in 1966, now section 314 of the Public Health Service Act, because the underlying concepts of that legislation are directed at the development of stronger, more effective State and local health services and programs. However, on that occasion, and since then, we have stated our conviction that Federal money for tuberculosis control must be distributed through the project grant mechanism and must be adequate in amount in order to accomplish an acceleration in tuberculosis control.

These were also the conclusions of the Surgeon General's Task Force on Tuberculosis in 1963. I will provide the committee with a copy of that report. As a result, project grants were adopted by the Public Health Service in subsequent years as the main method for furnishing Federal support to tuberculosis control programs. Although funding never reached the level suggested by that task force, these project grants brought about outstanding improvements in tuberculosis control in nearly the entire country—improvements which are documented in the reports from areas receiving those grants.

And I have such a report with me, Mr. Chairman, in case you wish it.

Senator HUGHES. We can receive it for the files of the subcommittee, if you would like.

Dr. ANDERSON. Fine.

In the meantime, the comprehensive health features of section 314 of the Public Health Service Act have become operative, with formula grants available for support of any health programs that States and localities want to carry on and with project grants for the financing of innovative activities and those determined to be of national significance. Our observations of this program now force us to conclude that implementation of communicable disease control, and especially tuberculosis control, is not soundly approached by the provisions of 314(d) and 314(e).

The formula used for allotment of 314(d) funds is based on population and per capita income which, as I will explain later, does not relate well to the variations in the tuberculosis problem. Furthermore, the States with large tuberculosis problems are forced to make choices within the constraints of these formula funds between tuberculosis control activities and other health services. To fund an effective tuberculosis control program in such States takes a large proportion of their formula funds.

Section 314(e) grants for health services development have as their principal purpose the initiation of new health programs. Tuberculosis and other communicable disease programs hardly qualify as new types of activities. Thus, the systems of (d) and (e) grants are not applicable to assuring the maintenance of communicable disease control, an activity which is basic to protection of the public health.

Because the features of S. 2264 being considered here today augment 314(d) and 314(e) and assure programs for prevention and control of tuberculosis and other communicable diseases, we support this bill. S. 2264 encompasses all of the purposes of S. 1622 but also has the desirable addition of providing for the control of tuberculosis and venereal diseases.

We believe S. 2264 is important for the control of tuberculosis and other communicable diseases because:

First, the bill sets up a separate authorization for tuberculosis and other communicable diseases, thus enabling the Congress to make certain that the primary and elemental public health function of communicable disease control is carried out. Because the grants are solely for communicable disease, State and local authorities are not obliged to make a choice between these later programs and the innovative and other numerous health activities that are eligible for 314 funding. In short, the bill sets a national policy that communicable disease prevention and control is fundamental to public health.

Second, the bill recognizes that the spread of communicable disease is potentiated by our people's extreme mobility and that the control of these diseases is a function which, if not performed well in each State and locality, has great import for other States and localities. In this regard, it also enables States to survey and assess their communicable disease problems.

Third, it recognizes that the techniques for the control of tuberculosis and many other communicable diseases are known and simply need to be applied for the public to benefit.

Fourth, the bill provides that the awarding of grants shall give consideration to the relative extent of the communicable disease problem and to level of performance in preventing and controlling such diseases. Tuberculosis is a health problem which varies considerably from State to State and even more so, within States.

For 1967 data, there was a 22-fold difference in death rates and an eightfold difference in case rates between the lowest and highest ranking State. Obviously, if the Congress wants to reduce the incidence of tuberculosis, it must get support and programs to where the problem is. A formula based on population and per capita income such as governs 314(d) will not do so.

As I understand this bill, it provides that grants be made in such a way that the record of performance in preventing or controlling such diseases must be considered and rewarded. This means to us that operational workloads for activities that are important and critical in preventing or controlling diseases be taken into consideration in the awarding and paying of these grants.

Such considerations might include the number of children who were vaccinated against communicable diseases during the year, the number of contacts of TB and VD cases who were examined, the number of identified cases who complete their courses of drugs for preventive and definitive treatment of tuberculosis.

This record of performance should be documented in the report which the Secretary is required to submit annually under the bill, we presume, to Congress. This report will enable the Congress and the public to see what has been accomplished with the funds they have provided.

However, I should like to see the legislation more explicit in two regards than it is in its present wording.

First, there should be authority for grants for eradication-type, intensive, short-term, one-time campaigns in areas whose entitlement on the basis of extent of the disease problem would not provide funds adequate for such campaigns.

Second, the bill provides clearly that grants be available on entitlement bases on extent of the problem, and that payment be in consideration of performance. In addition, however, there is need, in my opinion, for an intermediate step in the award process which might be spelled out in the legislation. We believe that there should be a requirement that a State or a political subdivision requesting a grant submit a plan of operation to HEW for review and final approval.

Such a plan should include definitive descriptive information on administrative, organizational, budgetary, and technical aspects of operations, as well as a definition of the population groups to be served. Agreement between HEW and the State or political subdivision on this plan should relate to the performance factors that would be the basis for final payment and to the reports required of the recipient.

Intensive control programs will have significant effects on the tuberculosis problem. In 1968, under such programs, new active cases of tuberculosis reported in the United States—there were 42,758 in 1968—dropped 6.3 percent, the largest annual percent decline in the preceding 5 years.

In spite of this progress, we expect that the eradication of tuberculosis will be slow and difficult—truly as the word signifies—a pulling out of the roots. We still have about 25 million people who have been infected with the tubercule bacillus, a large number of whom may break down. It is essential that we apply preventive treatment widely enough that the number of such events will be reduced.

S. 2264 will make it possible to continue such efforts. Therefore, we hope that the Congress will insure the eradication campaign by enacting this bill.

Thank you, sir.

Senator HUGHES. Thank you very much, Dr. Anderson, for an excellent statement.

Do you think there is a real danger of a rapid increase in the incidence of tuberculosis if the administration's block grant approach is used in the tuberculosis area?

Dr. ANDERSON. I think that the very effective tuberculosis control operations within the States are going to be hampered by a switch from 314(e), or a project grant approach, to the formula grant approach.

For example, there are 29 States, according to the figures that we have seen, which under the formula approach, would receive less, and considerably less, money than they do under the project grant approach.

In addition to that, to illustrate the pressures that are present on 314 (d) funds, I took a look at the States in which the present project grants for tuberculosis control programs constitute 20 percent or more of the moneys that would be available under the addition of this \$18 million to the total of formula 314(d) funds bringing them up to \$90 million. There are 32 States, Senator Hughes, in which the project grant for tuberculosis alone constitutes 20 percent or more of the formula (d) funds that would be available under distribution of \$90 million.

So you can see the choices that would be given a State are very difficult choices.

Senator HUGHES. Are you familiar with these 32 States? In your opinion, do they need the amounts of money they are getting?

Dr. ANDERSON. Yes, sir. Most of these are States of very high prevalence. The project grant money has tended to go to the States where the tuberculosis problem is great, but as I point out, tuberculosis programs are no longer properly considered as being innovative-type programs, so they have to go somewhere other than 314(e).

Senator HUGHES. Could you furnish a list for the record of those 32 States?

Dr. ANDERSON. Yes, sir.

Senator HUGHES. It will be entered at this point. We would appreciate it very much.

(The material referred to follows:)

TUBERCULOSIS CONTROL GRANTS COMPARED

States where 1969 TB project grants awarded under 314(e) equal or exceed 20% of the state's allotment of \$90 million under 314(d) formula reduced by the 15% required for mental health and by 1% for DHEW evaluation: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, District of Columbia, Florida, Georgia, Hawaii, Kansas, Maryland, Michign, Mississippi, Missouri, Montana, Nevada, New Jersey, New Mexico, New York, North Carolina, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, West Virginia, Puerto Rico and the Virgin Islands.

Senator HUGHES. You mentioned in your testimony the need for concentrated programs in certain areas or regions, for example, in which there is not enough funding to do an adequate job presently. Is this possible under this new legislation?

Dr. ANDERSON. I think it would be possible if the legislation carried the addition that I suggested. For example, the extent of the disease problem in Iowa compared to many other States is not relatively high. It is relatively low, as a matter of fact. Under any formula which considered only an award made on the basis of the extent of the disease problem, the money that you could get into Iowa for a special intensive campaign, let's say, in Des Moines or over in one of the river communities, would probably not be sufficient in amount to encourage an eradication-type campaign in that area in a short space of time.

In other words, in these areas of low prevalence it might be that it would be sounder with regard to certain communicable diseases to put on an intensive campaign once every few years rather than dribble it out over a large number of years.

Senator HUGHES. Well, this is one of the points I was trying to get at and not doing it very well, I am afraid, with the Surgeon General, a concentration of a program in a regional area in which there is not enough funding for that type of a program and it must be spaced out periodically with the accrued benefits. But you think the concentrated program would be better?

Dr. ANDERSON. In certain types of activities I think a concentrated program might be the best approach. To go in on an intensive case-finding program, using tuberculin testing, let's say, skin testing and trying to get every person who reacts, and especially those that are in the very susceptible groups that can be defined, to take isoniazid, a drug that is so effective in preventive treatment, this would make a lot of sense in a certain geographic area within a low-prevalence State.

Senator HUGHES. How many of the schools in America, do you know, or what percentage of school children are skin-tested every year, for tuberculosis?

Dr. ANDERSON. No, I do not have that figure precisely, but it is sizeable. I would estimate there are about 18 million skin tests performed in the United States annually. Now, this is for more than just schoolchildren, but this gives a dimension of the tuberculin testing activity that is going on.

Senator HUGHES. Is it not true that 15 percent of the \$18 million must go to mental health and thus cannot possibly be used for tuberculosis control?

Dr. ANDERSON. The provisions of 314(d), require that at least 15 percent of the money must go for mental health activities, so that any increase in appropriations for 314 automatically increases the amount of money that must be spent for mental health activities.

Senator HUGHES. Is there anything additional you would like to say for the record that I am not getting at back here?

Dr. ANDERSON. I think not, sir. I think my statement covers it.

Senator HUGHES. Well, thank you very much for your testimony.

Dr. ANDERSON. Thank you.

Senator HUGHES. I next call Dr. Charles A. Pigford, director of the department of public health, city of Houston, Tex.

Dr. Pigford, we appreciate very much your being here today to present your testimony, and you may proceed as you wish.

STATEMENT OF DR. CHARLES A. PIGFORD, DIRECTOR, DEPARTMENT OF PUBLIC HEALTH, HOUSTON, TEX.

Dr. PIGFORD. Thank you, Mr. Chairman, members of the committee. I appreciate the opportunity of appearing here.

If there are any accomplishments of which health workers may be justifiably proud, it is the progress that has been made in the past 75 years in the diagnosis, treatment, and control of infectious and contagious diseases. It is because of the dedicated efforts of public health workers and of those farsighted and humanely motivated organizations and individuals that disability and death from pneumonia, smallpox, tuberculosis, tetanus, diphtheria, poliomyelitis, and whooping cough have been minimized to provide us in this Nation with an increased lifespan and with the freedom from disability most of us now enjoy.

The man-hours saved and the increase in human productivity as a result of these advances in health knowledge and practice is virtually incalculable. The value of the control of communicable disease is most forcefully illustrated by figures contained in the national communicable disease center booklet on rubella surveillance, June 1969.

There were 22,500,000 rubella cases in the 1964-65 rubella epidemic; 2,160 of these died; 20,000 of them were afflicted with rubella syndrome. The national communicable disease center estimates direct cost of this epidemic to have been \$1,026,795,000, and indirect costs \$434,379,000, for a total economic loss to this Nation of \$1,461,274,000. This figure may be conservative. Best estimates for lifetime care of a mental retardate or a deaf blind victim come to \$250,000. There were 5,370 cases in these categories in the 1964-65 epidemic. At \$250,000 each, this comes to \$1.5 billion for the care of these cases alone.

While it is true that marvelous advances have been made in the control of communicable diseases, to assume that tuberculosis, diphtheria, poliomyelitis, measles, and the others have been conquered and that there is no further danger would be a gross miscalculation of the facts. No communicable diseases have been totally eradicated in this country. We have constructed an effective wall against them, we have reduced their incidence, but only one of them—smallpox—to a significant level. All of the safeguards that we are now employing have to be maintained to continue the present level of control even in smallpox, which has been mastered only after more than 50 years of intensive national and international efforts.

Forty years ago we were saying that diphtheria could be eradicated because we have an absolutely foolproof vaccine. We do have a most effective diphtheria vaccine; we could reduce diphtheria cases to practically zero—if we could get families to see that their children take the vaccine. This emphasizes a point I would like to make in the cost of communicable disease control. It is by no means limited to buying vaccine and paying people to inject it. Families have to be motivated to take their children to their doctor and to our clinics. This means we need nurses for home visits, the development of health awareness in our population, the utilization of indigenous workers in deprived neighborhoods, and all the health education and salesmanship that we can muster.

Last year in Houston we had two cases of poliomyelitis—one of which died—in a Mexican-American family who lived just three blocks from a city of Houston health center. We found 54 percent of the preschool-age children in that neighborhood susceptible to poliomyelitis. They had not been immunized. We had to organize a crash campaign in order to prevent an outbreak, using all our resources, health educators, nurses, and doctors.

We enlisted people in the neighborhood, the OEO people, the neighborhood centers association, the Martin Luther King Center, and the Protestant charities, among others, in mobilizing our effort to protect as many of the children as we possibly could. This is the kind of intensive effort that is going to have to be made continually to prevent recurrent outbreaks of poliomyelitis and other communicable diseases. This means that the cost of this control is not limited to the purchase of vaccine and the employment of nurses and doctors to administer it.

Houston and Harris County, Tex., like other major metropolitan areas in the United States have serious and significant problems in communicable disease control. In 1968, there were reported to the Houston Health Department 600 new active cases of tuberculosis—there were more than 3,000 cases under medical care—1,795 cases of syphilis, 540 of which were acutely infectious, 10,326 cases of gonorrhea, 223 cases of infectious hepatitis, 660 cases of infectious enteric disease—salmonellosis and shigellosis—121 cases of meningitis, and 20 cases of amebic dysentery.

Houston receives a total of \$342,991 annually in Federal grants for the control of communicable diseases. This money finances the very core of our control efforts. With it we are beginning to get our tuberculosis problems in hand. With it we are desperately trying to make headway in the ever-present dangerous venereal disease situation. With it, we have immunized 100,000 children against measles.

I am informed by the Texas State Health Department that the block grant to Texas, under Public Law 89-749, will not provide enough money to replace that which will be lost by the elimination of categorical project grants. The State of Texas has not appropriated the funds to replace the money that will be lost. The city of Houston is unable to do so. We feel like we are justified in asking for Federal assistance because we have no residency requirements for admissions to our communicable disease clinics and because communicable disease is more than a local problem.

We have no quarrel with the Partnership for Health Act or with the concept of comprehensive health care. Municipal health officers were asked to support the provisions of Public Law 89-749, and we did. We are committed to making it work and we are developing plans for a comprehensive health care system and we believe that communicable disease control can be integrated into that system but that system does not exist and we need additional time to effect these changes and we need the project grants to continue during this time so that our people will not suffer.

I would like to add, Senator, that I am a trustee of the U.S. Conference of City Health Officers, which is an organization of 75 municipalities associated with the U.S. Conference of Mayors, and I am authorized by the President to say that the U.S. Conference of City Health Officers heartily supports these two bills.

Senator HUGHES. Thank you very much, Dr. Pigford.

What do you expect the effect would be in Houston if you no longer had funds for communicable disease control from categorical grants?

Dr. PIGFORD. We will have to curtail our program.

Senator HUGHES. Would this result in an increase in the problem as you have defined it here so adequately?

Dr. PIGFORD. I do not think there is any question about it.

Senator HUGHES. I see at the end of your statement, you say, "We are committed to making it work and we are developing plans for a comprehensive health care system * * *"

Does that indicate that you are at least in the process of developing? You do not presently have adequate planning for this, is that right?

Dr. PIGFORD. Yes, sir; that is correct. We do not have an adequate plan. The State does not have a plan, and we do not have one locally. However, the State is working on it. They have just recently completed the formation of their Governor's Advisory Commission.

In Houston, we have the regional group, the Council of Governments, the Houston-Galveston Council, consisting of eight counties. We have only this year begun to develop an organization to get this started beyond a plan.

Senator HUGHES. This is the point I was trying to get at earlier, rather unsuccessfully, I am afraid, of pointing up at least in many areas of the country, that planning at this level is very inadequate. And your indications are, Doctor, that it certainly is at the present time in your city and in your region of your State.

I take it, then, that you are emphatically supporting one or both of the new bills?

Dr. PIGFORD. I am, sir.

Senator HUGHES. And that you feel that it is essential in even continuing the level of the programs you are presently conducting, and hopefully to be able to expand on those in other areas?

Dr. PIGFORD. Yes, sir.

Senator HUGHES. Thank you very much.

Dr. PIGFORD. Thank you, sir.

Senator HUGHES. Thank you for your testimony.

Dr. Virginia Apgar, vice president for medical affairs, The National Foundation—March of Dimes, New York, accompanied by Gabriel Stickle, medical statistician, National Foundation.

Dr. Apgar, you may proceed.

STATEMENT OF DR. VIRGINIA APGAR, VICE PRESIDENT FOR MEDICAL AFFAIRS, THE NATIONAL FOUNDATION—MARCH OF DIMES, NEW YORK; ACCOMPANIED BY GABRIEL STICKLE, MEDICAL STATISTICIAN, NATIONAL FOUNDATION

Dr. APGAR. Thank you, sir.

I would like to add that within 12 hours Mr. Stickle will be the executive director of our medical department at the March of Dimes.

Senator HUGHES. Congratulations.

Dr. APGAR. Mr. Chairman, the National Foundation—March of Dimes, is pleased to have been invited to present its views on proposals to the Senate for the control of communicable disease. Our interest in immunization is well known and extends back to 1938, the

year in which the National Foundation was organized by Franklin D. Roosevelt to lead the fight against polio.

During an era in which Government support of health research and development was minimal, the National Foundation was the principal source for the funding of major advances in virology and immunology which culminated in the licensure of the Salk vaccine in 1955 and the elimination of epidemic polio as a public health problem in the United States. Underlying all the developments leading to subsequent virus vaccines were the laboratory techniques perfected in polio vaccine research.

Since 1958, the National Foundation—March of Dimes, has been dedicated to the prevention and amelioration of birth defects which are this Nation's primary problem of child health. An estimated 7 percent of the live born—that is, some 250,000 a year—have defects which are evident during infancy; that is, during the first year of life. Through programs of laboratory and clinical research, medical care, professional and public education, and community service, this organization strives to advance the fight against birth defects.

S. 1662 addresses itself to the problem of the control through vaccination of certain communicable diseases of childhood, namely, poliomyelitis, diphtheria, whooping cough, tetanus, measles, and rubella. S. 2264 adds to this list tuberculosis, venereal disease, and other communicable diseases determined to be of national significance.

With the exception of rubella, existing prophylactic measures have brought each of the specified diseases under control to varying degrees—from virtually complete control in the case of polio to less than adequate control for tuberculosis, measles, and the venereal diseases. Our particular interest, however, is directed to the prospects for prevention of rubella, since the recent approval of a vaccine for this disease represents a significant step forward in the fight against birth defects.

Rubella is usually a mild childhood disease but may cause serious defects in the unborn baby when the mother is infected in the early months of pregnancy. Young children are the principal source of the infection of pregnant women, not just in the first trimester but as late as the fourth and fifth months of pregnancy.

Epidemics of rubella occur in the United States at irregular intervals of 6 to 9 years. The last major epidemic, in 1964, caused an estimated 50,000 abnormal pregnancies, resulting in some 20,000 live-born babies with birth defects and about 30,000 fetal deaths before birth.

The consequences of rubella in pregnancy are varied and unpredictable. Spontaneous abortion, stillbirth, live birth with one or more anomalies, and normal infants are represented in the spectrum. Virtually every organ may be involved, either temporarily or permanently.

Cooper and Krugman, in a review of 271 abnormal infants followed to age 18 months, found congenital heart disease in 142, 52 percent; confirmed or suspected hearing loss in 140, 52 percent; cataract or glaucoma in 107, 40 percent; severe or moderate psychomotor retardation in 65, 24 percent; and neonatal thrombocytopenic purpura in 85, 31 percent. The mortality rate was 13 percent, 34 infants.

Thousands of victims of congenital rubella from the 1964 epidemic and from subsequent outbreaks of the disease have been cared for at the 107 birth defects centers supported by the March of Dimes. Many of these children continue to require intensive medical and educational services if they are to realize their full potential, as just pointed out so well by Dr. Pigford.

With widespread immunization of children with the new rubella vaccine, this tragedy may not be repeated.

In our view, however, there are formidable obstacles to the rapid and widespread use of the rubella vaccine in time to prevent another wave of rubella babies which may occur as early as 1970 or 1971.

Some of these obstacles are educational in nature; others are fiscal. On the educational side, the idea of vaccinating children against rubella to protect unborn babies from birth defects will not be easy to get across to the public. But public understanding is crucial if the vaccine is to prevent another epidemic.

Accordingly, the National Foundation has pledged itself to render voluntary service when requested by health departments and medical societies to foster public understanding and acceptance of the vaccine, as supplies become available. A review article on rubella by Dr. Louis Cooper, has been mailed to 145,000 physicians and other health professionals throughout the Nation—and I have a copy of it here—and millions of educational flyers are being readied for widespread public use.

We are confident that educational measures such as these, undertaken in cooperation with other voluntary health agencies, organized medicine, and public health departments, can and will overcome the barriers to public understanding and acceptance.

As for the fiscal obstacles, however, we are less optimistic. There are approximately 56 million children aged 1 to 14 in the United States. This is the target group for rubella immunization. If 75 percent of these boys and girls are to be vaccinated—and I believe that we can achieve this level of participation—some 42 million doses would be required initially. If as much as half this amount were to be administered on a private, fee-for-service basis—and I personally view this as an optimistic estimate—then governmental sources will need to furnish at least 20 million doses to achieve primary protection against another epidemic. At current prices, this is equivalent to \$30 million, exclusive of necessary laboratory, surveillance, and administrative costs.

In view of the cyclical nature of rubella epidemics and the consequent need to achieve rapid vaccine coverage, neither of the legislative proposals under consideration appears to be entirely adequate to meet this challenge. The appropriations authorized in S. 2264, however, more nearly approach the requirements.

S. 2264, moreover, would permit expeditious use of rubella vaccine through the well-established mechanisms of the National Communicable Disease Center which has proven its competence in earlier programs authorized under the Vaccination Assistance Act. The coming rubella epidemic, whether it strikes next year or the year after, constitutes a real emergency for the more than 4 million American babies who will be conceived that year. Under the circumstances, it would seem ill advised for the Federal Government to approach the problem of rubella prevention along a circuitous route, with all due respect to

the Surgeon General, which involves untried and necessarily slower administrative mechanisms.

In urging your favorable decision on S. 2264, we should like to call your attention to the need for amendment of the measure to comprehend the prevention of another disease which constitutes a more serious threat to children than most of the others included, and for which there is an effective vaccine, and to which Senator Kennedy spoke so eloquently this morning.

This is hemolytic disease of the newborn due to Rh incompatibility, otherwise known as erythroblastosis fetalis, or more simply Rh disease, some of the sequelae of which are death before birth, severe anemia, jaundice, and others.

Unlike the vaccines for the other diseases, this vaccine prevents, instead of fostering, immunization, in this case the immunization of the Rh negative mother against the Rh positive blood of her unborn baby, which trait he inherited from his father. Each year an estimated 250,000 women and their families in the United States face the possibility of having an affected child.

Prevention of Rh disease now is possible with the use of a specially prepared blood fraction known as Rh immune globulin. This product has been available to hospitals since June 1968. Injected into an unsensitized Rh negative mother soon after the birth of an Rh positive baby—by “soon” I mean within 72 hours—the Rh immune globulin effectively prevents her sensitization and the possible development of the disease in a subsequent Rh positive baby. About 8.4 percent of white maternity patients and 4.1 percent of Negro maternity patients are candidates for this vaccine.

With optimal use of this vaccine, the incidence of Rh disease can be expected to decline continuously from year to year, so that in 20 to 25 years the present pool of sensitized women of child-bearing age will be exhausted, thus eliminating the disease as a public health problem.

Our surveys of hospitals and our consultations with State public health departments, however, indicate that in many parts of the country substantially fewer doses of the Rh vaccine are being administered than are need to eliminate the disease. While the situation differs from one community to another, we estimate that nationally about one out of every four women who need the vaccine is not receiving it.

The reasons for underutilization of this preventive are varied, but since the vaccine is relatively expensive, cost may be a serious obstacle for many low- and moderate-income families, especially in areas where public programs of medical assistance are absent or inadequate to meet this need. For this reason, we ask you to consider the inclusion of Rh disease in any vaccination assistance measure you approve.

Senator HUGHES. Thank you very much, Dr. Agar.

How high a funding authorization do you think would be necessary in S. 2264 to do the task as outlined in here?

Dr. APGAR. Well, I believe, omitting the Rh problem, it is something around \$54 million, depending on the cost of the vaccine.

Senator HUGHES. I think you covered this, but is it not true that the administration does not have a specific plan to control rubella beyond the 2-year period, even though it will take much, much longer to eradicate rubella, if it is possible to do it?

Dr. APGAR. I think it is possible to do it, or to keep it under control, and it will probably be a period of nearer 5 years rather than 2.

Senator HUGHES. Nearer 5.

Dr. APGAR. But I think there certainly needs to be some plan of continuous fiscal support during that period of time.

Senator HUGHES. I take it, then, from your statement that you are supporting, basically, S. 2264.

Dr. APGAR. Yes, sir.

Senator HUGHES. And this is a more adequate approach to the need as you view it, to The National Foundation?

Dr. APGAR. That is correct.

Senator HUGHES. And you feel it still falls short of doing the job?

Dr. APGAR. It is a good start toward it.

Senator HUGHES. You would be pleased with it, I would imagine.

Dr. APGAR. Yes, sir.

Senator HUGHES. Do you have anything to add, sir?

Mr. STICKLE. Nothing at all.

Senator HUGHES. Thank you very much, Dr. Apgar, for your testimony.

I would like to read a statement for Senator Kennedy into the record.

Senator Kennedy has asked me to say that he regrets he was called away from these hearings this morning, and he has requested that in light of the important issue raised by the testimony of the Surgeon General, he would like to address a further series of written questions to the Surgeon General, and hopes the replies can be made a part of the record of these hearings. And I will so direct that these written questions be submitted to the Surgeon General and the replies be entered into the record at the appropriate place.

(The information referred to appears on p. 125.)

Senator HUGHES. I now call Dr. Murray Grant for the Association of State and Territorial Health Officers, Director of Public Health, District of Columbia.

Due to the lateness of the hour, if I could prevail on you to be brief and to file your complete statement, to give it in more concise form, the Chair would appreciate it.

Dr. GRANT. I will be glad to try and do that, Mr. Chairman.

Senator HUGHES. If you are going to be longer in briefing than you would reading it, please read it. [Laughter.]

STATEMENT OF DR. MURRAY GRANT, ON BEHALF OF THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS; DIRECTOR, DEPARTMENT OF PUBLIC HEALTH, DISTRICT OF COLUMBIA

Dr. GRANT. Mr. Chairman, I am Dr. Murray Grant. I serve as Director of the Public Health Department for the District of Columbia, but I am here really as a member and representative of the Association of State and Territorial Health Officers.

We would like to support, Mr. Chairman, this bill S. 2264 primarily, Mr. Chairman, because while we have been supportive of Public Law 89-749, namely, the Comprehensive Health Planning Act, since it was initiated, the difficulties have been, Mr. Chairman, that our efforts have been somewhat in vain.

We support wholeheartedly the concepts of comprehensive health planning.

As a matter of fact, we believe we had a role to play in establishing those concepts. But the difficulties have been that we have not received funds to carry forward that particular law.

We believe that this bill, on the other hand, provides a mechanism for continuing tuberculosis and other communicable disease project grants which we believe are absolutely necessary at this time.

May I point out, Mr. Chairman, that in the action being proposed by the Department of Health, Education, and Welfare, and which has already been testified on this morning, they are proposing to take \$18 million, as you know, from 314(e) project grants and transfer that same amount of money to 314(d) or formula grants.

The Surgeon General, I believe, if I have interpreted him correctly, indicated that this would enable the States in their wisdom to use these funds as they deem it desirable.

I would suggest, Mr. Chairman, that this would be fine if it were true that the same amount of money would be available to each State under 314(d) as would be the case under 314(e). However, this is not the case. And as has been stated by, I believe, Dr. Anderson, approximately half the States will stand to lose money as the result of this transfer.

Unfortunately, those jurisdictions that stand to lose money are those that currently have rather substantial tuberculosis project grants, because of the fact that they have the largest tuberculosis problems in the country.

May I point out, Mr. Chairman, that approximately 30 percent of all cases of tuberculosis occur in cities of over 500,000. These are the jurisdictions, these are the places that have by and large secured tuberculosis project grants and will stand to lose as a result of the transfer of these moneys from 314(e) to 314(d).

To give you a specific example, in the case of my own jurisdiction here in Washington, we at the present time have a tuberculosis project grant in the amount of approximately three-quarters of a million dollars. We will stand to get, if this transfer is effected, \$68,000 in formula grants. So that, in fact, Mr. Chairman, we stand to lose almost \$700,000 of our tuberculosis control money.

The effect of this would be that it will decimate our tuberculosis control program. We would have practically no tuberculosis control program, because it is this grant that we rely upon, these Federal funds that we have relied upon for many years to carry out our tuberculosis program, to carry it through. And this transfer then will result in our having a very small program left.

So we really do not have the opportunity to take the formula grant money and use it in the way the Surgeon General, I believe, implied, because we would be losing substantial funds.

Therefore, Mr. Chairman, we believe that these funds that would be authorized in 2264 would enable us in our various jurisdictions to continue our efforts in tuberculosis control and in the control of venereal disease and other communicable diseases in ways that we will not otherwise be able to do if this transfer of the \$18 million is effected. Mr. Chairman, I think this perhaps summarizes our statement.

Basically, we support, and support wholeheartedly, Public Law 89-749, the Comprehensive Planning Act, and were it possible to secure substantially increased block grants to the States and to the other citizen localities, we would be most supportive of it. The fact is we have not been able to increase the appropriations, and this latest change by HEW in transferring these \$18 million will place us in a very difficult position, Mr. Chairman. Therefore, we support S. 2264 as being a mechanism to enable us to carry out our commitments in tuberculosis control and in the control of other communicable diseases.

Senator HUGHES. If I understand you correctly, you feel about the same way, you support in theory what is attempted to be done but in practicality you are going to have such a loss of funds that it will destroy your program.

Dr. GRANT. Yes.

Senator HUGHES. Is it not true that the District of Columbia has one of the highest tuberculosis incidence rates in the United States?

Dr. GRANT. That is correct, sir.

Senator HUGHES. And then the loss of these funds, the way it sounds, about 90 percent of your funds, would mean disaster.

Dr. GRANT. This is the same problem, though, Mr. Chairman, that occurs in most of the other large cities. These are the cities that have a large tuberculosis problem and who will be denied as a result of this change in the mechanism by transferring these funds, they will be denied substantial amounts of money with which to carry out tuberculosis control programs.

Senator HUGHES. It would be my guess that the same is true with venereal disease.

Dr. GRANT. Yes, sir. One of the problems, Mr. Chairman, with the formula grant mechanism, one that we have spoken about on frequent occasions, is the fact that the formula grant as currently calculated is parceled out to the States on the basis of two things: population and per capita income. It does not take into consideration the fact that in many of these jurisdictions we can have an average per capita income, but a high percentage of low-income people. You can have a large percentage of people with major health problems. And this is not taking into consideration in the allocation of formula grants.

Senator HUGHES. Then, just as a word of finality, the basis of your total testimony is full support of S. 2264?

Dr. GRANT. Yes, sir.

Senator HUGHES. Thank you very much, Dr. Grant.

Dr. GRANT. Thank you, Mr. Chairman.

(The prepared statement of Dr. Grant follows:)

PREPARED STATEMENT OF DR. MURRAY GRANT, REPRESENTING THE ASSOCIATION OF
STATE AND TERRITORIAL HEALTH OFFICERS

Mr. Chairman. I am Murray Grant and I serve as Director of Public Health of the District of Columbia Department of Public Health. The testimony I am presenting today is on behalf of the Association of State and Territorial Health Officers.

First of all I want to express the support of our Association for S. 2264, the Communicable Disease Control Amendments of 1969, and S. 1622, the Vaccination Assistance Act of 1969. We strongly endorse the financial assistance for vaccination programs that would be provided by S. 2264 and S. 1622 and the financial assistance for preventing and controlling tuberculosis, venereal diseases and other communicable diseases as authorized by S. 2264. Since S. 2264 is a more comprehensive bill we urge its approval by the Congress.

COMPREHENSIVE HEALTH PLANNING

As this Committee knows, the Association of State and Territorial Health Officers has been a leading supporter of the legislation that authorizes financial assistance for comprehensive health planning and formula and project grants for health services under section 314 of the Public Health Service Act. When this legislation was originally considered it was our hope that section 314 of the Public Health Service Act would be funded at a level that would permit the States to meet their most urgent public health needs. Unfortunately this hope has been in vain.

The Association of State and Territorial Health Officers continues to urge that the authorization for appropriations and the actual appropriations under section 314 be increased substantially. But, we cannot ignore pressing health problems while we wait for additional funding under section 314. Consequently, we urge the enactment of S. 2264.

I want to make it very clear that the Association of State and Territorial Health Officers strongly supports the concept of the legislation that is identified as the "partnership for health." We question whether we really have an effective partnership, however, when the contribution of the Federal Government to public health program is less than 5 percent of the total cost.

Our Association endorses the "bloc" grant. But we are faced with a conflict in theory and practice. Simply stated, the States at present have the broadest legislative authority but no money. We have complained about the inflexible aspects of categorical grants but the bookkeeping problem is minor in relation to the alternative—not enough funds for urgent public health needs. I repeat that we endorse the enactment of S. 2264.

TUBERCULOSIS

In 1968 the Surgeon General's Task Force on Tuberculosis recommended a ten-year program to combat and control tuberculosis. This was some ten years after drugs were discovered that made specific chemotherapy for the disease possible—therapy that has since proved to be potentially effective in more than 95 percent of newly diagnosed cases.

This ten-year program has yielded significant progress. Between 1965 and 1968 the number of new active cases of tuberculosis was reduced from 49,016 to 42,758. The number of deaths due to tuberculosis declined from 7,934 in 1965 to 6,901 in 1967. See attached table.

Despite this progress, the Department of Health, Education and Welfare proposes that the \$18 million of project grants for the control of tuberculosis under section 314(e) of the Public Health Service Act be discontinued. At the same time, the Department recommends that a corresponding dollar figure, \$18 million, be added to formula grants under section 314(d) and be used for combatting tuberculosis, venereal disease and alcoholism.

The problem caused by this decision of the Department is no minor matter. By shifting the \$18 million from project to formula grants, the allocation on a State-by-State basis is radically changed. See attached State-by-State table. The project grants were distributed with consideration given to the relative extent of the tuberculosis problem. The formula grants, however, by law are allocated among the States on the basis of population and per capita income. The States with a significant tuberculosis problem, therefore, for the most part have greatly reduced funds for the control of tuberculosis. If, as the Department suggests, these funds are also used to combat venereal disease and alcoholism, the amount for tuberculosis control will be further curtailed. The enactment of S. 2264 would provide a continuing source of stable financial support for the control of tuberculosis.

VENEREAL DISEASE

The venereal diseases are another pressing public health problem that is in need of attention at the Federal level. While it is true that there has been a gradual decline in the number of cases of syphilis, there has been a dramatic rise in the incidence of gonorrhea. See attached table. As a Nation, we should be doing much more to combat venereal diseases that now account for some 2,400 deaths each year and take a needless toll in disability. The steady increase in the number of cases of gonorrhea is evidence enough of the need for new legislation to control communicable diseases:

Year:	Newly reported cases of gonorrhea
1958	232, 513
1960	258, 933
1962	263, 708
1964	300, 667
1966	351, 738
1968	431, 380

IMMUNIZATION

Despite the fact that we have preventive agents for diphtheria, measles, polio, rubella, and tetanus, these diseases continue to take a needless toll in death and disability. See the attached table. Diphtheria has increased in each of the last four years, 1965 through 1968, from 164 to 209, to 219 and to 243. We still have 22,000 cases of measles reported and this is an understatement since the reporting is less than complete. German measles is another communicable disease that can be prevented with a vaccine. A vaccine has recently been developed and has been licensed. Only 50,000 cases of German measles are reported, but the actual incidence is estimated to be approximately 2.5 million. This disease causes mild discomfort but in a pregnant woman carries the risk of death and disability to the unborn child. It is imperative that a continuing program of Federal financial assistance be provided to the States so that we may have a continuing program of vaccination against preventive illnesses.

The National Nutrition Survey as well as the Office of Economic Opportunity has reported that less than one-half of the preschool children in poverty areas are adequately immunized against polio, measles and other preventable diseases. If we are to eliminate the possibility of an epidemic in these ghetto areas, we must provide national leadership and a national commitment against them. Such a commitment would be provided for by the enactment of S. 2264.

The Association of State and Territorial Health Officers is honored by this opportunity to present testimony on S. 2264. We urge its enactment at the earliest opportunity.

REPORTED CASES AND DEATHS OF CERTAIN NOTIFIABLE DISEASES

Disease	Cases		Deaths	
	1965	1968 ¹	1965	1967 ¹
Diphtheria.....	164	243	18	32
Measles.....	261,904	22,527	276	81
Polio.....	72	57	16	16
Rubella.....	46,975	48,433		
Tetanus.....	300	159	181	144
Tuberculosis.....	49,016	42,758	7,934	6,901
Syphilis.....	112,842	² 98,195	2,434	2,381
Gonorrhea.....	324,925	² 431,380	9	11

¹ Preliminary.

² Fiscal year figures.

Source: Public Health Service.

COMPARISON OF PROPOSED 314(d) BUDGET INCREASE FOR FISCAL YEAR 1970 WITH AMOUNT BUDGETED IN
FISCAL YEAR 1969 FROM SEC. 314(e) FOR TUBERCULOSIS PROJECTS

States and territories	Formula grants		Increase	1969 TB project grants
	1969	1970		
Total	\$56,011,400	\$75,641,700	\$19,630,300	\$20,689,971
Region I:				
Connecticut	795,900	1,047,700	251,800	31,675
Maine	472,600	573,000	100,400	48,676
Massachusetts	1,314,400	1,788,700	474,300	257,290
Boston				(125,317)
New Hampshire	398,200	467,000	68,800	53,548
Rhode Island	436,200	519,500	83,300	116,391
Vermont	341,100	387,300	46,200	71,697
Region II:				
Delaware	350,000	403,100	53,100	105,000
New Jersey	1,591,900	2,219,900	628,000	782,250
New York	3,732,900	5,229,100	1,496,200	1,715,843
Erie County				(258,476)
New York City				(1,128,105)
Pennsylvania	2,636,400	3,729,200	1,092,800	943,283
Allegheny County				(239,969)
Philadelphia				(320,589)
Region III:				
Washington, D.C.	399,500	467,700	68,200	759,046
Kentucky	1,010,800	1,359,000	348,200	255,082
Louisville-Jefferson County				(41,063)
Maryland	981,800	1,331,700	349,900	514,659
Baltimore				(389,384)
North Carolina	1,437,300	2,005,800	568,500	648,764
Puerto Rico	988,000	1,330,700	342,700	414,318
Virginia	1,246,300	1,709,100	462,800	367,858
Richmond				(134,159)
Norfolk				(94,585)
Virgin Islands	200,700	200,700		40,380
West Virginia	688,100	885,400	197,300	310,265
Region IV:				
Alabama	1,134,500	1,556,800	422,300	864,678
Jefferson County				(330,904)
Florida	1,564,200	2,186,400	622,200	868,488
Georgia	1,290,500	1,784,400	493,900	1,036,918
Mississippi	983,100	1,180,100	287,000	471,095
South Carolina	904,000	1,224,500	320,500	256,127
Tennessee	1,180,600	1,624,700	444,100	854,523
Hamilton County				(122,529)
Shelby County				(104,026)
Knox County				(96,056)
Davidson County				(110,489)
Region V:				
Illinois	2,311,800	3,271,600	959,800	202,714
Chicago				(74,514)
Indiana	1,260,700	1,755,500	494,800	336,516
Marion County				(156,047)
Michigan	1,933,700	2,769,500	835,800	1,004,242
Ohio	2,367,700	3,384,100	1,016,400	406,238
Wisconsin	1,111,500	1,510,200	398,700	183,260
Milwaukee				(183,260)
Region VI:				
Iowa	815,800	1,079,600	263,800	65,745
Kansas	728,600	951,400	222,800	190,466
Minnesota	995,900	1,348,000	352,100	179,922
Minneapolis				(40,908)
St. Paul				(62,327)
Missouri	1,222,400	1,670,500	448,100	679,918
St. Louis				(265,697)
St. Louis County				(147,463)
Kansas City				(119,327)
Nebraska	551,100	687,800	136,700	109,818
North Dakota	400,600	465,200	64,600	56,693
South Dakota	407,300	471,200	63,900	77,238
Region VII:				
Arkansas	751,700	1,002,200	250,500	302,000
Louisiana	1,115,400	1,522,300	406,900	268,985
New Mexico	484,100	597,500	113,400	155,795
Oklahoma	816,900	1,076,400	259,500	187,878
Texas	2,665,100	3,766,100	1,101,000	968,536
San Antonio				(130,358)
Houston				(256,181)

See footnote at end of table, p. 57.

COMPARISON OF PROPOSED 314(d) BUDGET INCREASE FOR FISCAL YEAR 1970 WITH AMOUNT BUDGETED IN
FISCAL YEAR 1969 FROM SEC. 314(e) FOR TUBERCULOSIS PROJECTS—Continued

States and territories	Formula grants		Increase	1969 TB project grants
	1969	1970		
Region VIII:				
Colorado.....	662,100	866,800	204,700	280,892
Denver.....				(101,244)
Idaho.....	412,200	487,700	75,500	55,449
Montana.....	406,800	475,100	68,300	103,916
Utah.....	483,200	594,600	111,400	167,051
Wyoming.....	312,800	347,400	34,600	
Region IX:				
Alaska.....	306,800	323,900	17,100	249,269
American Samoa.....	200,700	200,700		
Arizona.....	625,200	791,300	166,100	328,284
Maricopa County.....				(59,952)
Pima County.....				(42,751)
California.....	3,908,900	5,594,000	1,685,100	1,692,305
San Francisco.....				(153,538)
Guam.....	245,900	259,900	14,000	22,000
Hawaii.....	402,000	480,200	78,200	103,398
Nevada.....	332,800	381,400	48,600	241,158
Clark County.....				(66,502)
Oregon.....	667,700	861,800	194,100	137,141
Portland.....				(47,767)
Trust territories.....	252,500	255,100	2,600	
Washington.....	862,500	1,181,200	318,700	145,290

Note: Figures in parentheses are included in the State totals.

Senator HUGHES. I call Dr. William L. Fleming, board member and chairman of the Venereal Disease Advisory Committee, American Social Health Association, and chairman, Department of Preventive Medicine, School of Medicine, University of North Carolina.

Dr. Fleming, if you will observe, if you can, my advice to the previous witness, it will be appreciated, but either way will be advantageous.

STATEMENT OF DR. WILLIAM L. FLEMING, CHAIRMAN, DEPARTMENT OF PREVENTIVE MEDICINE, SCHOOL OF MEDICINE, UNIVERSITY OF NORTH CAROLINA, ON BEHALF OF THE AMERICAN SOCIAL HEALTH ASSOCIATION

Dr. FLEMING. I will be glad to summarize.

I am also pleased to have an opportunity to testify in support of what I think is a very important bill.

I refer in my written statement to a publication, copies of which I have left for the members of the committee, "Today's VD Control Problem." This is a "point statement" published by the American Social Health Association, but involving a number of other health and medical organizations also.

My testimony includes a summary of the current VD situation which was taken from this document, which appeared just this spring.

It was estimated that in 1968 there were approximately 75,000 newly acquired cases of infectious syphilis and a million and a half cases of gonorrhea. This is almost four times the total actually reported to the health authorities. Also even with infectious syphilis, in which there has been a recent decrease in reported cases, there actually was an increase in quite a number of States in 1968. So we have no reason for complacency with that disease.

With gonorrhea, the largest number of cases ever reported were reported in fiscal 1968. So we certainly have no reason for complacency there. On the basis of data in my written statement taken from the

published "joint statement", the American Social Health Association and cooperating health and medical organizations believes that the Federal Government would do well to spend more than \$20 million in fiscal 1970 in an effort to control the venereal diseases.

Last April when the board of directors of the American Social Health Association met, great concern was expressed at reports that Federal project grant fundings for VD and other forms of communicable disease control were to be discontinued. We understood that tuberculosis was going to be the first to have project grant funds stopped, but that venereal disease would be a close second.

We felt that it was essential that national coordination which goes along with Federal project, or categorical grant funding, be continued since these communicable diseases not only know no State boundaries but vary in seriousness from State to State.

As documentation of variation, the reported infectious syphilis rate, not the number of cases, but the number of cases per hundred thousand, currently varies 100-fold and the reported gonorrhea rate currently varies 25-fold among States, territories, and the District of Columbia.

Coordination on a national basis was felt to be particularly important. The board felt that new Federal legislation was required to assure Federal coordination and that the project grant funding was imperatively needed.

In the 1950's Federal funding for VD control was drastically curtailed, and in circumstances very similar to the present time. The argument was made that the communicable diseases were problems that should be handled by the States and localities. Federal funds were drastically curtailed at the time the first issue of the joint statement appeared.

The projection at that time was that there would be no Federal funds for the next fiscal year. Fortunately, that did not quite happen. But the reduction in Federal funds was not met by an increase by the States and localities. We had a dramatic resurgence of the syphilis attack rate which has only recently been partly contained. We have no evidence that gonorrhea has been controlled. And the number of cases, as I mentioned, is the largest ever recorded, in fiscal 1968.

We feel that we have documented the need for more than \$20 million in appropriations in this document for fiscal year 1970.

We would contend that even the \$60 and \$75 million recommended in the bill for fiscal 1970 and for 1971 and ensuing years, are timely and important, but still inadequate for the control of the communicable diseases.

Thank you, Mr. Chairman.

Senator HUGHES. In line with your statement that \$20 million should be spent next year on VD control, do you know how much is being spent by the Federal Government right now per year?

Dr. FLEMING. Yes. The Federal Government is now spending \$10 to \$12 million. The total nationally is about \$27 million. The States are spending something better than \$15 million.

Senator HUGHES. If I understand you correctly, you consider the administration proposal totally inadequate and even the other proposals as less than adequate to meet the needs of the coming years?

Dr. FLEMING. Yes, sir; that is my belief.

Senator HUGHES. Well, I thank you very much, Dr. Fleming, for your patience and your testimony.

I believe this concludes the list of witnesses for this morning—

Dr. FLEMING. I did leave some suggestions for inclusion of material in the record—

Senator HUGHES. Your statement—

Dr. FLEMING. Not only my written statement but also either the entire "joint statement" on "Today's VD Control Problem" (copies of which I have left) or the key sections of this document, a list of which I have attached to my statement.

Senator HUGHES. Your entire statement will be made a part of the record.

Dr. FLEMING. I suggested that in addition, the "joint statement" be included or certain key sections which I listed. This is attached to my written statement.

Senator HUGHES. We can include the sections you recommend in your statement.

Dr. FLEMING. Thank you.

Senator HUGHES. Thank you very kindly, sir.

(The prepared statement of Dr. Fleming follows:)

PREPARED STATEMENT OF WILLIAM L. FLEMING, M.D., CHAIRMAN, DEPARTMENT OF PREVENTIVE MEDICINE, UNIVERSITY OF NORTH CAROLINA

I am William L. Fleming, M.D., Chairman, Department of Preventive Medicine, School of Medicine, University of North Carolina. I appreciate the opportunity of testifying regarding S. 2264 which I regard as a very important bill.

I am appearing on behalf of the American Social Health Association one of whose major interests since its founding more than 50 years ago has been the control of the venereal diseases. I am a member of its Board of Directors and Executive Committee and am Chairman of its Advisory Committee on the Venereal Diseases. I am also Chairman of the Committee which prepares the publication entitled "Today's VD Control Problem." This document which has appeared annually for 16 years is a joint statement sponsored by the American Public Health Association, the American Social Health Association, and the American Venereal Disease Association prepared in cooperation with the American Medical Association, the American Osteopathic Association, the Association of State and Territorial Health Officers and the National Medical Association and is written and published by the American Social Health Association.

The 1968 issue of the Joint Statement on Today's VD Control Problem which appeared in the spring of 1969 summarized its findings prior to its recommendations. This summary together with its first recommendation which concerned federal funding are as follows:

"The 1968 National Survey of VD Incidence indicates that there were approximately 75,000 newly acquired cases of infectious syphilis and 1,500,000 cases of gonorrhea in the United States in 1968. The estimated number of cases of both infectious venereal diseases was almost four times the total number reported to health authorities by all sources during the same period.

"The survey documents the existence of a presently uncontrolled epidemic of gonorrhea, as had been forecast by public health authorities. It also documents a decrease in the prevalence of infectious syphilis, testifying to the effectiveness of the aggressive campaign which has been waged against this disease since 1962. However, optimism about this decrease is tempered by the fact that the reported incidence of infectious syphilis increased by 15% in 18 states in 1968 over 1967; and by the lessons learned from the recrudescence of the disease which began in 1958.

"Findings of the survey in regard to the high incidence of both infectious venereal diseases document the need for substantial increases by federal, state and local governments in funds for VD control in fiscal 1970; for syphilis, to protect the gains made thus far and to continue its downward trend; for gonorrhea, to mount an effective program based on pilot studies and research undertaken during the past two years with special funds earmarked by Congress for this purpose; for both diseases, to find immunizing agents and other new approaches to control and eventual eradication.

"The Sponsors of the Joint Statement present their conviction that the continued high incidence of infectious syphilis and an epidemic of gonorrhea in the United States mandate continued basic federal financial support of the effective federal-state-local partnership manifest in the national venereal disease control

program. This support, on a continuing long-range basis, cannot be considered as a project type program competitive with a wide range of other health programs.

"Therefore, we the undersigned recommend:

1. That \$20,275,000 be made available from federal funds for VD control in fiscal 1970.

"That the \$20,275,000 be allocated as follows: \$5,000,000 for maintaining the activities of the Venereal Disease Program of the National Communicable Disease Center of the Public Health Service; \$1,500,000 additional, including 50 additional positions, to the Venereal Disease Program for special gonorrhea control program development; \$500,000 and 15 additional positions to the Venereal Disease Program for increasing intra-mural VD research; \$2,000,000 and 100 additional positions to the Venereal Disease Program for innovative control programs; \$275,000 to the Venereal Disease Program, to be allocated as follows: \$75,000 to provide for five additional Venereal Disease Research Laboratory researchers; \$100,000 to provide for teaching programs in 10 medical schools at \$10,000 per school; \$100,000 for pilot educational studies to control venereal disease infection among high risk groups; making a total appropriation to the Venereal Disease Program of the National Communicable Disease Center of \$9,275,000 and that \$1,000,000 earmarked for project grants for extra-mural VD research in medical research institutions of the country be appropriated to the National Communicable Disease Center to begin to meet critically short research needs in this area, \$1,000,000, and that, in keeping with the concept of Public Law 89-749 in relation to a major national health problem, Congress clearly declare to the Secretary of the Department of Health, Education and Welfare its intent that \$10,000,000 be set aside within the 314(e) mechanism of Public Law 89-479 to meet the needs of the national venereal disease control program. This recommendation is made for the purpose of reducing confusion and uncertainty among the states and major urban areas concerning the future of the national venereal disease control program and to reduce fragmentation of program activity and health services which may result from competitive project funding, \$10,000,000; total \$20,275,000."

The Board of Directors of the American Social Health Association at its annual meeting in April went on record as expressing great concern at reports that federal project grant funds for VD and other forms of communicable disease control were to be discontinued. It felt that it was essential that national co-ordination which goes along with federal project or categorical grant funding be continued for communicable diseases which know no state boundaries and which vary in seriousness from state to state. As documentation of variation, the reported infectious syphilis *rate* (not number of cases) currently varies 100 fold and the reported gonorrhea *rate* currently varies 25 fold among states, territories and the District of Columbia. Coordination on a national basis was felt to be particularly needed not only for control of the venereal diseases but also for control of tuberculosis, for the vaccination assistance program and for other aspects of communicable disease control. The Board felt that new federal legislation to assure federal coordination and project grant funding was imperatively needed.

Federal funding for VD control was drastically curtailed in the 1950's and a resurgence of the syphilis attack rate ensued which only recently has been contained but not yet dramatically reduced. We have no evidence that gonorrhea has been controlled and the number of cases reported in fiscal year 1968 was the largest ever reported. Consequently, adequacy *now* of federal funding for VD control is very important. The Joint Statement on Today's VD Control Problem documented the need for more than \$20 million for fiscal 1970. Consequently, the American Social Health Association contends that even the \$60 million and \$75 million recommended in the bill for fiscal 1970 and 1971 and ensuing years are timely and important but still inadequate for the control of the communicable diseases.

I have a number of copies of the 1968 edition of Today's VD Control Problem (published Spring of 1969) which I can leave for the use of the Committee. If it is not possible to reproduce the entire publication in the proceedings of the Committee, I would urge strongly that the following pages be reproduced:

Page 2: Committee on the Joint Statement 1968.

Pages 5, 6, 7: Recommendations.

Pages 9 through 15: Incidence and Trends.

Pages 42 through 50: Tables.

Pages 51 through 54: Summary Report, National Survey of VD Incidence.



Today's VD Control Problem

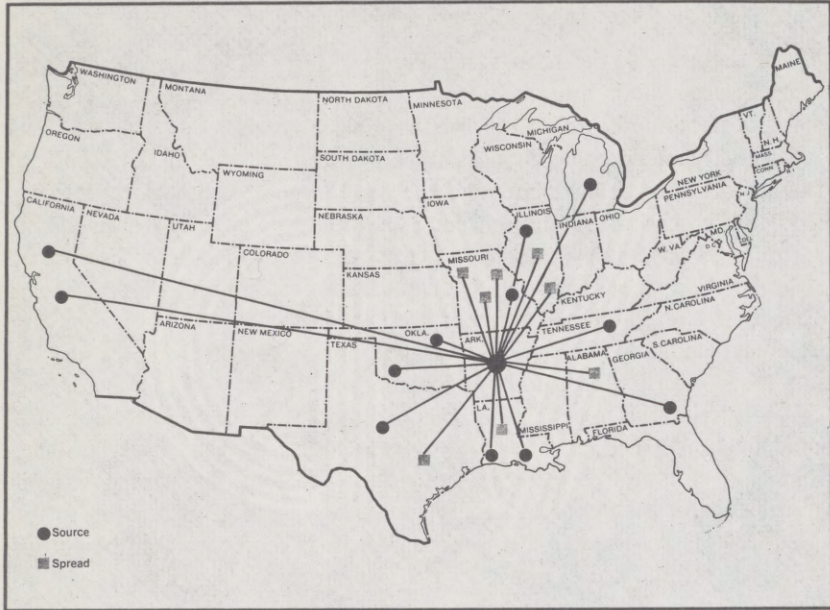
A JOINT STATEMENT BY • American Public Health Association •
American Social Health Association • American Venereal Disease
Association • With the Cooperation of the American Medical Association • American Osteopathic Association • Association of State
and Territorial Health Officers • National Medical Association

THE JOINT STATEMENT IS WRITTEN AND PUBLISHED BY THE
AMERICAN SOCIAL HEALTH ASSOCIATION

1969

(61)

SOURCE AND SPREAD CASES LOCATED IN OTHER STATES



PRIMARY AND SECONDARY SYPHILIS SOURCE AND SPREAD TABLE

Total Cases	Source Cases Located		Total Source Cases	Spread Cases Located		Total Spread Cases
	in state	out-of-state		in state	out-of-state	
160	105	12	117	81	8	89

Acknowledgement

The Sponsors of the Joint Statement, "Today's VD Control Problem," again express their appreciation for the cooperation which has made possible its annual publication for the past 16 years.

Special thanks are due the personnel of the 50 state health departments, 146 local health departments and the health departments of the District of Columbia and the Commonwealth of Puerto Rico who responded to a comprehensive questionnaire on VD control problems in their areas of jurisdiction; the VD Program of the National Communicable Disease Center of the Public Health Service, which cooperated by supplying statistical and other material; and the World Health Organization for supplying information on VD problems and trends in other countries.

Analysis of this material has made possible: a continuous review of incidence and trends in infectious syphilis and gonorrhea on a national, state and community basis; an analysis of the effectiveness of various approaches to the control of the venereal diseases; an evaluation of the adequacy of program funding to cope with the size and complexity of the problem, and a description of progress in research and experimentation to find new and better ways to bring an end to the historic scourge of the venereal diseases.

The Sponsors of the Joint Statement welcome this year the addition of the American Osteopathic Association and the National Medical Association as officially cooperating organizations in the preparation and presentation of the Statement. The other cooperating organizations are the American Medical Association and the Association of State and Territorial Health Officers.

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Recommendations

The 1968 National Survey of VD Incidence (pages 51-54) indicates that there were approximately 75,000 newly acquired cases of infectious syphilis and 1,500,000 cases of gonorrhea in the United States in 1968. The estimated number of cases of both infectious venereal diseases was almost four times the total number reported to health authorities by all sources during the same period.

The survey documents the existence of a presently uncontrolled epidemic of gonorrhea, as had been forecast by public health authorities. It also documents a decrease in the prevalence of infectious syphilis, testifying to the effectiveness of the aggressive campaign which has been waged against this disease since 1962. However, optimism about this decrease is tempered by the fact that the reported incidence of infectious syphilis increased by 15% in 18 states in 1968 over 1967; and by the lessons learned from the recrudescence of the disease which began in 1958.

Findings of the survey in regard to the high incidence of both infectious venereal diseases document the need for substantial increases by federal, state and local governments in funds for VD control in fiscal 1970; for syphilis, to protect the gains made thus far and to continue its downward trend; for gonorrhea, to mount an effective program based on pilot studies and research undertaken during the past two years with special funds

earmarked by Congress for this purpose; for both diseases, to find immunizing agents and other new approaches to control and eventual eradication.

The Sponsors of the Joint Statement present their conviction that the continued high incidence of infectious syphilis and an epidemic of gonorrhea in the United States mandate continued basic federal financial support of the effective federal-state-local partnership manifest in the national venereal disease control program. This support, on a continuing long-range basis, cannot be considered as a project type program competitive with a wide range of other health programs.

THEREFORE, we the undersigned recommend:

I. THAT \$20,275,000 be made available from federal funds for VD control in fiscal 1970.

THAT the \$20,275,000 be allocated as follows:

\$5,000,000 for maintaining the activities of the Venereal Disease Program of the National Communicable Disease Center of the Public Health Service;

1,500,000 additional, including 50 additional positions, to the Venereal Disease Program for special gonorrhea control program development;

500,000 and 15 additional positions to the Venereal Disease Program for increasing intra-mural VD research;

2,000,000 and 100 additional positions to the Venereal Disease Program for innovative control programs;

275,000 to the Venereal Disease Program, to be allocated as follows: \$75,000 to provide for five additional Venereal Disease Research Laboratory researchers; \$100,000 to provide for teaching programs in 10 medical schools at \$10,000 per school; \$100,000 for pilot educational studies to control venereal disease infection among high risk groups;

making a total appropriation to the Venereal Disease Program of the National Communicable Disease Center of \$ 9,275,000

and that \$1,000,000 earmarked for project grants for extra-mural VD research in medical research institutions of the country be appropriated to the National Communicable Disease Center to begin to meet critically short research needs in this area 1,000,000

and that, in keeping with the concept of Public Law 89-749 in relation to a major national health problem, Congress clearly declare to the Secretary of the Department of Health, Education and Welfare its intent that \$10,000,000 be set aside within the 314(e) mechanism of Public Law 89-749 to meet the needs of the national venereal disease control program. This recommendation is made for the purpose of reducing confusion and uncertainty among the states and major urban areas concerning the future of the national venereal disease control program and to reduce fragmentation of program activity and health services which may result from competitive project funding

10,000,000
 20,275,000

II. THAT state and local planning agencies, as provided for in the Comprehensive Health Planning Act (PL 89-749), set a sufficiently high priority on VD control to assure that state and local appropriating bodies, in allocating funds for public health needs in their areas, make adequate provision for VD control from a combination of state and local funds and from formula

grant and project grant funds available to the state or locality under Public Law 89-749.

III. THAT physicians in private practice accept their responsibility for the prevention of the spread of VD. Findings of the National Survey of VD Incidence documented the fact that three-fourths of all cases of VD are now treated in the office of the private physician, and that private physicians report an average of only one in eight cases treated by them. Further,

THAT private physicians accept guidance and direction from their professional societies to participate fully in the VD control program.

IV. THAT health departments, physicians' professional societies and health planning agencies jointly accept responsibility for reviewing the status of laws and regulations on reporting of reactive laboratory findings relating to syphilis, and urge their respective legislative bodies to establish laws, or health department regulations having the force of law, requiring that *all* laboratories, public and private, report *all* reactive laboratory findings relating to syphilis *by name* to the health department having jurisdiction; that in states now having this requirement, state and city health departments continue to implement complete adherence to it by all laboratories.

V. THAT, since statistics indicate that 40% of all reported infectious syphilis cases are brought to treatment as a result of the syphilis epidemiologic procedure, health departments and physicians in private practice accept responsibility for its complete application. Further,

THAT, in view of the epidemic of gonorrhea and the need for development of control measures, each state and local health department develop pilot projects or methods of approaching the control of gonorrhea by finding asymptomatic males and females.

VI. THAT, since the application of epidemiological (preventive) treatment to all adequately identified sex contacts exposed to infectious venereal diseases is now approved by the vast majority of state health departments, every effort be made to close the gap between policy and practice as a means of preventing the further spread of venereal disease.

VII. THAT serologic tests for syphilis be routinely performed on all routine hospital admissions and on all persons treated in outpatient clinics, and that performance of such tests be considered as an accrediting factor by all accrediting authorities. (Presently available equipment for automating serologic tests for syphilis should facilitate the routine performance of such tests.)

VIII. THAT, in view of the fact that statistics indicate an average of one VD infection in every 200 teenagers (ages 15-19) in the United States, state and local departments of education consider VD education for teenagers as an urgent need; that colleges preparing teachers include instruction in VD education in their curricula; and that state and local health departments provide assistance to schools and colleges in the furtherance of these programs.

IX. THAT, since one-fourth of all infectious venereal disease is found among young people under 21 years of age, legislation permitting the treatment of minors without parental consent be considered by all states not having such legislation as a means of removing present restrictions and delays in providing prompt treatment for VD.

X. THAT, since the 1968 National Survey of VD Incidence indicates the existence of a national epidemic of gonorrhea and a continuing high incidence of infectious syphilis, national, state and local civic, religious

and professional groups give increased emphasis to creating awareness of the venereal diseases, and that they actively support the inclusion of VD education in the schools.

XI. THAT, since the venereal diseases are a world-wide problem, the Congress appropriate sufficient funds to plan and conduct an international conference, inviting representatives from throughout the world, for the purpose of assessing the current status of the control of syphilis and gonorrhea on a world-wide basis and of bringing about an exchange of information about new approaches to control and about new developments in research; that the Secretary of Health, Education and Welfare be given the responsibility, through the National Communicable Disease Center, for planning and conducting the conference and for inviting the participation of representatives of the World Health Organization, United Nations Children's Fund, the International Union against the Venereal Diseases and Treponematoses and other international organizations working in the cause of VD control.

Lester Breslow
President

American Public Health Association

Samuel S. Heflin
Executive Director

Walter Thurston Jr.
President

American Social Health Association

Earle Lippincott
Executive Director

John M. Kiser
President

American Venereal Disease Association

W. B. Moore Jr.
Secretary-Treasurer

Progress Report

For the past several years the Joint Statement has recommended a follow-up to the 1962 National Survey of VD Incidence. This was accomplished, and the findings of the 1968 National Survey of VD Incidence are included elsewhere in this report.

In line with recommendations of the Joint Statement that federal funds be appropriated for the initiation of a campaign against gonorrhea, the Congress appropriated funds in both 1967 and 1968 for planning such a program. The amount allocated in 1968 was \$657,000, an increase of \$157,000 over the \$500,000 allocated in 1967. A section on the "Gonorrhea Control Program" is contained in this year's Joint Statement which describes special studies made possible by this earmarked appropriation.

The 1968 Joint Statement reported on action taken by the Surgeon General of the U.S. Public Health Service in directing that a group of outside research experts be convened for the purpose of suggesting new research approaches and stimulating the expansion of research in the venereal diseases. Initial planning steps in this direction were taken by an *ad hoc* Expert Panel of six university professors prominent in the fields of infectious diseases, immunology, and dermatology, which met in March 1968 at the National Communicable Disease Center in Atlanta. Others who met with the Panel included five scientists from outside the Venereal Disease Program, the three principal scientists of the Venereal Disease Research Laboratory, the Director of the National Communicable Disease Center, and the Chief of the Venereal Disease Program.

The *ad hoc* Panel made two principal recommendations. First, it was recommended that five or six young

investigators be recruited into VD research each year for several years, with the goal of starting the program by the summer of 1969. It was envisioned that these investigators should be recruited into the Venereal Disease Research Laboratory for initial training, and then be sent to carry out VD research in other outstanding laboratories specializing in infectious disease and immunology.

The second recommendation made by the Panel was that a maximal attempt be made to find funds on a continuing basis for 10 schools, at \$10,000 annually each, to have a faculty individual spend a significant proportion of his time on the teaching of venereal diseases and the encouragement of VD research.

In background discussions concerning these recommendations, the Panel members felt that it was extremely important to bring a small number of highly motivated young investigators into the field of VD research. It was pointed out that since there is little research in the venereal diseases outside of the Venereal Disease Research Laboratory at the National Communicable Disease Center, young investigators "never learn of the intriguing and important research problems that remain to be solved."

It was also proposed for consideration that a meeting be held at the National Communicable Disease Center in early 1969 at which young investigators who were prospects for the program, and the professors who might be their hosts, could hear about current VD research. The suggestion was also made that the Chief of the Venereal Disease Research Laboratory consult, in his travels, with university professors and deans of medical schools in order to personally encourage VD research and teaching.

Incidence and Trends

Primary and Secondary (P&S) Syphilis and Gonorrhea

For the third successive year, a slight decline, 4.3%, was recorded in the number of reported cases* of P&S syphilis in the United States in fiscal** year 1968.

For the sixth consecutive year, the number of gonorrhea cases continued to increase; the rise of 14.8% in reported cases in 1968 was the sharpest yet recorded.

New information on the estimated actual incidence

National Surveys of VD Incidence.

Both the reported figures and the findings of the two national surveys document an actual decline in P&S syphilis in the United States. This decline provides convincing evidence that the concentrated efforts of the VD Program of the Public Health Service and of state, local and military health authorities in searching for, finding and treating persons exposed to infectious syphilis are an effective method of controlling this disease.

TABLE A. CASES TREATED AND REPORTED

P&S Syphilis	1962	1963	1964	1965	1966	1967	1968
Number of Cases	20,084	22,045	22,733	23,250	22,473	21,090	20,182
Percent change from previous year	+ 6.9%	+ 9.8%	+ 3.1%	+ 2.3%	- 3.3%	- 6.1%	- 4.3%
Rate per 100,000	11.0	11.9	12.1	12.3	11.6	10.8	10.3
Gonorrhea							
Number of Cases	260,468	270,076	290,603	310,155	334,949	375,606	431,380
Percent change from previous year	- 2.0%	+ 3.7%	+ 7.6%	+ 6.7%	+ 8.0%	+ 12.1%	+ 14.8%
Rate per 100,000	142.8	145.7	154.5	163.8	173.6	193.0	219.2

of both diseases (1968 National Survey of VD Incidence) indicates that the number of persons treated for P&S syphilis in 1968 was 3.73 times the number reported. The number treated for gonorrhea was 3.36 times the number reported.

Tables A and B present the trend in reported cases of both diseases for the last seven years and the estimated incidence as indicated by the 1962 and 1968

*"Reported cases" means newly reported cases during the fiscal year.

As for gonorrhea, both reported figures and the findings of the two national surveys document a sharp increase in the number of persons in the United States infected with gonorrhea. The increase in the incidence of gonorrhea may well be attributed to lack of concentration on gonorrhea control, both because of inadequate funds and lack of knowledge about how to mount an effective control program.

**Throughout the Joint Statement, any year referred to is the Federal fiscal year, July 1 through June 30, unless otherwise specified.

TABLE B. ESTIMATED CASES TREATED

	From 1962 Survey	From 1968 Survey	Net Change
Number of Cases			
P&S Syphilis	106,442	75,207	-29.3%
Gonorrhea	1,071,125	1,449,584	+ 35.3%
Rate per 100,000			
P&S Syphilis	58.1	37.8	-20.3
Gonorrhea	585.3	727.6	+ 142.3

The need for pinpointing control programs in urban-suburban areas of high incidence is illustrated in Tables C and D, which group these areas in terms of relative incidence. All of the areas included have populations in excess of 100,000.

The sub-groups in Table C, showing groups of urban areas with P&S syphilis rates ranging from just above the national average of 10.3 up to more than five times the national rate, further refine the areas where program concentration is most needed.

The striking differences in rates of infection in these

like areas are illustrated by comparison between the two major groupings in Table C., one including 60 and the other 86 urban areas. While the population of each group is almost identical, the rate of P&S infection in the 60 areas is exactly six times the rate in the other 86 areas. More than half of all P&S cases reported in the United States are found in these 60 areas, which comprise only 19.8% of the U.S. population.

The parallel presentation of the concentration of gonorrhea cases (Table D.) shows that a larger proportion of urban areas have rates above the national average

TABLE C. REPORTED INCIDENCE OF P&S SYPHILIS IN METROPOLITAN AREAS

	Rate per 100,000	Number of Health Departments	Population	Percent of U.S. Population	Number of Cases	Percent of U.S. Cases
50-Up		5	3,081,100	1.6	2,298	11.4
40-50		5	2,472,700	1.2	1,125	5.6
30-40		11	7,182,200	3.6	2,435	12.1
20-30		14	15,592,800	7.8	3,887	19.2
10.4-20		25	11,151,000	5.6	1,610	8.0
Sub Total	28.8	60	39,479,800	19.8	11,355	56.3
(National)	10.3					
5-10.3		30	17,676,400	8.9	1,291	6.4
2-5		29	15,052,700	7.6	495	2.4
0-2		27	6,622,300	3.3	84	0.4
Sub Total	4.8	86	39,351,400	19.8	1,870	9.2
Grand Total	16.8	146	78,831,200	39.6	13,225	65.5

TABLE D. REPORTED INCIDENCE OF GONORRHEA IN METROPOLITAN AREAS

	Rate per 100,000	Number of Health Departments	Population	Percent of U.S. Population	Number of Cases	Percent of U.S. Cases
1000-Up		7	3,090,800	1.6	45,449	10.5
700-1000		10	7,904,900	4.0	68,857	16.0
500-700		10	5,757,100	2.9	33,069	7.7
400-500		12	12,620,000	6.3	57,630	13.4
300-400		20	16,064,600	8.1	58,702	13.6
220-300		21	8,203,200	4.0	20,510	4.7
Sub Total	529.9	80	53,640,500	26.9	284,217	65.9
(National)	219.2					
100-220		40	14,609,400	7.4	23,928	5.5
0-99		21	9,024,300	4.5	4,541	1.1
Sub Total	120.5	61	23,633,700	11.9	28,469	6.6
Grand Total	404.6	141	77,274,200	38.8	312,686	72.5

— ranging up to five times as high. The average rate in 80 of the areas is about two and one-half times the national rate, and almost five times the rate in the other 61 areas. These 80 areas comprise 26.9% of the U.S. population and have 65.9% of all reported gonorrhea cases in the country. In contrast, the other 61 areas have 11.9% of the U.S. population and only 6.6% of the gonorrhea cases.

The statistics in these tables thus illustrate that venereal disease infection in urban-suburban areas of over 100,000 population varies as much as in non-urban areas, and that the real concentration is in about one-half of all urban-suburban areas with populations over 100,000.

The areas included in these tables are listed by name, together with information on rates, in Tables IV and VII, pages 44 and 46.

Reinfections

Exploration of the question of the number of persons who are reinfected with P&S syphilis or gonorrhea one or more times within one year has been attempted in the Joint Statement for the past several years. The purpose is to determine the actual number of *different* persons involved in incidence statistics which reflect a count of the number of infections rather than the number of persons infected. This is especially important in considering gonorrhea.

Responses to the question on reinfections show that more than half of the state and local health departments maintain statistics on reinfections of P&S syphilis. On reinfections of gonorrhea, only four states and 40 local health departments kept complete records in 1968, according to their replies to the Joint Statement questionnaire.

The average rate of reinfections of P&S syphilis was the same among 31 state and 99 local health departments replying — 1.7%. In 20 of these states and 71 localities, "0" reinfections were reported.

The four states reporting on gonorrhea reinfections represented too small a sample for tabulation. However, the 40 local health departments keeping complete records showed an average rate of reinfection of 14.7% among the 22,176 gonorrhea cases reported by them. Only three of the 40 reported "0" reinfections. The 14.7% of reinfections for gonorrhea cases is an average of the following:

Percentage Range	Number of Local Health Departments
1- 5%	12
5-10%	10
10-20%	10
20-30%	1
30-40%	2
50%-up	2

If the average rate of reinfection of 14.7% among gonorrhea patients, as reported here, is the same for the total number of gonorrhea cases reported in 1968, the number of reinfections within one year would be 63,402 and the number of different persons involved would be reduced by the same figure. When applied to the approximately one and one-half million cases of gonorrhea estimated by the 1968 VD Incidence Survey to have been treated in 1968, the number of repeaters is 220,500, correspondingly reducing the number of different persons infected.

Rise and Fall

While national incidence of reported infectious syphilis dropped by 4.3% in 1968 over 1967, increases averaging 15.4% were recorded in 17 states and the District of Columbia. In the remaining 33 states, the number of cases reported dropped by an average of 13.5%.

The rise and fall in the number of cases of gonorrhea reported shows an average increase of 15.1% in 45 states and the District of Columbia, and an average decrease of 15.6% in four states. In one state the incidence of gonorrhea was stable.

These statistics on "rise and fall" illustrate that national statistics alone are not a sound guideline for evaluating trends in the incidence of infectious venereal disease. The disease is as mobile as its carriers — and its spread across state and national boundaries is only a reflection of the mobility characteristics of this era.

Control programs must be continued in areas of decreasing incidence as well as in those of increasing incidence if the gains recorded in some areas are to be maintained and accelerated. The report on "Exchange of Information" on page 23 shows that venereal diseases are imported from other cities, other states and other countries, and thus that constant vigilance is required to prevent the "seeding" of new infections in areas which are considered almost infection free.

Commonwealth of Puerto Rico

Individual replies from the Commonwealth of Puerto Rico to this year's Joint Statement questions are counted as a state reply henceforth in this report. For the record, statistics on P&S syphilis and gonorrhea incidence in Puerto Rico during fiscal 1968, not included in the U.S. totals previously reported, are as follows:

Puerto Rico	Number of Cases	Rate per 100,000
P&S Syphilis	1,039	39.1
Gonorrhea	2,481	93.4

Reasons for Increases and Decreases

One health officer stated that the reduction in infectious syphilis was a "dividend of the campaign since 1962." Most health officers who experienced a reduction in the incidence of infectious syphilis in their areas of jurisdiction in 1968 were in general agreement with him. A number of other related reasons for decreases were given, stressing particular parts of the national campaign against syphilis which has been conducted with increasing vigor since the dramatic resurgence of the disease, beginning in 1958. Other reasons included both better and poorer reporting by private physicians, better laboratory reporting, more and better education in schools and communities, accelerated case-finding — including clustering and treatment of all sex contacts of infected persons, establishment of a central registry and concentration on high incidence areas. Four health officers stated they believed the large number of persons receiving massive doses of penicillin to cure gonorrhea is a factor in the decline in infectious syphilis in their areas.

Reasons for increases in state and local areas most frequently given were better laboratory and better private physician reporting, more effective case-finding in the search for persons exposed to infection, and lack of concentration on high incidence areas. In three areas, increases were attributed to importation of infection from outside the area, and in one, to an "outbreak."

Two health departments stated that the enactment of better reporting laws caused the increase in reported cases of infectious syphilis.

Lack of diagnostic tools and of proper therapy, lack of personnel for interviewing and locating female contacts, and lack of funds to conduct a comprehensive program for the control of gonorrhea were reasons given by the majority of health officers for the continuing increase in gonorrhea incidence.

On the other hand, a small number of health officers reported the initiation of control methods, including case-finding programs and prophylactic treatment of sex contacts, extended clinical coverage, screening of high risk groups, visits to hospitals and laboratories and increased work with private physicians. These efforts brought increases in cases reported in most instances, decreases in a few.

Education in school and community was recognized as a factor contributing more to the increase or decrease of gonorrhea than to the increase or decrease of infectious syphilis. An increase in self-referrals to clinics was cited as a by-product of education and awareness.

Better cooperation and better reporting by private physicians, enactment of a state law permitting treatment of minors for VD without parental consent, increased promiscuity, and "indifference to the disease by the age

group predominately affected" were other reasons given for increases in the incidence of gonorrhea.

The "large pool of asymptomatic persons infected with gonorrhea and not seeking treatment" which was given as the reason for the high prevalence of gonorrhea by one health officer was echoed in different ways by many other health officers.

Early Latent Syphilis

The decline in reported early latent syphilis in 1968 was only 1.5%, compared with a reduction of 8.0% in 1967. The trend lines of both primary and secondary and early latent syphilis are presented in Table II, page 43. When early latent cases decline more rapidly than P&S syphilis, it is an indication that a larger proportion of cases is being detected in the infectious stage. This occurred in 1967 when the rate of decline in P&S syphilis was 6.1%; for early latent, 8.0%. However, in 1968 P&S syphilis declined by 4.3%, while early latent declined by only 1.5%. The decline in early latent syphilis has continued for six consecutive years (see Table I, page 42).

Late and Late Latent Syphilis

In spite of better laboratory reporting of reactors, the decline in reported late and late latent syphilis has continued for the past five years. The rate of decline in 1968 was 6.0%, compared with 5.3% in 1967. Thus the number of persons who may suffer from the late disabling manifestations and mortality due to syphilis is steadily being reduced. (See Table I, page 42.)

Congenital Syphilis

Reported cases of congenital syphilis in the newborn have followed closely the trend of early acquired syphilis. Among infants (less than one year of age) congenital syphilis reached a low point of 180 cases in the United States in 1957, coincidental with the low point for acquired syphilis incidence. In the period from 1962 to 1968, the per cent of reported congenital syphilis cases under one year of age has increased, reaching its peak in 1967. This is in line with the experience of public health authorities that if acquired syphilis is increasing, then, within a year or two, congenital syphilis will also increase. The peak of acquired early syphilis was reached in 1965, and then began a slight decline. The per cent of cases of congenital syphilis in infants under one year of age, which reached a peak in 1967, declined slightly in 1968. The chart in Table XII, page 50, presents this trend, together with total incidence of congenital syphilis, per cent and number of cases under

one year of age from 1962 to 1968.

Total VD: Reported

Total reported VD, gonorrhea combined with all stages of syphilis, increased by 10.5% in 1968 as compared with 1967. The number of reported cases in the United States was 529,575; the rate per 100,000 population was 269.1. All of the increase was accounted for by the 14.8% rise in gonorrhea; incidence dropped in all stages of syphilis (see Table I, page 42).

Total VD: Estimated as Treated

The total number of cases of VD estimated as treated in the United States in fiscal 1968, based on replies to the 1968 National Survey of VD Incidence (see page 51) is projected to 1,696,732 or a rate of 851.6 per 100,000 population. This compares with 1,412,180 cases estimated as treated from the 1962 survey, or a rate of 771.7 per 100,000 population. Based on these estimates, total VD in the United States increased 20.1% in the six year period.

Outbreaks of VD

"Outbreaks" of VD are defined as chains of infection involving 10 or more persons. These chains are discovered by the consecutive tracing of all sex contacts of each person involved. They are "broken" by bringing every contact to examination and treatment as needed. It is the policy of most health departments to give epidemiological (preventive) treatment to exposed persons showing no clinical or serological evidence of infection on first examination. This avoids later development of syphilis in case the disease is in an incubating stage at the time of the examination.

The following is a report of outbreaks of VD, reported by state and local health officers in 1968, with known duplications removed:

Number of Outbreaks reported:	
by 14 state health departments	30
by 17 local health departments	25
Number of persons involved	6,401
Number of P&S cases found	718
Number of other syphilis cases found	248
Number of gonorrhea cases found	134

The above report shows a slight increase in the number of outbreaks in 1968 as compared with 1967.

VD Among the Military

Military installations within the United States reported 764 cases of P&S syphilis and 29,270 cases of gonorrhea to civilian health departments in 1968. These figures reflect a slight decrease in the number of P&S syphilis

cases and an increase in gonorrhea as compared with 1967. They follow closely the national trend in civilian infections.

Reported case rates of infection among members of the Armed Forces cannot be directly compared with civilian rates because of sex and age distribution differences between the military and civilian populations. Rates for the military and rates for civilian males in the age groups which would span the ages of the majority of the military population are as follows:

Civilian Males	Cases per 100,000 Population	
	Primary and Secondary Syphilis	Gonorrhea
Age 15-19	21.4	699.1
Age 20-24	59.0	1830.4
Age 25-29	50.0	1178.6
Age 30-39	27.5	447.2
Military Stationed in U.S. (All Ages)	34.8	1334.1

The data indicate no marked difference between the civilian and military populations as to reported incidence of VD infection.

For the past several years, an attempt has been made in the Joint Statement to determine, on the basis of data collected from state and local health departments, whether all military installations report cases of syphilis and gonorrhea to civilian health departments as is required by military regulations, and what percentage of infected military persons are interviewed by civilian health department personnel to find the source of their infection and to trace all contacts who have been exposed to infection. Full cooperation between military and civilian health authorities is vital to control because the "source and spread" contacts to military cases are usually found in the civilian population and some of the source and spread cases in the civilian population are related to military personnel.

Comparison of the 1968 data with 1967 data shows that the proportion of military patients with infectious syphilis, who were interviewed by civilian health department personnel for their civilian (as well as military) contacts, increased from 77.3% in 1967 to 86.1% in 1968, as reported by state health departments, and from 46.4% to 58.6% as reported by local health departments.

Military gonorrhea patients were interviewed by only six state and nine local health departments, according to replies to the questionnaire. In the six states, which had a total of 3,115 military gonorrhea patients, 1,082 or 34.7% were interviewed. In the nine local health

jurisdictions, having 748 military gonorrhea patients, 89 or 11.9% were interviewed.

The military recognizes the importance of the case interview in the control of venereal disease as evidenced by the military regulation that "every patient diagnosed as having venereal disease will be interviewed, preferably by a trained venereal disease contact interviewer, either military or civilian, to determine those persons with whom he has had sexual contact during the course of his illness or from whom he could possibly have contracted the disease." (TBMED 230, 9 July, 1965.)

The growing number of interviews with infectious syphilis patients by civilian personnel is undoubtedly due to the greater emphasis which civilian health departments have given to syphilis control in the last few years. In their efforts to increase the surveillance of syphilis in their areas, a number of state and local health departments have worked out agreements whereby military installations will routinely call civilian interviewers to interview early cases of syphilis among military personnel. This has not been done to any appreciable extent for gonorrhea patients.

Another cooperative effort between military and civilian authorities which is explored by the Joint Statement is the sending of VD epidemiological reports by military authorities to civilian health authorities in other states or cities. These reports name civilian contacts of a member of the Armed Forces who received an infection while in another area.

Thirty-three state health departments reported that they had received 3,234 of these forms from military jurisdictions in other areas, and that 2,093 or 64.7% contained satisfactory information for tracing the source of the infection. Eighty-six local health departments reported the receipt of 3,596 forms; 2,594 or 72.1% were satisfactory.

This same procedure is followed in the exchange of contact reporting forms among civilian health departments. About the same percentage of such forms provide the necessary information for tracing contacts of the infected person as do the forms sent by military authorities.

Consultation between civilian and military health authorities designed to improve cooperative efforts was reported by 48 state and 70 local health departments in 1968.

Cooperative efforts reported by the Venereal Disease Program of the U.S. Public Health Service include the assignment of a VD representative to each of four large military bases in the U.S., selected by the Department of Defense. Further, personnel returning from overseas are being individually informed of the problem of diagnosis of incubating disease, and of the importance of

seeking a blood test about 90 days after a sex exposure.

The measures which should be carried out to improve cooperation between military and civilian authorities are spelled out in the "Seven Point Agreement of 1967," the text of which was quoted in the 1968 Joint Statement.

VD and Prostitution

Only one-third of the state and one-half of the local health departments reported this year the number of persons with infectious syphilis and gonorrhea who named prostitutes among their contacts. It should be noted that the naming of a prostitute as a sex contact does not prove that she was the source of the infection; it indicates only that if she herself was infected, she may have been the source.

In 18 states, 8.8% of persons with infectious syphilis named prostitutes; in 77 urban areas, 13.7% named prostitutes. The per cent of persons infected with gonorrhea who named prostitutes among their contacts was 1.5% in five states reporting, 4.4% in 42 urban areas reporting. These percentages reflect only minimal variations from those reported in each of the past several years.

The aggressive pursuit of contacts of infectious syphilis cases would certainly indicate that a prostitute named as a contact would be found and treated if sufficient identifying information were available. As for gonorrhea, however, the low percentage of cases interviewed by a majority of health departments leaves the question of the degree to which prostitution is a potential source of gonorrhea infection undetermined.

The percentage ranges of persons infected with P&S syphilis who named prostitutes in the 18 states and 77 urban areas were:

Percentage Naming Prostitutes	Number of States	Number of Urban Areas
0%	5	33
1-10%	3	16
10-20%	5	8
20-30%	3	10
30-40%	2	2
40-50%	—	3
Over 50%	—	5

VD and Homosexual Behavior

The number of males infected with P&S syphilis who named contacts of their own sex reached a higher percentage in fiscal 1968 than in any of the four previous years in which data on this subject have been reported in the Joint Statement.

The average percentage of cases in which males named other males as sex contacts in 1968 was 15.0% in the 45 states reporting. In 123 local health jurisdictions, representing urban areas, the average was 17.6%. When the six state and 31 local health departments reporting "zero" cases are excluded from the averages, percentages rise to 15.7% for states and to 18.1% for urban areas.

The per cent of P&S syphilis patients who named contacts of their own sex during the past five years, as reported in the Joint Statement, was as follows:

State Health Departments				
1964	1965	1966	1967	1968
14.7%	12.3%	11.0%	11.9%	15.0%

Local Health Departments				
1964	1965	1966	1967	1968
19.1%	16.8%	14.7%	15.5%	17.6%

The above percentages relate male homosexual contacts to the total incidence of P&S syphilis. When related only to the number of males in the total incidence reported, the percentage of male to male contacts for 1968 increases to 25.4% among cases reported by the 45 states, and to 29.3% among cases reported by the 123 local health departments.

Recording of the number of females naming females as sex contacts is maintained by 42 states and 113 local health departments. Cases recorded by 14 states totaled 94, or 0.9%. Twenty local health departments recorded 57 cases or 1.6%. Twenty-eight state and 93 local health departments recorded "zero" cases.

A tabulation of percentage ranges of males naming male contacts in states and urban areas reporting in 1968 is presented here.

Percentage of Males Naming Males	Number of States	Number of Urban Areas
1-10%	12	31
10-20%	18	34
20-30%	5	8
30-40%	3	6
40-50%	—	5
Over 50%	1	8

No common characteristics could be identified from a review of state and urban areas which correlated with low, medium or high percentages of homosexuals, as presented here.

Control Problems

Private Physician Participation

The degree of participation of private physicians in the VD control program is measured mainly by 1) the percentage of infectious syphilis and gonorrhea cases treated by them which they report to public health authorities, and 2) the percentage of their infectious syphilis patients whom they permit public health personnel to interview for their sex contacts.

When private physicians report their infectious syphilis patients to public health departments, they are contacted by public health program representatives who thus have the opportunity to request permission to interview the patient, and, failing to secure this permission, to urge the physician himself to interview his patient, identify the patient's sex contacts, and attempt to follow up, examine and treat, if necessary, all persons whom the patient has exposed to infection. It has been demonstrated that trained VD interviewers, whose full-time assignment is the search for persons who have been exposed to infection, are more productive in securing information on sex contacts and in locating and bringing them to examination than are busy private physicians.

Trend in Public Versus Private Treatment

Since the discovery in the late 1940's that penicillin would cure both syphilis and gonorrhea, the treatment of the major proportion of infected persons has gradually shifted from public health clinics to the office of the private physician. This shift resulted in decreasing information as to the actual size of the VD problem. When treated in public clinics, all cases were routinely reported; when treated in the office of the private physician, the degree of reporting was unknown. The rapid rise in reported cases of infectious syphilis and gonorrhea which began in 1958, together with the realization that the private physicians were treating an unknown number of cases which they were not reporting, resulted, in 1962, in a national survey to determine the actual number of VD cases treated by private physicians.

A second national survey, similar to the 1962 study,

was conducted in 1968. The rate of response by private physicians to both surveys was very high, 71.8% in 1962 and 65.3% in 1968. This cooperation made possible a reliable estimate of the number of cases of VD treated by private physicians, and thus of the actual dimensions of the VD problem in the United States.

Survey Findings

Both surveys show that the estimated number of cases of infectious syphilis and gonorrhea in the U.S. is almost four times the number reported by all sources, public and private.

Both surveys indicate that more than 75% of all cases of infectious syphilis and gonorrhea are treated by the private physician in his own office. The remainder, a little less than 25%, are treated in public health clinics or other public facilities.

The surveys show that the ratio of cases reported to the estimated number of cases treated by private physicians improved from 1962 to 1968: from 8.1% to 12.0% for infectious syphilis; from 7.7% to 10.9% for gonorrhea.

The number of persons in the U.S. who were treated by private physicians for infectious syphilis in 1968, but whose infection was not reported to public health authorities, was estimated as 55,025 in the 1968 survey. The number of cases treated and reported by them was 7,229. The number of persons treated for gonorrhea, but not reported, was estimated as 1,018,201. The number of cases treated and reported by private physicians was 123,756.

The findings of the 1968 National Survey of VD Incidence are included in this issue of the Joint Statement, replacing the annual tabulation of the number of private physicians treating VD, number of cases reported and per cent of patients interviewed which has, heretofore, been presented in this section.

Liaison with Physicians' Professional Societies

As a means of securing better cooperation from pri-

vate physicians in the reporting of cases of venereal disease treated by them, health departments have turned to physicians' professional societies which provide leadership for physicians in setting standards of professional practice.

The liaison which has been established between these societies and state and local health departments has been productive in many ways. Medical and osteopathic societies, both state and local, have given space in their professional journals and newsletters to articles emphasizing the size and seriousness of the venereal disease problem, have supported efforts to secure legislation and regulations requiring laboratories to report findings suggestive of VD by name of patient, and have urged their membership to discharge their responsibilities as physicians by reporting all cases of venereal disease to health departments as required by law.

During the past year, a number of societies publicized the 1968 National Survey of VD Incidence and urged physicians to respond to the survey questionnaire.

The report from state and local health departments on liaison with physicians' professional societies shows that this was established by 47 state and 128 local health departments. The 47 state health departments have also worked directly with local societies.

The reports on action taken by professional societies indicate that 47 state and 97 local societies have urged their membership to cooperate in the VD control program. The kinds of action taken are illustrated by the following quotations from state and local health department reports to the Joint Statement:

"The President of the Academy of Medicine sent out a letter to all members which told of the recent increase in VD rates and reminded them of the necessity of reporting each case. He stated that physicians who failed to report would be referred to the Ethics Committee."

"January 1968 — endorsed bill legalizing treatment for VD of persons under 21 years. February 1968 — approved VD Incidence Survey of American Social Health Association. March 1968 — published approval of survey in bulletin and alerted members to problem."

"Meetings have been held with local medical societies asking their cooperation in the eradication of syphilis. The State Medical Society continues to follow AMA recommendations, asking all physicians to report cases of syphilis and gonorrhea to their local health authorities."

"VD committee of State Medical Association made four recommendations to the House of Delegates: 1) Encourage participation in the 1968 National VD Incidence Survey, 2) Promote VD professional education, 3) Report VD cases to health authorities, 4) Promote public VD information-education programs."

Laboratories

Laboratory notification of persons with evidence of a venereal disease is of major importance in both control of the spread of infection and in identifying persons who, though not in an infectious stage, nevertheless need treatment to prevent further manifestations of the disease. The Joint Statement reports each year the efforts of state and local health officers to improve laboratory reporting.

One of the means that has been employed is visiting laboratories to inform and advise laboratory personnel on the contribution which notification makes to prevention of the spread of VD infection. Another is the presentation to legislative bodies and boards of health of the documentation of the need for laws or regulations requiring that laboratories report all reactive serological tests for syphilis *by name*. Still another is that laboratories performing such tests should be subject to inspection and approval in order to assure a high standard of technical performance.

In many states and communities where reporting *by name* is not required, laboratories have nevertheless cooperated in the control program by routinely reporting *by name*.

The analysis presented on laboratories includes sections on the per cent of laboratories, performing serological tests for syphilis, which routinely report to health departments, either *by name* or number; the number of states having laws or regulations requiring reporting *by name*; a summary of action taken to secure such laws or regulations; and the number of state and local health jurisdictions in which approval of the laboratory by the health department is required for performance of serological tests.

Routine Reporting of Reactive STS by Laboratories

The goal of receiving routine reports of reactive serological tests for syphilis from all laboratories performing such tests was reached in 1968 in the category of public health laboratories, according to this year's replies from 138 local health jurisdictions. State health departments came close to that goal, as the percentage reached 98.8%, according to the reports from 46 states. Considerable improvement was recorded in the per cent of laboratories of all categories which routinely report to state and local health departments, as can be seen in Table E.

Comparative figures for 1963, the first year in which the Joint Statement requested reports on this question, showed that only 68.6% of public laboratories performing serological tests for syphilis routinely reported to state health departments; thus the progress is from

TABLE E. LABORATORIES TESTING AND ROUTINELY REPORTING

Type of Laboratory	Number Testing	Number Reporting	Percent Reporting 1968	Percent Reporting 1967
Public Health				
In 46 states	346	342	98.8	92.9
In 138 locals	158	158	100.0	99.4
Private				
In 41 states	2,693	2,444	90.8	80.5
In 136 locals	1,901	1,512	80.0	72.7
Public Hospital				
In 39 states	1,169	1,078	92.2	85.8
In 137 locals	323	307	95.0	88.8
Private Hospital				
In 38 states	2,859	2,632	92.1	84.7
In 137 locals	1,242	1,127	90.7	82.8
TOTAL LABORATORIES				
From state reports	7,067	6,496	91.9	83.7
From local reports	3,624	3,104	85.7	78.9

68.6% reporting in 1963 to 98.8% in 1968. Comparable figures for 1963 and 1968 from local health departments were not available.

While progress is substantial, the total number of laboratories which still do not routinely report is indicated by state health departments as 571, and by local health departments as 520. Also, it should be noted that routine reporting would be much more helpful if such reporting were always *by name*.

Laws and Regulations on Laboratory Reporting by Name

All but one state health officer and all but two local health officers now favor the mandatory reporting of all reactive serological tests for syphilis *by name*. The difference between the conviction expressed by health officers on the importance of reporting *by name* and the actual status of laws or regulations in 1968, as reported by each state to the Joint Statement, is shown in Table F.

Tabulation of data on this subject for local health departments is omitted because of inconsistencies in reporting by both state and local health departments on the status of state legislation. Local legislation on report-

ing *by name* exists in a number of areas which have no state law or regulation, but the Joint Statement question must be rephrased to secure accurate information on such local legislation.

Action Being Taken to Secure Satisfactory Laws or Regulations

Health officers in 15 of the states which do not now have laws or regulations requiring laboratories to report all reactive STS *by name* replied to the question of what action was being taken to secure satisfactory laws or regulations.

Six replied that new legislation had been prepared and had been or would be submitted to the state legislature; four, that laws or regulations were in various stages of revision and would be submitted to either state boards of health or the legislature; two, that present laboratory reporting is satisfactory, but consideration is being given to a future need for stronger reporting requirements; one, that "laws or regulations are unnecessary since 100% of the laboratories forward specimens to the state laboratory for further testing"; and one, that "at the present time the medical profession . . . is not prepared to accept legislation of this nature."

TABLE F.
STATUS OF LAWS OR REGULATIONS REQUIRING REPORTING OF REACTIVE STS BY NAME

State	Public Health Laboratories	Private Laboratories	Public Hospital Laboratories	Private Hospital Laboratories
Alabama	All STS	All STS	All STS	All STS
Alaska	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal
Arizona	All STS	All STS	All STS	All STS
Arkansas	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal
California	All STS	All STS	All STS	All STS
Colorado	None	None	None	None
Connecticut	All STS	All STS	All STS	All STS
Delaware	All STS	Premarital	Premarital	Premarital
Florida	None	None	None	None
Georgia	All STS	All STS	All STS	All STS
Hawaii	All STS	All STS	All STS	All STS
Idaho	None	None	None	None
Illinois	All STS	All STS	All STS	All STS
Indiana	None	None	None	None
Iowa	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal
Kansas	All STS	All STS	All STS	All STS
Kentucky	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal
Louisiana	None	None	None	None
Maine	None	None	None	None
Maryland	All STS	None	None	None
Massachusetts	None	None	None	None
Michigan	All STS	All STS	All STS	All STS
Minnesota	All STS	All STS	All STS	All STS
Mississippi	All STS	All STS	All STS	All STS
Missouri	All STS	All STS	All STS	All STS
Montana	All STS	All STS	All STS	All STS
Nebraska	All STS	All STS	All STS	All STS
Nevada	All STS	All STS	All STS	All STS
New Hampshire	All STS	All STS	All STS	All STS
New Jersey	All STS	All STS	All STS	All STS
New Mexico	None	None	None	None
New York	All STS	All STS	All STS	All STS
North Carolina	All STS	All STS	All STS	All STS
North Dakota	All STS	None	None	None
Ohio	All STS	All STS	All STS	All STS
Oklahoma	All STS	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal
Oregon	All STS	All STS	All STS	All STS
Pennsylvania	All STS	All STS	All STS	All STS
Rhode Island	All STS	All STS	All STS	All STS
South Carolina	All STS	All STS	All STS	All STS
South Dakota	None	None	None	None
Tennessee	All STS	All STS	All STS	All STS
Texas	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal	Premarital-Prenatal
Utah	All STS	All STS	All STS	All STS
Vermont	All STS	All STS	All STS	All STS
Virginia	All STS	All STS	All STS	All STS
Washington	None	None	None	None
West Virginia	All STS	All STS	All STS	All STS
Wisconsin	All STS	All STS	All STS	All STS
Wyoming	All STS	All STS	All STS	All STS
Puerto Rico	All STS	All STS	All STS	All STS
D.C.	All STS	All STS	All STS	All STS

TABLE G. HEALTH DEPARTMENT APPROVAL REQUIRED

For Performance of:	Public Health Laboratories	Private Laboratories	Public Hospital Laboratories	Private Hospital Laboratories
All STS	24 States	19 States	20 States	20 States
Premarital-Prenatal	16 States	19 States	18 States	18 States
Premarital Only	6 States	8 States	8 States	8 States
Prenatal Only	1 State	1 State	1 State	1 State
No Law	4 States	4 States	4 States	4 States

Health Department Approval of Laboratories

There has been no increase in the number of states having legislation which requires health department approval of laboratories performing serological tests for syphilis, according to this year's replies to the Joint Statement. Table G reports on existing legislation as it applies to the several classifications of laboratories and to different groupings of patients.

Because of inconsistencies between replies from state and local health departments, as in the section on legislation requiring reporting *by name*, tabulation on local health departments has been omitted this year. Local replies indicate, however, that in more than half of the local areas approval of laboratories by local health departments is required for performance of serological tests for syphilis. Such legislation exists in only 19 states.

The purpose of requiring that laboratories be approved by health departments for performance of serological tests for syphilis is, of course, to insure high standards in both the performance of the tests and in the evaluation of findings. Until health department approval of laboratories is required, there can be no assurance that high technical standards of performance are being maintained.

New Federal Legislation on Laboratories

It is expected that an improvement in all laboratory testing performance will be brought about when the new federal legislation pertinent to interstate commerce, the "Clinical and Laboratories Improvement Act of 1967," is implemented. Present status is that proposed regulations prepared by the Laboratory Program of the National Communicable Disease Center were published on October 15, 1968. After a 30-day waiting period for comments and criticism, the regulations will be rewritten and prepared for publication. The major objective is

setting high standards to insure high quality of laboratory service in all laboratories performing serologic tests for syphilis and smears and cultures for gonorrhea.

Epidemiology

The epidemiological process involves, first, an interview with the infected person in which he is informed of the possibility that he may have passed on his infection to other persons who, unless alerted to the possibility of being infected, may go undiagnosed and untreated for an indefinite period. Further, if these contacts are sexually promiscuous they may, if infected, pass on a venereal disease to their other sex contacts.

The experience of sophisticated interviewers has shown that the person infected with VD seldom gives information about all of his sex contacts in an initial interview, and so a "reinterview" is now routinely scheduled. In the interim between the first interview and the reinterview, the infected person, now under treatment and relieved of anxiety about himself, has had time to consider soberly the possible consequences to other persons with whom he has had sex contact. In this reinterview he may name additional persons with whom he has been in contact—persons whom he did not remember, or whose names or addresses he did not recall, at the time of the first interview.

But in the thorough search for persons who may have been exposed to infectious syphilis, as now practiced in most health departments in the United States, there is still one more step. This is "cluster" interviewing. In this process, the infected person, having now become interested and impressed with the concern shown by the interviewer about all persons who have been exposed to infection, is asked to name friends or acquaintances who may have been exposed to the same contacts or who may, like himself, have lesions. These "cluster" contacts are likewise interviewed — and the result is

identification of additional cases of venereal disease.

Epidemiological treatment of sex contacts of an infected person is preventive treatment to insure that if the "contact" has incubating venereal disease, not detected by clinical or serological tests, the disease will be aborted.

The importance of interviewing is indicated by the fact that the only presently known method of controlling the spread of infectious syphilis is by the identification of all sex contacts of the infected person, followed by their examination and treatment, if found to be infected.

An analysis of the degree to which the epidemiological process is applied to persons reported infected with P&S syphilis, presented in Table H, provides a measure of the effectiveness, nationally, of the syphilis control program.

If this process could be applied to all cases which actually occur, incidence could be lowered at a more rapid rate, and the goal of eradication of syphilis as a public health problem could be achieved. The infected persons to whom the process is not applied are those whose infection is not reported to public health authorities, and whose source of infection remains untreated and free to spread disease.

The number of such cases of infectious syphilis indicated by the 1968 National Survey of VD Incidence was 55,025 — representing the estimated number of cases treated by physicians in private practice but not

reported to public health authorities. If the average number of contacts per infected person for the estimated 55,025 unreported cases were the same as for the 20,182 cases reported — 2.5 per case — then the number of their contacts would have been 137,563. If the per cent of contacts brought to treatment were also the same as that for reported cases — 13.7% — the number of additional cases of P&S syphilis brought to treatment in fiscal 1968 would have been 18,846. Further, if the same per cent of "uninfected" contacts of the estimated 55,025 unreported cases had been given epidemiologic (preventive) treatment — 42.6% for reported cases — the potential spread of infection by 58,602 contacts of infected persons would have been prevented. No comment is needed as to the effect this would have had upon the reduction of the incidence of syphilis in the United States, nor is comment needed on this illustration of the reason physicians in private practice should report all cases treated by them.

In addition to the national summary in Table H, an analysis of the application of the epidemiological process to reported cases of P&S syphilis, as submitted by each state to the Joint Statement, is presented in Table I. This information has been requested by several health officers in responding to the invitation to submit suggestions for the improvement of the Joint Statement. Table I is presented for states only; space does not permit this presentation for local health departments.

TABLE H. APPLICATION OF THE EPIDEMIOLOGICAL PROCESS

Number of:	States	Local
Cases reported	17,089	11,793
Patients interviewed	16,575	11,373
Patients reinterviewed	14,562	10,672
Patients cluster interviewed	13,054	10,006
Sex contacts located and examined	43,323	29,109
Contacts given epidemiologic treatment	15,934	12,700
Cases of P&S syphilis brought to treatment	5,948	3,346
Analysis:		
Percent interviewed	97.0%	96.4%
Percent reinterviewed	87.9%	93.8%
Percent cluster interviewed	76.4%	84.8%
Percent of "uninfected" contacts given epidemiologic treatment	42.6%	49.3%
Percent of contacts brought to treatment	13.7%	11.5%
Number of contacts per infected person	2.5	2.5

TABLE 1. P&S SYPHILIS — ANALYSIS OF THE EPIDEMIOLOGICAL PROCESS BY STATE

State	Per Cent Interviewed	Per Cent Reinterviewed	% Cluster interviewed	% Uninfected Contacts Given Epi. Treatment	Per Cent of Contacts Brought to Treatment	Number of Contacts Per Infected Person
Alabama	100.0	100.0	100.0	62.8	11.6	4.7
Alaska	100.0	100.0	N.R.	N.R.	N.R.	N.R.
Arizona	97.4	58.9	87.9	38.9	11.9	1.9
Arkansas	99.3	99.3	99.3	57.3	11.9	3.2
California	82.2	92.1	N.R.	43.3	13.6	1.6
Colorado	87.5	89.3	62.5	22.2	7.4	2.1
Connecticut	84.6	23.4	16.5	26.2	12.8	2.1
Delaware	100.0	88.1	88.1	37.3	30.6	1.4
Florida	98.9	71.0	70.0	51.7	26.9	2.7
Georgia	100.0	98.1	100.0	50.3	15.6	3.6
Hawaii	85.7	100.0	85.7	37.5	—0—	1.1
Idaho	87.5	100.0	87.5	10.0	—0—	1.3
Illinois	97.6	95.0	88.7	43.8	13.7	2.0
Indiana	N.R.	N.R.	—0—	23.9	7.3	3.5
Iowa	98.0	100.0	18.0	66.7	41.2	2.0
Kansas	100.0	97.4	100.0	N.R.	N.R.	N.R.
Kentucky	98.2	99.4	100.0	34.6	10.5	2.6
Louisiana	99.5	93.1	99.5	53.4	11.4	2.8
Maine	100.00	100.0	100.0	16.7	—0—	1.5
Maryland	98.6	92.7	79.7	46.1	16.6	2.5
Massachusetts	N.R.	N.R.	68.4	N.R.	N.R.	N.R.
Michigan	93.5	91.0	93.5	24.0	9.0	2.3
Minnesota	98.4	96.7	98.4	45.9	7.5	2.9
Mississippi	99.7	98.2	99.7	47.4	12.9	3.5
Missouri	99.4	83.9	99.4	45.5	15.4	2.5
Montana	100.0	50.0	25.0	35.3	—0—	2.1
Nebraska	100.0	94.6	43.2	N.R.	N.R.	N.R.
Nevada	100.0	97.4	100.0	45.2	20.8	1.4
New Hampshire	100.0	50.0	25.0	75.0	20.0	2.5
New Jersey	98.3	97.3	98.3	40.1	10.4	1.8
New Mexico	97.0	96.9	51.5	39.9	11.5	2.0
New York	86.8	88.2	86.8	49.2	8.8	1.5
North Carolina	100.0	100.0	100.0	59.2	10.1	3.1
North Dakota	100.0	100.0	—0—	8.3	14.3	2.3
Ohio	99.8	97.5	99.8	31.7	7.4	2.8
Oklahoma	100.0	95.4	N.R.	60.2	14.1	3.3
Oregon	97.2	82.9	88.9	21.0	4.6	1.8
Pennsylvania	98.3	91.9	55.6	40.6	15.8	2.0
Rhode Island	97.3	—0—	2.7	62.5	55.6	0.5
South Carolina	99.3	96.7	96.1	21.0	12.7	3.9
South Dakota	100.0	78.6	100.0	42.7	4.3	2.2
Tennessee	100.0	98.9	100.0	27.5	12.1	5.3
Texas	99.0	71.3	5.0	28.6	12.0	1.9
Utah	100.0	100.0	100.0	36.4	31.3	1.6
Vermont	100.0	100.0	100.0	—0—	33.3	2.0
Virginia	99.0	90.3	88.0	35.1	14.7	2.5
Washington	100.0	94.6	100.0	57.7	8.9	3.2
West Virginia	100.0	100.0	100.0	25.3	6.8	7.3
Wisconsin	100.0	90.9	90.9	57.7	21.2	1.5
Wyoming	100.0	75.0	100.0	27.3	21.4	2.0
Puerto Rico	98.7	70.0	N.R.	7.3	17.2	2.0
AVERAGE	97.0	87.9	76.4	42.6	13.7	2.5

Public health authorities have thus far placed little emphasis on the interviewing of gonorrhea patients for several reasons: the short period of incubation of the disease, which makes it almost impossible to reach exposed persons before the disease has developed; the likelihood that the infected person will seek treatment promptly because of the discomfort it causes (particularly in males); and the sheer size of the gonorrhea problem.

New approaches to control of gonorrhea are being explored in a series of pilot studies now being conducted in state and local health departments under contract with the VD Program of the Public Health Service.

Exchange of Information

The high degree of mobility of the American people requires a continuing exchange of information between

health departments in one state or city and health departments in other states and cities. The same applies to different countries of the world.

The procedures used by health departments in the United States begin with an interview with the infected person in which he is asked to identify his sex contacts. If any of his sex contacts are in other cities or states, the health department immediately sends a VD Epidemiological Report Form to the health department in the place of residence of the named sex contact. The health department receiving the form quickly informs the named person of his exposure to infection, sees that he is examined, and that treatment is provided if he is infected. Interchange of information by telephone is also used within the United States to speed up identification and treatment of infected persons and their contacts.

This interchange of information, or contact tracing

TABLE J. EXCHANGE OF INFORMATION

FORMS RECEIVED	Forms From Other States	Forms From Other Countries
Number of forms received:		
By states*	13,389	112
By locals**	10,101	243
Number of forms containing sufficient information to initiate investigation:		
As reported by states	11,572	93
As reported by locals	8,155	162
Percentage of forms containing sufficient information:		
Computed for states	86.4%	83.0%
Computed for locals	80.7%	66.7%
Number of contacts located:		
As reported by states	7,974	46
As reported by locals	5,230	108
Number of contacts found to have VD:		
As reported by states	1,689	15
As reported by locals	1,118	13
Percentage of contacts located who were found to have VD:		
Computed for states	21.2%	32.6%
Computed for locals	21.4%	12.0%

*38 states reported on forms received from other states; 31 states reported on forms received from other countries.

**104 local health departments reported on forms received from other states; 115 on forms received from other countries.

TABLE J. (Continued)

Breakdown of Forms Received From Other Countries					Country	Forms Sent	States Sending	Forms Sent	Locals Sending
Country	Forms Received	States Receiving	Forms Received	Locals Receiving					
Canada	84	11	17	8	Finland			2	1
France	1	1	1	1	Formosa	2	2	3	2
Germany	13	4	12	10	France	8	3	17	8
Korea	2	2	1	1	Germany	42	16	39	21
Mexico	1	1	21	2	Ghana	6	1	2	1
Okinawa			1	1	Greece	2	1		
Panama	1	1	1	1	Guatemala			3	2
Viet Nam	3	1	10	5	Holland	5	2	3	2
APO-FPO	1	1			Honduras	1	1		
Unlisted	6	1	179	3	Hong Kong			2	2
	112		243		Iceland	1	1		
					Iraq			1	1
					Ireland	1	1		
					Israel	1	1		
					Italy	1	1	3	2
					Ivory Coast	6	1		
					Jamaica	3	2	4	2
					Japan	3	3	7	6
					Kenya			1	1
					Korea	10	9	9	9
					Mexico	337	21	652	27
					Morocco	1	1		
					New Zealand	2	1	4	2
					Nicaragua			3	2
					Norway			2	2
					Okinawa	3	3	3	3
					Pacific Islands	1	1	2	2
					Panama	10	4	4	4
					Peru	1	1		
					Philippines	5	3	6	4
					Portugal	4	2	1	1
					Santo Domingo	2	2		
					Scotland			1	1
					Seychelles Islands			1	1
					Spain	7	4		
					Sweden			1	1
					Switzerland	1	1	1	1
					Taiwan	1	1	1	1
					Thailand	8	3	5	3
					Trinidad	1	1		
					Uganda	1	1		
					Viet Nam	65	20	120	32
					West Africa	2	2		
					APO-FPO	19	2	1	1
					Unknown	13	2	190	4
						761		1,165	

FORMS SENT TO OTHER STATES AND COUNTRIES

Number of forms sent to other states:

As reported by 48 states 15,751

As reported by 116 locals 9,275

Number of forms sent to other countries:

As reported by 46 states 761

As reported by 118 locals 1,165

Breakdown of Forms Sent to Other Countries

Country	Forms Sent	States Sending	Forms Sent	Locals Sending
Argentina			3	2
Australia			1	1
Austria	1	1	2	2
Azores	3	1		
Bahamas	15	1	5	1
Belgium	1	1		
Brazil	13	3	1	1
Canada	118	18	38	11
Chile			1	1
Colombia			2	2
Costa Rica	2	1	1	1
Cuba			2	1
Denmark	1	1	1	1
Dominican Republic	24	2	2	2
Egypt	1	1		
El Salvador			1	1
England	6	4	11	8

on a national and international basis, results in the identification and treatment of infected persons who might, otherwise, go undetected and untreated, and thus continue spreading infection among their other sex contacts. Table J reports the numbers of forms exchanged among state and local health departments and between health departments in the United States and those in other countries; the number of contacts located; and the number and percentage found to have a venereal disease.

It should be noted that the percentage of contacts brought to treatment through these procedures, 21.2% by state and 21.4% by local health departments, exceeds the percentage brought to treatment through contact tracing by state and local health departments within their own jurisdictions: 13.7% for states, 11.5% for locals.

Gonorrhea Control Program

Special studies to develop methods for the control of gonorrhea were initiated in 13 cities in the latter part of fiscal year 1968, according to information provided by the Venereal Disease Program of the Public Health Service. Funds for the studies were provided by the earmarked Congressional appropriation of \$500,000 in fiscal 1968 "to plan a program for the control of gonorrhea."

For 1969, the appropriation for studies in gonorrhea control was increased by \$157,000, thus making a total of \$657,000 available in fiscal 1969 for this purpose.

The major objective of the studies, initially, as stated by the Chief of the VD Program, "is to determine the extent of asymptomatic gonorrhea among females, and the demographic characteristics of high risk segments of the population. These 11 contracts, supporting studies in 13 cities, should provide information on 340,000 females tested. In addition, in several areas, attention is being directed toward approaches to interviewing patients, particularly the comparative yield of utilizing various interviewing periods of time.

"In a few studies we are beginning to gather data on the extent of asymptomatic gonorrhea among males through tracing contacts of female patients and through routine testing on premarital examinations.

"All of these areas of study will be expanded during fiscal year 1969, and other types of information will be developed."

The following health departments are participating in this first phase of study:

1. Alabama State Department of Health (Birmingham, Mobile and Montgomery)
2. Baltimore City Health Department
3. Chicago Board of Health

4. District of Columbia Department of Public Health
5. City of Houston Health Department
6. Louisiana State Department of Health (New Orleans)
7. Memphis-Shelby County Health Department
8. City of New Haven Department of Health
9. St. Louis City Health Department
10. San Francisco County Health Department
11. Seattle-King County Department of Public Health

The concern of state and local health officers about the mounting incidence of gonorrhea is attested to by the fact that 45 state and 103 local health officers responded to a request that they submit their suggestions of new approaches to gonorrhea control. A majority of the replies proposed a similar approach to that described above by the Chief of the VD Program of the Public Health Service.

Many additional suggestions were made, with major emphasis being placed on the need for faster and more accurate diagnostic tests for gonorrhea. Several expressed the hope that a serologic test for gonorrhea could be developed.

Performance of cultures and smears on all females attending cancer, prenatal and other clinics; periodic physical and laboratory examinations of suspected asymptomatic female carriers; and epidemiological treatment of female contacts of infected males were suggested in a majority of the responses.

Interviewing of all gonorrhea patients and tracing of all sex contacts were proposed by many health officers, with the qualification that major increases in staff and funds would be required to carry out such a program. Extension and improvement of VD education in the schools, and increased efforts to create public awareness of VD were proposed by many health officers as essential elements of an effective gonorrhea control program.

(Copies of representative replies received are being mailed to responding health departments. Additional copies are available upon request.)

VD Infection Among Younger Age Groups

While the total number of persons in the United States reported as newly infected with gonorrhea continues to increase each year at a progressively higher rate, the number of teenagers, 15-19 years old, who become infected rises even more rapidly. The total number of gonorrhea cases in the U.S. increased by 15.1% from calendar year 1966 to 1967; the number of cases among teenagers increased by 20.2%. In age group 20-24 years, which has the highest rate of all age groups, the number of cases increased by 17.8% from 1966 to 1967.

While the rate of infection of P&S syphilis for all age groups combined declined slightly from 1966 to 1967, it remained a constant for teenagers. In each other age grouping there was a slight decline.

Based on reported cases only, the ratio of gonorrhea infection among teenagers in 1967 was one to every 200 teenagers in the U.S. Similarly, for young men and women 20-24, the ratio in 1967 was one to every 100.

These ratios are based on reported cases only. By reference to the findings of the 1968 National Survey of VD Incidence, included in this Joint Statement, it will be seen that the number of cases of P&S syphilis estimated as treated in 1968 is 3.73 times the number reported. The number of cases of gonorrhea estimated as treated in 1968 is 3.36 times the number reported.

Calculation of ratios based on the estimated number of teenage cases treated indicates that one in every 50 teenagers in the United States contracted gonorrhea in 1968, and that the ratio in the 20-24 age group was one in every 25.

National rates, which have been referred to above, obscure the sharp differences in the proportion of persons infected with venereal disease in different geographical areas of the country. Tables III and VI, pages 44 and 46, present rates of reported P&S syphilis and gonorrhea by states. Tables X and XI, page 49, present the same information for teenagers.

The information on teenage rates by states pinpoints areas of high incidence where informational and educational programs for teenagers are of paramount importance. Although the rate of infection is much higher in the next two older age groups, 20-24 and 25-29 (see Table IX), only teenagers and children in the 10-14 age group represent a relatively "captive audience" for preventive education about the venereal diseases. Perhaps if these younger people were fully informed about the dangers of VD infection and the means of its prevention, they might retain this knowledge when they become

members of age groups 20-24 and 25-29 where the highest percentage of VD incidence is now found.

If the reader wishes to know the ratio of infection in any state, the relationship between rates and ratios as presented in the table below may be applied to the rate for that state:

Rate per 100,000 Population	=	Ratio
1.0	=	1 per 100,000
5.0	=	1 per 20,000
10.0	=	1 per 10,000
20.0	=	1 per 5,000
30.0	=	1 per 3,333
40.0	=	1 per 2,500
50.0	=	1 per 2,000
100.0	=	1 per 1,000
200.0	=	1 per 500
300.0	=	1 per 333
400.0	=	1 per 250
500.0	=	1 per 200
600.0	=	1 per 166
700.0	=	1 per 143
800.0	=	1 per 125
900.0	=	1 per 111
1,000.0	=	1 per 100
4,000.0	=	1 per 25

These ratios refer to the number of infections rather than the number of different persons involved. No accurate estimate is available as to the percentage of reinfections of either P&S syphilis or gonorrhea, but information contained in the section on "Reinfections" indicates a rate of approximately 15% for gonorrhea and 1.7% for syphilis. Until accurate statistics are maintained on reinfections, the number of different persons involved in any given number of "cases" will not be known.

VD Education

In the Schools

In 1968, VD education was included in the curriculum in 2,479 out of a total of 4,010, or 61.7%, of the junior and senior high schools in 93 urban areas, according to reports of local health departments. In 10 areas, no schools provided VD education. In 25 areas, VD was included in the curriculum of all junior and senior high schools. In the remaining 58 areas providing information on the question, the percentage of inclusion varied widely. This question was asked of local health departments only.

Health departments in 42 states and 115 urban areas reported that working relationships have been established with departments of education to discuss inclusion of VD education in the curriculum and to implement the program. An additional six state and 15 local health departments stated they were working toward establishing such relations.

As a result of these relationships, inclusion of VD education in the curriculum of junior and senior high schools has been approved by departments of education in 35 states and 103 urban areas. In four states and nine urban areas, inclusion of VD education was not approved by departments of education.

Implementation of VD education by development of curriculum materials was reported by 31 state and 95 local health departments; consultation with departments of education on teaching methods was reported in 30 states and 86 local areas; workshops for preparation of teachers were conducted in 29 states and 71 local areas. These reports indicate continuing progress in both inclusion of VD education in school curricula and the development of a sound approach to presentation of a sensitive subject.

The courses and the grades in which VD is taught are listed below:

Grades	Number of Local Health Depts.
6th	13
7th	51
8th	74
9th	80
10th	77
11th	73
12th	78
Courses	
Biology	63
Family Life Education	77
Health Education	90
Home Economics	42
Physical Education	74

Other courses mentioned were:

Science, Driver Education, Counseling, English, Government, Social Science, Social Studies, Life Science, Religion, Civics, Sociology, Security Education, Special Education, Sex Education, Humanities, Home Room, Moral Guidance, Child Care, History, Zoology, Christian Doctrine, Marriage, Problems in Democracy.

Effect of VD Education on VD Incidence

This year's question on the effect of VD education in the schools asked also whether any method of evaluating its effects had been developed. Replies were received

from 92 local health officers. Of these, 42 reported that no method of determining the effect of education had been devised. Four stated they were working on the problem, two said there was too little VD among teenagers in their areas to attempt evaluation, two that there was no educational program in schools in their areas, and two that VD education had no effect.

A majority of the 40 health officers who had attempted to determine the effect of VD education based their evaluation on the increased number of teenagers who voluntarily sought examination at public health clinics, and who stated when interviewed that they had learned about VD either in school or through TV and radio presentations. Several based their conclusions on statistical studies of the trend of teenage VD infection in their areas, and several had conducted pilot studies

among teenage students and their parents. In two instances the studies included school dropouts and persons living in poverty areas.

Only three of the 40 health departments which had attempted to evaluate the effect of VD education on VD incidence indicated that education had brought about a downward trend in incidence. Twelve noted specifically that more teenagers were seeking treatment as a result of education, and that reported incidence was thus increased. These increases were viewed as positive effects of VD education which would eventually result in decreases in incidence.

The other 25 health departments noted broader knowledge about VD: how it is contracted, how it can be prevented, and how it can be cured. These findings were also positive and, although incidence had not been

TABLE K. ADEQUACY OF CLINICAL MATERIAL AND INSTRUCTION
IN SCHOOLS OF MEDICINE, OSTEOPATHY AND NURSING

	Schools of Medicine and Osteopathy		Schools of Nursing	
	States	Local	States	Local
Number of health departments reporting one or more schools in their jurisdiction	42	53	46	122
Number of schools reported by them	86	81	844	513
Adequacy of clinical material:				
Number adequate	35	47	177	184
Number inadequate	35	20	273	144
Number adequacy unknown	16	14	394	185
Number for which health department provided clinical material	44	53	160	218
Adequacy of instruction in diagnosis and treatment:				
Number adequate	55	53	191	196
Number inadequate	14	12	178	52
Number adequacy unknown	17	26	475	265
Adequacy of instruction in epidemiology:				
Number adequate	50	41	231	175
Number inadequate	18	14	87	63
Number adequacy unknown	18	26	526	275

decreased as yet, health departments concluded that the possession of knowledge would eventually have the effect of reducing VD incidence among teenagers.

(Copies of representative replies received are being mailed to responding health departments. Additional copies are available upon request.)

VD Education in Professional Schools

The findings of the 1968 National Survey of VD Incidence document the fact that 43,720, or 32.5% of the physicians in private practice in the United States who responded to the survey, treated one or more cases of venereal disease during the period April 1 through June 30, 1968. This should be convincing evidence that schools of medicine, osteopathy and nursing should provide adequate instruction in the diagnosis and treatment of the venereal diseases. In the survey it is estimated that these physicians treated 62,254 cases of infectious syphilis, 139,230 cases of "other" syphilis and 1,141,957 cases of gonorrhea during fiscal year 1968. These estimates offer further evidence of the need for adequate training of students who soon will be engaged in the practice of their professions and who will be participating in the treatment of persons infected with a venereal disease.

Public health authorities believe that training in these schools should also include instruction in the epidemiological aspects of VD control so that they will be fully prepared to make a maximum contribution to the effort to reduce VD infection progressively from its present epidemic proportions to an absolute minimum. The estimate that private physicians report an average of one case of every eight treated underlines the need for such instruction.

Table K presents the judgment of state and city health officers on the adequacy of instruction in schools of medicine, osteopathy and nursing located in their jurisdictions. The report for 1968 indicates considerable improvement over a similar report for 1967.

VD Education in the Community

"Saturation" informational and educational programs about VD over TV and radio, combined with headline stories in daily newspapers, billboard displays and posters, were again carried out in a number of major cities. These programs were credited with sharply increasing the number of persons who voluntarily appeared at public health clinics or at the offices of private physicians seeking information and advice or requesting an examination. Some of these programs also used the innovation of a 24-hour VD 'phone information service, and free distribution of informational pamphlets on VD.

Sponsors included the communications media, industrial and business corporations and various civic and professional groups.

Greater concern about reaching "high risk" populations was noted in the reports of health officers in states and in both large and small urban areas. School drop-outs and jobless young people in poverty areas were reached through community action groups, Neighborhood Youth Corps, Job Corps and other welfare and health agencies. A "self-education" program in which teenagers are given a training course in VD and then become VD educators for their peers is being tried out in one local health area. In one state, labor camp operators distribute VD literature to men in their labor camps — a particularly high risk group. Another innovative program was a lecture and discussion series given in all local 4-H clubs throughout the state.

Health officers in smaller urban areas and in states with a largely rural population also made use of the media in telling their story about VD, but placed greater emphasis on VD education in the schools, education of physicians, and public education through talks to civic and church groups.

The reports of activities in 1968 indicated some diminution of effort as compared with 1967, particularly in smaller urban areas. A count of replies showed that health departments in 107 urban areas of 100,000 population or over had initiated some education or public information program about VD. Eleven reported no programs. The same health departments reported that public information or educational programs had been carried out by community groups in 65 areas, but in 23 areas there had been no participation by such groups.

(Copies of representative replies received are being mailed to responding health departments. Additional copies are available upon request.)

Public awareness of the venereal diseases increased in only about one-half of the states and local areas in 1968, compared with increases in almost all areas in 1967, according to the check list completed by almost all of the 51 state and 145 local health departments responding to the Joint Statement questionnaire. In the remaining states and local areas, the level of public awareness in 1968 remained about the same as in 1967, dropping in a few. Table L shows replies for both 1967 and 1968.

The status of public awareness, indicated in Table L, correlates with the efforts made by health departments themselves to stimulate public awareness. Table M, which tabulates action taken by state and local health departments, shows a reduction in the number of departments which took action to stimulate public awareness in 1968 as compared with 1967.

TABLE L. PUBLIC AWARENESS OF THE VENEREAL DISEASES

As evidenced by:		State		Local	
		1967	1968	1967	1968
Coverage by mass media	Increased	47	26	127	72
	Decreased	1	3	7	7
	Stable	1	22	6	61
Requests for VD information	Increased	48	31	120	79
	Decreased	1		11	8
	Stable		20	10	50
Requests for educational material	Increased	47	37	120	84
	Decreased			8	5
	Stable		14	8	49
Self-referrals to clinics	Increased	38	28	117	89
	Decreased	2		4	4
	Stable	2	17	9	40
Cooperation of private physicians	Increased	37	23	117	66
	Decreased	1		4	5
	Stable	5	27	16	65
Requests for talks and information by professional physicians' societies	Increased	30	14	51	29
	Decreased	4	5	32	12
	Stable	5	31	24	85

TABLE M.
STIMULATION OF PUBLIC AWARENESS BY HEALTH DEPARTMENTS

Action taken:		State		Local	
		1967	1968	1967	1968
Gave releases on the VD problem to:					
	Newspapers				
	Yes	50	48	123	109
	No		3	23	28
Radio	Yes	42	39	94	78
	No	6	11	42	51
TV	Yes	41	37	79	69
	No	8	13	53	57
Initiated presentations on:					
	Radio				
	Yes	37	33	76	61
	No	11	18	61	66
TV	Yes	38	30	63	51
	No	11	20	71	71
Initiated meetings with:					
	Health groups				
	Yes	45	45	104	91
	No.	4	6	34	36
Civic groups	Yes	47	46	116	102
	No	3	5	27	29
Professional physicians' societies	Yes	39	38	64	66
	No	7	12	66	63

Cost of VD Control

While federal funds made available to states and cities for VD control in 1968 and 1969 under Public Law 89-749 represent some increased aid, the reason for this is that project grants administered by the VD Program from Congressional appropriations for categorical grants had been committed in advance, with projected increases, through fiscal year 1969. These commitments

have been honored and the grants continued and increased under the project grant appropriation [section 314(e)] in the new legislation, PL 89-749, the Comprehensive Health Planning and Public Health Services Act of 1966. The full effect of the new method of determining federal aid to states and cities will not be known until fiscal year 1970.

TABLE N. FEDERAL AID FOR VD CONTROL

	Fiscal 1967	Fiscal 1968	Fiscal 1969
Congressional appropriation to VD Program, USPHS	\$ 4,329,000	\$ 4,866,000	\$ 4,952,000
Earmarked for Gonorrhea Control Program, from above appropriation		(500,000)	(657,000)
Federal Project Grant Funds for states and cities	6,229,000*	6,866,675**	6,975,162**
TOTAL FEDERAL MONEY FOR VD Increase over previous year	\$10,558,000	\$11,732,675 + 1,174,675	\$11,927,162 + 194,487
Federal aid to states and cities:			
Additional federal aid representing cost of field personnel assigned to states and cities from appropriation to VD Program, USPHS	\$ 1,400,000	\$ 1,250,000	\$ 1,550,000
Federal Project Grant Funds for states and cities	6,229,000*	6,866,675**	6,975,162**
TOTAL FEDERAL AID TO STATES AND CITIES	\$ 7,629,000	\$ 8,116,675	\$ 8,525,162
Increase over previous year		+ 487,675	+ 408,487

*Categorical grant appropriation by Congress

**Project grants under Public Law 89-749

Beginning in 1970, states and cities must initiate new project grant applications, under the procedures established for the administration of PL 89-749 and must justify their requests in competition with requests for project grants for other public health programs in their areas. The total federal appropriation for project grants for fiscal 1969 has been increased to \$77,000,000 — \$14,500,000 more than the 1968 appropriation of \$62,500,000.

Direct appropriations by Congress to the VD Program of the Public Health Service remained at almost the same level for fiscal years 1967, 1968 and 1969, except for the addition of \$500,000 for planning a program for gonorrhea control in 1968, which was increased to \$657,000 in 1969.

The VD Program has used a part of its appropriation each year for field personnel who are assigned to work with state and local health departments. This program, which provides personnel in lieu of funds, represents additional federal aid to states and localities for VD control. The provision of personnel in lieu of funds has also been a practice in allocation of project grant funds. States and localities have chosen to receive personnel trained by the VD Program in various aspects of VD control at a cost of approximately one-half of their grant awards.

Table N presents the picture of federal aid for VD control for fiscal years 1967, 1968 and 1969.

In addition to project grant appropriations, Public Law 89-749 provides for formula grant appropriations to states, based on population and income. The amount contained in the fiscal 1968 appropriation act for formula grants was \$60,250,000; in 1969 it was increased to \$66,032,000. Formula grant money is not "earmarked"; it may be spent by states for any public health purpose, provided that purpose is included in the state plan which has been approved in accordance with the section of Public Law 89-749, as amended by Public Law 90-174, for "comprehensive" state planning. The 1968 amendment, PL 90-174, provides that 70% of formula grant monies be used for local services. Thus, some portion of formula grant funds may be allocated by states for VD control, provided that plans for VD control are included in the state's approved comprehensive health plan.

VD Appropriations in the Past

Each year since 1954, state and local health departments have been asked to submit, for the Joint Statement, estimates of the amount of additional funds needed for VD control in their areas. Also requested was an estimate of the amount of additional funds available or expected to be available from state and local

appropriating bodies. On the basis of these estimates of additional funds needed and additional funds available from state and local sources, plus federal categorical appropriations, there was computed each year, in the Joint Statement, the total amount of funds needed and total amount available for VD control from all sources.

The Sponsors of the Joint Statement have then presented to the Sub-Committees on Appropriations, Department of Health, Education and Welfare, of both House and Senate, their recommendations for the amount of federal appropriations needed for the nationwide VD control effort. Congressional appropriations, based on the recommendations of the Sub-Committees on Appropriations, have increased each year since 1955, a low point of VD incidence, through 1965, when the peak was reached in the incidence of infectious syphilis (see Table O).

VD Appropriations in the Future

While the Sub-Committees on Appropriations of the House and Senate will continue to determine the amount of each year's appropriation for the VD Program of the Public Health Service, they can no longer determine the amount of federal funds which shall be made available for grants-in-aid to states and cities for VD control. This determination, as previously explained, depends entirely upon the priorities established by states and cities themselves, and their successful presentation of requests for project grant funds for VD control.

In order to obtain for the Joint Statement a complete picture of the current funding of VD control programs, state and local health departments were asked to report the amounts made available from state and local sources in fiscal 1968 and budgeted or appropriated for fiscal 1969.

Table P presents the report on amounts appropriated for VD control by 46 states and 92 urban areas in 1968 and 1969, and the totals of federal, state and local funds available. The states and cities which did not submit reports on VD appropriations for their areas would, of course, add to these figures, but no estimate has been attempted as to the amounts which should be added.

Table P shows an increase of \$2,049,540 in total funds available for VD control in 1969. Of this amount, \$194,487 represents increases in federal funds, and \$1,855,053 in state and local funds.

In 1968, state and local health departments presented estimates for the Joint Statement, indicating the need for an additional \$11,000,000 for VD control in 1969: approximately \$2,000,000 for infectious syphilis and approximately \$9,000,000 for gonorrhea control programs. The increased amounts available fall far short

TABLE O.
CONGRESSIONAL APPROPRIATIONS FOR VD CONTROL

Fiscal Year	Total	Direct Operations	Grants
1954	\$5,000,000	\$3,023,500	\$1,976,500
1955	3,000,000	2,300,000	700,000
1956	3,626,000	2,426,000	1,200,000
1957	4,195,000	2,495,000	1,700,000
1958	4,415,000	2,715,000	1,700,000
1959	5,400,000	3,000,000	2,400,000
1960	5,400,000	3,000,000	2,400,000
1961	5,814,500	3,414,500	2,400,000
1962	6,000,000	3,415,000	2,585,000
1963	8,000,000	3,665,000	4,335,000
1964	9,599,000	3,704,000	5,895,000
1965	10,105,000	3,876,000	6,229,000
1966	10,392,000	4,163,000	6,229,000
1967	10,593,000	4,364,000	6,229,000
1968	4,866,000	4,866,000	—*
1969	4,952,000	4,952,000	—

*No specific funds were appropriated for Venereal Disease Project Grants. Projects were funded from the appropriation to Section 314(e) of the Public Health Service Act as amended by PL 89-749.

TABLE P. TOTAL FUNDS FOR VD CONTROL

	Fiscal 1968	Fiscal 1969
Appropriated by 46 states	\$ 4,477,966	\$ 5,152,773
Appropriated by 92 cities	9,067,653	10,247,899
Total state and local appropriations	13,545,619	15,400,672
Federal funds	11,732,675	11,927,162
TOTAL FUNDS FOR VD CONTROL	\$25,278,294	\$27,327,834

of the estimated need. The presented known dimensions of the VD problem in the United States, as indicated by the 1968 National Survey of VD Incidence, should stimulate federal, state and local governments to provide adequate financing to bring the national epidemic of gonorrhea under control, and to continue and accelerate the reduction in the incidence of infectious syphilis.

Congressional Sub-Committee Testimony

Excerpts from the minutes of hearings held March 11, 1968, by the Sub-Committee on Appropriations, Department of Health, Education and Welfare, of the House of Representatives, on appropriations for VD control are quoted here. David J. Sencer, M.D., Director of the National Communicable Disease Center, U.S. Public Health Service, is questioned by Congressman Daniel J. Flood, Chairman, and two other members of the Sub-Committee.

MR. FLOOD. In our report last year, we strongly encouraged you to do more about the ever-increasing incidence of gonorrhea.

DR. SENCER. Yes, sir.

MR. FLOOD. What are you planning in this area for 1969? Is there a flareup of gonorrhea?

DR. SENCER. I would say it is out of control; yes, sir.

MR. FLOOD. Out of control?

DR. SENCER. Yes. There has been a 12 per cent increase in reported gonorrhea cases in each of the last few years. You can say it is increasing, and increasing dangerously.

MR. LAIRD. The budget does not indicate that.

MR. FLOOD. You used the word "dangerously."

MR. LAIRD. And "out of control." What do you have in the budget to handle this?

DR. SENCER. We have an increase of \$157,000 for gonorrhea.

MR. LAIRD. This is a serious problem?

DR. SENCER. Yes, it is a serious problem. There is much we do not know about gonorrhea. We found in limited studies that in certain population groups 35 per cent of the women are silent carriers of the disease and we know we do not have the tools for control yet.

MR. FLOOD. You are talking about \$157,000 and you say this disease is out of control? And you say it is dangerous. I am quoting you.

DR. SENCER. Yes.

MR. FLOOD. What did you ask the Bureau of the Budget for?

DR. SENCER. We were reduced by the Bureau of the Budget \$1,537,000.

MR. FLOOD. What did you ask for?

DR. SENCER. An increase of \$1.7 million.

MR. FLOOD. You asked for an increase of \$1.7 million and the Bureau of the Budget gives you \$157,000?

DR. SENCER. Yes, sir.

MR. FLOOD. And they knew it was out of control?

DR. SENCER. I think our justifications pointed this out; yes sir.

MR. FLOOD. Go ahead. What about treatment for gonorrhea? This is not just a bad cold.

DR. SENCER. No, sir. We have adequate treatment for it.

MR. FLOOD. Will one shot in the arm clear it up?

DR. SENCER. Probably two. You have to have a high level of penicillin in the blood for some time to kill it off.

MR. FLOOD. Now they know two shots in the arm are enough. How often do they come back?

DR. SENCER. There is a high percentage of recurrence.

MR. FLOOD. Can you cure the condition in the female as well as in the male?

DR. SENCER. The problem is we cannot diagnose it in females as well as in males.

MR. FLOOD. What about the reports from the family physician? Are they reporting these cases to you?

DR. SENCER. We have been trying to get physicians to report syphilis. We have not put much effort in gonorrhea but if our experience is the same as syphilis I do not think we will get good reporting. I think we need to try to find a method of screening populations so we can rapidly detect those people who are infected.

MR. LAIRD. Mr. Chairman, on this point, last year this committee increased the amount available for gonorrhea control by \$500,000 over the amount requested in the budget.

DR. SENCER. Yes, sir.

MR. LAIRD. What progress did you make? Was that money used?

DR. SENCER. It is in the process of being used. As you realize, we were under a continuing resolution until quite recently.

MR. LAIRD. What do you mean by quite recently?

DR. SENCER. Half the year. So that we were not able to put this money to use. We are now using it in communities where we are contracting with health units.

MR. FLOOD. Let us talk about gonorrhea and syphilis together.

MR. LAIRD. What was the amount available to you last year after we added the \$500,000?

MR. BERSANO. \$915,000.

DR. SENCER. That is for gonorrhea alone.

MR. LAIRD. Your budget request was for \$415,000, and added to it was \$500,000, making the total \$915,000 for 1968. This year it is how much?

MR. BERSANO. \$1,067,000 for gonorrhea control. That is what is in the 1969 budget before you.

MR. LAIRD. What request went to the Bureau of the Budget?

MR. BERSANO. \$2,478,000 for gonorrhea control.

DR. SENCER. The \$6.4 million went to the Bureau of the Budget for both syphilis and gonorrhea.

MR. LAIRD. And you will have unexpended, of that \$500,000 the committee added, about \$300,000?

DR. SENCER. No. I think, since much of it will be by contract, most of it will be obligated.

MR. LAIRD. But some of the work will be done in 1969?

DR. SENCER. Yes, sir.

MR. FLOOD. We are not talking about work with the Armed Forces here.

DR. SENCER. No. That is a separate problem.

MR. FLOOD. Is syphilis dangerous and out of control?

DR. SENCER. The incidence has stopped increasing. It has not turned the corner and gone down. Here our major problem is not being unable to diagnose it, but getting it reported.

Usefulness of the Joint Statement

As in past years, an analysis of comments on the usefulness of the Joint Statement indicates that its major value to health officers is . . .

As resource material which is used for:

- VD education in schools and community
- News media — including radio and TV — to create public awareness
- Talks and presentations to professional societies of physicians
- General information about incidence and trends;

For program evaluation and assessment:

- Comparison with other like areas

- As a means of identifying weak spots in programs

- As a guideline for program improvement;

As an aid in securing additional funds for the VD control program from state and local legislative bodies.

The Sponsors are happy to welcome as new members of the Committee on the Joint Statement, official representatives of the Michigan and Texas state health departments, the health department of Los Angeles County and the health departments of the cities of New York, Norfolk and Philadelphia. Their contribution to the text and tables of this edition is evident, and will be further reflected in the questionnaire for next year's Joint Statement.

VD Around the World

"The revival of the venereal diseases has engendered world-wide concern. It is estimated that there are now in the world 30 million to 50 million cases of venereal syphilis and more than 150 million cases of gonococcal infections."*

Note: This section is taken from a paper, "Climate of Opinion Regarding Venereal Diseases in a Changing Environment," by Dr. T. Guthe, Dr. R. R. Willcox and Dr. O. Idsoe, World Health Organization, Geneva, Switzerland.

It is postulated that the epidemic of so-called syphilis which spread through Europe in the middle ages evolved over the centuries into the epidemiological form we now know as venereal syphilis. The few foci of high incidence syphilis which remain are scientific curiosities which can be expected to disappear in a very few years.

In most countries there is evidence of a general regression of venereal syphilis in the last 100 years, notwithstanding intermittent recurrences and epidemic outbreaks associated with wars, economic upheavals and social unrest.

A major recurrence of early infectious syphilis took place during the Second World War, lasting into the immediate post-war period. This phase was followed by rapid decline which reached an all-time low incidence during 1956/58 in most countries. Then came a period of renewed recrudescence which still continues, although with minor variations in reported cases in some countries in the last three to four years, (e.g., U.S.A.). A decline of late syphilis, including cardiovascular and neurological manifestations, has been reported since the mid-1940s in most countries where statistics are available. This decline has continued, despite the traditional belief that increases in late complications might be expected 10 to 20 years after high incidence periods of early syphilis. The effect of penicillin treatment of early syphilis, preventing such a serious development, has been one of the great achievements of the antibiotic era. A general decrease in congenital syphilis since 1950 has also taken place. In some countries the incidence has remained stationary at a relatively low level—with occasional upswings—suggesting that control of syphilis of the newborn could be strengthened, notably in the maternal and child health part of public health programs.

Trend Noted in Developed Countries

In spite of the recognized limitations of morbidity reporting, and the fact that it depicts under- rather than over-reporting of new cases by doctors and/or clinics to health authorities, the demonstrated fall and rise of early syphilis is believed to mirror a true epidemiological trend in the developed countries, from which most of the data originate. At the same time, it is observed that there is little information coming from developing countries, although WHO data show that the disease is also becoming more frequent in parts of Africa (e.g., Dahomey, Niger, Nigeria, Senegal), countries in the Far East (South Viet Nam, Japan) and is epidemic in some urban areas in countries in South East Asia (e.g., Bombay, India). In Africa, as in Asia, this situation is the result of the enormous growth of the towns and the breaking up of the traditional tribal and family structures.

The incidence trend of gonorrhea has apparently, to some extent, followed the pattern of early syphilis with important but less marked recrudescence periods. Gonorrhea is reported, however, to be from 3 to 15 times more frequent than early syphilis in some countries, although in some instances it is recognized that little reliance can be put on available data on gonorrhea. We have selected data from nine developed countries for purposes of illustrating recent trends. Also in some areas of developing countries prevalence studies have shown gonorrhea and other urethritides to be endemic, e.g., parts of Sudan, Congo Kinshasa, Sarawak. Finally, in regard to chancroid, lymphogranuloma venereum and granuloma inguinale, these conditions are now reportedly rare in developed countries while remaining a problem in some developing areas.

*From the 1967 REPORT ON THE WORLD SOCIAL SITUATION by the Commission for Social Development of the United Nations Economic and Social Council.

The rise in incidence of early syphilis and gonorrhea in recent years has occurred during a period of relative peace. Important medical and public health progress has also taken place. But we must keep in mind that, during this period, demographic, economic, behavioral and other perspectives of society have been greatly altered and this has favored the spread of sexually acquired infections. These behavioral changes have had an influence on other social problems, such as addiction to drugs and alcohol.

The intensity of the epidemiological processes in infections acquired by sexual activity by man and woman depends, to a greater extent than in any other group of diseases, on the balance between the complex ecological, human and environmental forces which facilitate or restrain the spread of disease. The shifting aggregate weight of these interdependent forces may in one period drive the epidemiological pendulum in one direction—which facilitates spread and high incidence of disease—and in another period in the direction which favors control and possible “eradication.”

World Population Growth Is Factor

The world population increased by approximately 225 million during each of the decades 1930-40 and 1940-50; the rise was 500 million between 1950-60 and a further increase of 600 million is expected before 1970. Furthermore, the young sexually active age groups now represent a much larger proportion of the demographic tree. The number of sexual contacts, and hence the chance of acquiring a genital infection, increases in such a rapidly changing population.

Few factors have changed our environment and affected conditions of life as much as the immense technological progress and rapid industrialization and urbanization of the last few decades. Industrial activity increased by 50 per cent between 1956-1966 in some developed countries and as much as 200 per cent in some developing countries in the same period. New physical, mental health, and social problems have arisen.

Greater frequency of venereal disease is often the result of easy, casual sexual encounters and increased sexual activity, of commercialized prostitution and of homosexuality, all of which have been noted in behavior patterns of agglomerations of people in rapidly growing centers and metropolitan areas. As an example, the capital, Oslo, in 1967 accounted for some 90 per cent of Norway's total cases of new syphilis, Oslo being the only city in the country of metropolitan size. In some countries (e.g., U.S.A.) more venereal disease is reported in deteriorated areas or slums of large cities among socially disorganized groups (with low socio-

economic standards). One is led to believe that more systematic health education efforts, with emphasis on prevention of disease, are needed in relation to city planning and expanding urban agglomerations on the one hand, and that more attention in this respect should be focused on socio-economic risk groups in large cities on the other hand.

A phenomenon of today is the high rate of venereal disease among university students. In developing countries (e.g., in Africa), some 25 to 30 per cent have in some instances been reported to be infected. But also in some Western welfare states high rates are observed (e.g., Sweden), where 34 per cent of female student patients attending the university student clinic had gonorrhea. In Britain, settlement difficulties of foreign students have also been found to be involved.

In “chronic” itinerants such as seafarers, and migrating labour groups venereal disease has been shown to be many times more common than in static populations.

Tourism Contributes to Spread of VD

Tourism and international travel are also increasing the opportunity for acquiring and spreading the sexually transmitted diseases. Case and contact histories from several countries suggest the extent of this international problem; for example, in Sweden in 1966 there was evidence that more than 20 per cent, and in the Netherlands more than 25 per cent, of the new cases of syphilis were acquired abroad, exclusive of cases imported by seafarers.

Included among mobile populations inherently exposed to changing social environments are the armed forces. Epidemiological efforts in VD control can succeed only by close cooperation between military and civilian health authorities.

In most countries, available data tend to emphasize the causal links between venereal disease and war, social upheaval, expanding economy and inflation. On the other hand, in many countries the post-war cycle of fall and rise of early syphilis and gonorrhea covered an unbroken 20 to 25 year period of economic expansion. But changing moral and behavioral codes of the post-war years, female social and economic emancipation and general economic affluence contributed to changing patterns of sexual activity.

Rising venereal disease rates in young people of both sexes have attracted attention in recent years. An increase in acquired syphilis and gonorrhea between ages 15 to 19 in relation to the disease in all other age groups is reported in nine countries. In these teen-age groups there was—almost without exception—an equal distribution of reported disease among young females and

males, as contrasted to the older age-groups. Studies indicate that infected young people often have individual, family, educational and social problems. A certain correlation has been observed in special groups among venereal disease, illegitimacy and drug taking, suggesting that teen-age venereal infection is a symptom of "social disease" in problem groups of urbanized societies in developing or developed industrialized areas. When discussing the young, however, it is important to note that there are also studies contending that little basic change has occurred in the sexual behavior traits of the majority of the youngsters, but that the skeleton has been taken out of the cupboard, and that they are trying to adjust themselves to modern concepts of sex.

The level of knowledge of venereal infection in the young is remarkably incomplete, as shown in studies in Britain, France, Sweden and the U.S.A. Up to 50 per cent of those involved in these studies had little or no knowledge of venereal disease. There is need also for a better understanding among the medical profession concerning the control methods of venereal diseases, as recently pointed out by Dr. Bruce Webster in his report of *The Study On The Teaching Of Venereal Diseases In Medical Schools Throughout The World*.

Only the Pattern Is Changed

The 1949 United Nations Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others, to which numerous countries have subscribed, led to the official suppression of brothels and prostitution in the classical sense. The convention has not put an end to the "oldest profession"; it has helped to alter prostitution patterns; motels, bars, restaurants, caravans, holiday beaches, exhibits, fairs, etc., are now active operational fields for sexual encounter; the call-girls and car-prowling girls have become established features of today's metropolitan life. Demi-prostitutes and "good-time" girls engaged in normal jobs compete with the professionals in the sex market. Periodic medical examination and control of prostitution is attempted in some countries, although studies have shown that this method reaches only a fraction of those of epidemiological interest. The prevalence of venereal disease in prostitutes and demi-prostitutes is relatively high, varying from 10 to 90 per cent in different investigations.

The increasing role of male homosexuals in the spread of syphilis has been much discussed in recent years. They are less commonly identified, although they are known to contribute to the spread of gonorrhea. Homosexual contacts named by infected persons may range from 10 to 90 per cent in selected material. Generally, homosexuals are extremely promiscuous in different

social strata and, in addition, some have heterosexual contacts. As a risk group, they therefore pose difficult epidemiological problems. It has been suggested that the recent legislation in some countries permitting adult homosexuality may possibly facilitate contact tracing.

Although penicillin therapy was an important factor in reducing the incidence of new syphilis in the first decade after the Second World War, it failed to prevent the recrudescence of the disease in the 1950s. In the post-war decade, there was a widening use of penicillin for a multiplicity of medical conditions apart from syphilis. There was also an increasing misuse of this antibiotic in the population at large. This is believed to have prevented many syphilitic infections from arising in individuals actually exposed to the causal organism, because of the penicillin levels in their blood and tissues at the time of exposure, or to have cured unsuspected early disease. The micro-organism causing syphilis remains one of the most sensitive to penicillin. The resistance to reinfection, however, becomes of relatively short duration and "ping-pong" and "repeater" syphilis have been observed much more frequently in the penicillin era than after metal therapy. Reinfection rates in clinic patient material now range from 1.6 per cent to 8.2 per cent. These factors have contributed to the recrudescence of early syphilis in the present decade.

Gonorrhea Less Sensitive to Penicillin

Concerning gonorrhea, penicillin (and possibly streptomycin) therapy contributed to the somewhat reduced incidence of this disease during the first post-war decade, but not to the same extent as the reduction in early syphilis. In this period the unknown "penicillin fall-out" may have had a less preventive effect on gonorrhea in the population at large than on syphilis since the gonococcus is less sensitive to penicillin than the treponeme and since gonorrhea has a much shorter incubation period than syphilis. The subsequent development of resistance to penicillin and some other antibiotics by circulating strains of the gonococcus in several areas of the world can, however, probably be considered responsible only to a limited extent for the reported rise in incidence of gonorrhea in recent years. There can be little doubt that the easy, rapid, effective and relatively safe, individual antibiotic therapy both in syphilis and gonorrhea contributed to the changing climate of opinion concerning venereal diseases. Previous fear of syphilis and gonorrhea as dangerous diseases has waned and the public has assumed an attitude of unconcern; doctors and health administrators were lured into indifference concerning the need to maintain adequate control facilities by the falling incidence of the 1950s.

There is indication of renewed interest in the venereal disease problem now that some developed countries report gonorrhea as the most prevalent communicable disease after influenza and the common cold.

Ambulant treatment of venereal diseases is now undertaken in many countries, not only by recognized specialists and in clinics, but also by general practitioners. Failure by the latter (and by laboratories) to cooperate with the health authorities concerning epidemiological efforts is yet another cause of the upsurge of infectious syphilis and gonorrhea. Thus, in Sydney, Australia, in 1965 it was estimated that only 9.1 per cent of the total cases of venereal disease treated by private doctors were reported to the health authorities and in 1968 in the U.S.A. only 12.0 per cent were reported.

Finally, new anticonceptual practices may have a role in the spread of venereal disease. Intrauterine devices and oral gestogen pills are increasingly utilized in a world-wide orientation towards birth control and family planning. Freedom from fear of pregnancy added to indifference towards venereal disease may encourage sexual activity and multiple sexual contacts, particularly in the young, thus enhancing the chance of acquiring disease. Evidence in this respect has been furnished in Sweden and represents a new and stimulating area for socio-medical research. There is also evidence of the side-effects of steroid contraceptive pills in the form of more frequent vaginitis. An estimated 13 million women in Western societies are now "on the pill"—one million in Britain alone.

Many Questions Must be Answered

An attempt has been made to appraise the climate of opinion in which a rising trend of syphilis and gonorrhea—and possibly also other infections acquired sexually—has taken place in the last decade and apparently continues to take place in many parts of the world. Will our present form of medical and public health services relating to venereal disease be adequate for future needs? Should some diseases acquired sexually continue to be defined by legislation as "venereal," or should this term be changed? Will an improved climate of opinion favoring more international cooperation develop in recognition of the fact that approximately half of the cases of syphilis and gonorrhea diagnosed in

some countries are acquired outside the country? Can such cooperation be effective in containing disease or must we await the development of immunizing agents—at least in the case of syphilis, where research is now advancing along hopeful lines?

During its 25th General Assembly in 1967, the International Union against the Venereal Diseases and the Treponematoses reviewed the wide range of medical, public health, and sociological and educational problems concerned in the ecology of venereal diseases, and focused attention on the need for the broadest possible approach to the problems concerned, based upon close cooperation between governmental and non-governmental organization, particularly public and private medicine.

Conclusion

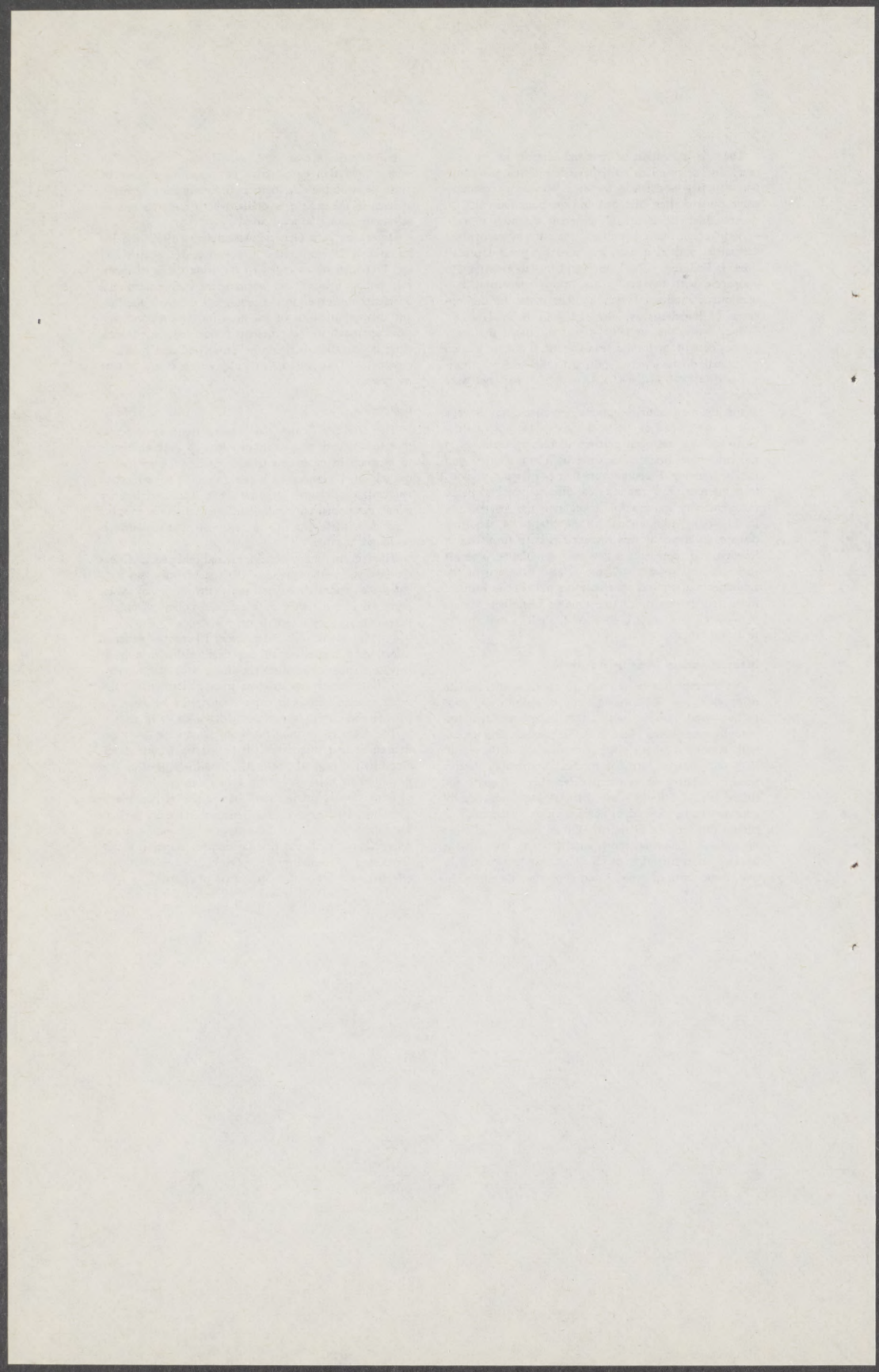
The above indicates the upward trend in venereal disease incidence as a world problem. Syphilis continues to increase in most countries from its all-time low in the mid-50's. Gonorrhea is recognized to have reached epidemic proportions in some areas. The complacency which developed nationally and internationally towards venereal disease control, in the post penicillin era, is no longer tenable.

The fact that many behavioral and other social forces are involved in the spread of the venereal diseases indicates that control measures must involve many disciplines, bound together by a national policy which can be encouraged by international assistance.

In many areas, nine out of every 10 cases of venereal infection, if treated at all, are dealt with clinically by private doctors or semi-trained indigenous practitioners, with little facility for contact tracing. Perhaps in few other disease entities is close cooperation between the private and public sectors of medicine more necessary.

The facts concerning the venereal disease problem, nationally and internationally, must be better understood by the general public, the medical profession and governments before effective action can result.

While focal "eradication" of syphilis is possible in some localized areas, surveillance of travelers poses a formidable obstacle in these days of expanding travel opportunity. Venereal disease control remains a personal and a community responsibility combined with effective international coordination of effort.



Tables

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TABLE I
CASES OF SYPHILIS AND GONORRHEA AND RATES FOR 100,000 POPULATION*
REPORTED BY STATE HEALTH DEPARTMENTS
FISCAL YEARS 1950-1968

FISCAL YEAR	PRIMARY AND SECONDARY SYPHILIS		EARLY LATENT SYPHILIS		LATE AND LATE LATENT SYPHILIS		TOTAL SYPHILIS**		GONORRHEA		TOTAL INFECTIOUS VD (P&S Syphilis & Gonorrhea)		TOTAL VD (Syphilis*** all stages & Gonorrhea)	
	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate
1950	32,148	21.6	64,786	43.5	112,424	75.5	229,723	154.2	303,922	204.0	336,070	225.6	533,645	358.2
1951	18,211	12.1	52,309	34.7	107,133	71.1	198,640	131.8	270,459	179.5	288,670	191.6	469,099	311.3
1952	11,991	7.9	38,365	25.2	101,920	66.9	168,734	110.8	245,633	161.3	257,624	169.2	414,367	272.1
1953	9,551	6.2	32,287	20.8	100,195	64.7	156,099	100.8	243,857	157.4	253,408	163.6	399,956	258.2
1954	7,688	4.9	24,999	15.9	93,601	59.4	137,876	87.5	239,661	152.0	247,349	156.9	377,537	239.5
1955	6,516	4.1	21,553	13.4	84,741	52.7	122,075	76.0	239,787	149.2	246,303	153.3	361,862	225.2
1956	6,757	4.1	20,014	12.2	89,851	54.8	126,219	77.1	233,333	142.4	240,090	146.5	359,552	219.5
1957	6,251	3.8	19,046	11.4	96,856	58.1	130,552	78.3	216,476	129.8	222,727	133.6	347,028	208.1
1958	6,661	3.9	16,698	9.8	85,974	50.5	116,630	68.5	220,191	129.3	226,852	133.2	336,821	197.8
1959	8,178	4.7	17,592	10.2	86,776	50.1	119,981	69.3	237,318	137.0	245,496	141.7	357,299	206.3
1960	12,471	7.1	16,829	9.5	84,195	47.6	120,249	68.0	246,697	139.6	259,168	146.7	366,946	207.6
1961	18,781	10.4	19,146	10.7	80,942	45.0	125,262	69.7	265,685	147.8	284,466	158.2	390,947	217.5
1962	20,084	11.0	19,924	10.9	78,264	42.9	124,188	68.1	260,468	142.8	280,552	153.8	384,656	210.9
1963	22,045	11.9	18,683	10.1	81,736	44.1	128,450	69.3	270,076	145.7	292,121	157.6	398,526	215.0
1964	22,733	12.1	18,104	9.6	72,184	38.4	118,247	62.9	290,603	154.5	313,336	166.6	408,850	217.4
1965	23,250	12.3	17,315	9.1	67,633	35.7	113,018	59.7	310,155	163.8	333,405	176.1	423,173	223.5
1966	22,473	11.6	16,974	8.8	66,149	34.3	110,128	57.1	334,949	173.6	357,422	185.2	445,077	230.7
1967	21,090	10.8	15,618	8.0	62,653	32.2	103,546	53.2	375,606	193.0	396,696	203.8	479,152	246.2
1968	20,182	10.3	15,379	7.8	58,905	29.9	98,195	49.9	431,380	219.2	451,562	229.5	529,575	269.1

*Source: U.S. Public Health Service

**Includes congenital and other syphilis

***Excludes chancroid, granuloma inguinale, and lymphogranuloma venereum

TABLE II
TREND LINES OF PRIMARY-SECONDARY AND EARLY
LATENT SYPHILIS REPORTED IN U.S.
1954-1968

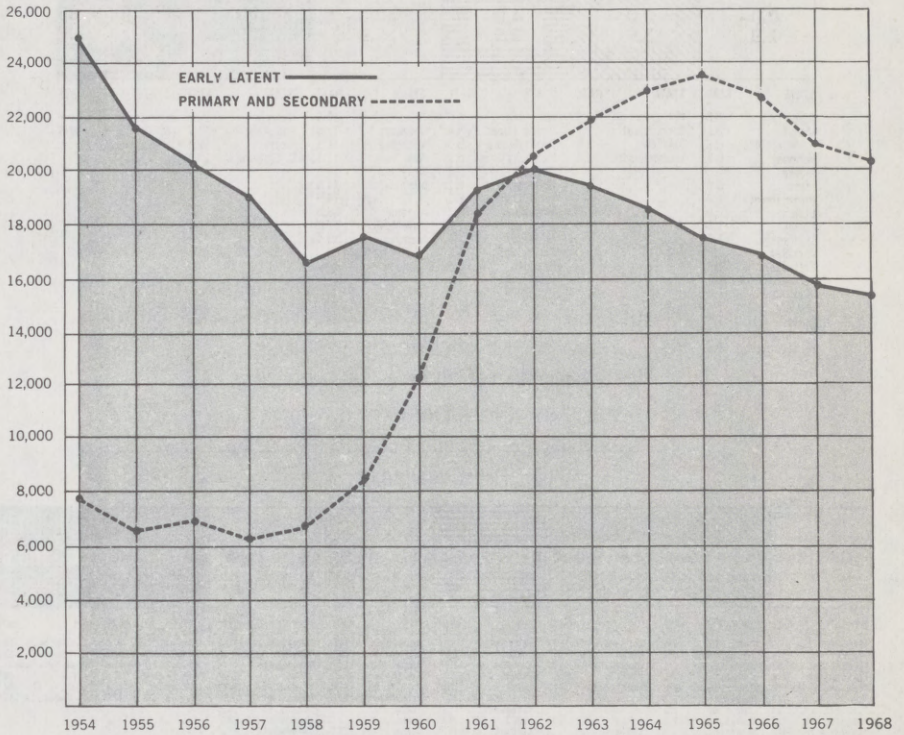


TABLE III
PRIMARY AND SECONDARY SYPHILLIS
Case Rates Per 100,000 Population for States*
Fiscal Year 1968

0.0 - 1.9		2.0 - 3.9		4.0 - 9.9		10.0 - 19.9		20.0 - 29.9		30.0 - 97.5	
STATE	RATE	STATE	RATE	STATE	RATE	STATE	RATE	STATE	RATE	STATE	RATE
Wisconsin	0.5	Nebraska	2.5	Missouri	4.0	Illinois	10.9	Georgia	20.6	Florida	31.4
Maine	0.6	Connecticut	3.1	Rhode Island	4.6	Delaware	11.5	Louisiana	21.7	D. C.	97.5
N. Hampshire	0.6	Oklahoma	3.6	Pennsylvania	5.0	Michigan	12.5	Texas	22.1		
Vermont	0.7	Massachusetts	3.7	Kentucky	5.3	New York	12.7	S. Carolina	24.1		
Alaska	0.8			Ohio	5.3	Maryland	14.5				
Idaho	0.9			Indiana	6.1	Mississippi	14.6				
North Dakota	1.0			South Dakota	6.3	N. Carolina	14.9				
Utah	1.0			Virginia	6.7	Arizona	16.5				
Hawaii	1.0			Arkansas	7.0	New Mexico	17.0				
Montana	1.3			N. Jersey	7.7	Alabama	19.4				
Wyoming	1.3			California	8.2						
Colorado	1.6			Nevada	8.7						
Kansas	1.7			Tennessee	9.3						
Minnesota	1.7										
Iowa	1.8										
Oregon	1.8										
Washington	1.8										
W. Virginia	1.8										

*Source: Public Health Service — Reported Cases Only.

TABLE IV
PRIMARY AND SECONDARY SYPHILLIS
Case Rates Per 100,000 Population for Cities
Fiscal Year 1968

0 - 1.9		2 - 4.9		5 - 9.9		10 - 19.9		20 - 29.9		30 - 39.9		50 - 106.6	
CITY	RATE	CITY	RATE	CITY	RATE	CITY	RATE	CITY	RATE	CITY	RATE	CITY	RATE
*Evanville, Ind.	0	*Peoria, Ill.	2.0	*Martinez, Calif.	5.0	Bridgeport, Conn.	10.2	Baton Rouge, La.	20.0	*Stockton, Calif.	30.3	*Charlotte, N.C.	40.3
Lorain, O.	0	*Topeka, Kans.	2.0	*Annapolis, Md.	5.5	Cincinnati, O.	10.2	St. Louis, Mo.	20.0	*Houston, Tex.	30.6	Cleveland, O.	42.4
*Pueblo, Colo.	0	*Battle Creek, Mich.	2.1	*Ventura, Calif.	5.5	*Cincinnati, O.	10.2	*Mobile, Ala.	20.2	*Indianapolis, Ind.	31.2	*Durham, N.C.	55.3
Roanoke, Va.	0	*Duluth, Minn.	2.1	*Tolosa, Okla.	6.0	*Atlantic City, N.J.	10.7	*Fayetteville, N.C.	21.4	*El Paso, Tex.	32.0	*West Palm Beach, Fla.	68.9
*Springfield, Mo.	0	*Rockford, Ill.	2.2	*Albany, N.Y.	6.1	*Pittsburgh, Pa.	11.4	*New Orleans, La.	21.5	*San Francisco, Calif.	48.9	D. C.	97.5
*Lansing, Mich.	0.4	*Dayton, O.	2.3	*Los Angeles, Calif.	6.5	*Greensboro, N.C.	11.6	*Tampa, Fla.	21.5	*Raleigh, N.C.	49.8	*Shreveport, La.	145.5
*Lockport, N.Y.	0.4	*Youngstown, O.	2.4	*San Bernardino, Calif.	6.5	*Lexington, Ky.	11.7	*Paterson, N.J.	22.2				
*Kingston, N.Y.	0.7	*Milwaukee, Wis.	2.5	*San Bernardino, Calif.	6.5	*Phoenix, Ariz.	11.7	*Gulfport, Miss.	22.5	*Birmingham, Ala.	36.3		
*Covington, Ky.	0.8	*Kansas City, Mo.	2.6	*Nashville, Tenn.	6.6	*Macon, Ga.	12.0	*New York, N.Y.	24.3	*Augusta, Ga.	36.7		
Monroe, Mich.	0.9	*Binghamton, N.Y.	2.7	*Albuquerque, N.M.	7.1	*San Benito, Tex.	12.1	Portsmouth, Va.	25.6	*Charleston, S.C.	32.4		
Waterbury, Conn.	0.9	*Buffalo, N.Y.	2.8	*Vallejo, Calif.	7.2	*Lake Charles, La.	12.3	Trenton, N.J.	28.7	*San Mateo, Calif.	39.6		
Akron, O.	1.0	*Mineola, N.Y.	2.9	*Cheverly, Md.	7.4	*Corpus Christi, Tex.	12.5	*Jacksonville, Fla.	29.1				
Saginaw, Mich.	1.0	*Wichita, Kans.	2.9	*Lubbock, Tex.	7.4	*Lexington, Ky.	12.5	Chicago, Ill.	29.2				
*Erie, Pa.	1.1	*Seattle, Wash.	3.1	*Des Moines, Iowa	7.8	*Savannah, Ga.	12.8						
*Spokane, Wash.	1.1	*St. Paul, Minn.	3.2	*Sacramento, Calif.	7.8	*Columbus, Ga.	13.8						
*Grand Rapids, Mich.	1.3	*San Jose, Calif.	3.3	*Albany, N.Y.	7.8	*St. Petersburg, Fla.	14.4						
*Towson, Md.	1.4	*San Diego, Calif.	3.4	*Asheville, N.C.	8.3	*Tucson, Ariz.	14.7						
*Kansas City, Kans.	1.5	*Mt. Clemens, Mich.	3.5	*Memphis, Tenn.	8.3	*San Antonio, Tex.	15.0						
*Charleston, W. Va.	1.6	*Rockville, Md.	3.5	*New Haven, Conn.	8.5	*Oakland, Calif.	15.1						
Canton, O.	1.7	*Salt Lake City, Utah	3.5	*South Bend, Ind.	8.7	Philadelphia, Pa.	15.1						
*Riverhead, N.Y.	1.7	*Minneapolis, Minn.	3.7	*Montgomery, Ala.	9.2	Richmond, Va.	15.7						
*Omaha, Neb.	1.8	*Santa Ana, Calif.	4.1	*Fresno, Calif.	9.3	*Winter Haven, Fla.	15.9						
*Port Huron, Mich.	1.8	*Utica, N.Y.	4.1	*Springfield, O.	9.4	*Norfolk, Va.	16.5						
*Winston Salem, N.C.	1.8	*Denver, Colo.	4.6	*Toledo, O.	9.6	*Berkeley, Calif.	16.8						
*N. Y.	1.9	*Portland, Ore.	4.7	*Salinas, Calif.	9.5	*Ft. Worth, Tex.	17.5						
*West Haverstraw, N.Y.	1.9	*Visalia, Calif.	4.7	*Rochester, N.Y.	9.7	*Ft. Wayne, Ind.	17.6						
Yonkers, N.Y.	1.9	*Flint, Mich.	4.8	*Newport News, Va.	9.8	*Knobsville, Tenn.	17.7						
		*Riverside, Calif.	4.8	*Austin, Tex.	9.9	Camden, N.J.	18.3						
						*Chattanooga, Tenn.	19.2						

*County Data

TABLE V
Primary and Secondary Syphilis
Case Rates Per 100,000 Population
Reported Cases Only
Fiscal Year 1968

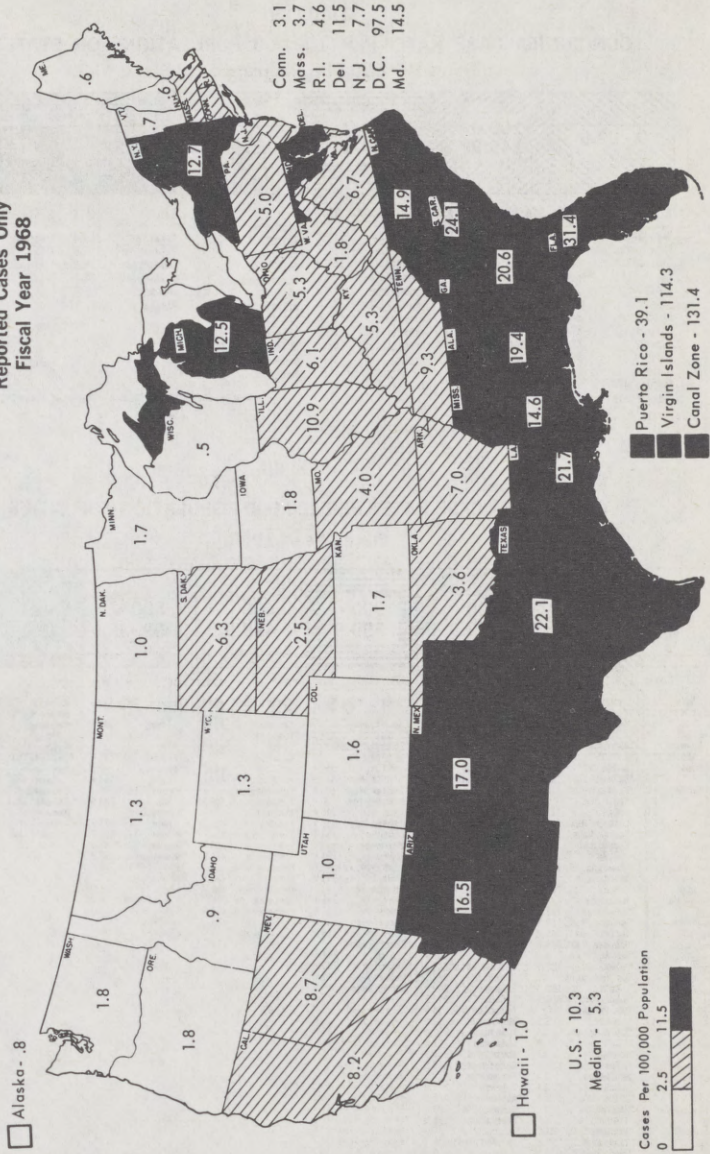


TABLE VI
GONORRHEA CASE RATES PER 100,000 POPULATION FOR STATES*
Fiscal Year 1968

0 - 99.9		100.0 - 149.9		150.0 - 199.9		200.0 - 299.9		300.0 - 399.9		400.0 - 1544.3	
STATE	RATE	STATE	RATE	STATE	RATE	STATE	RATE	STATE	RATE	STATE	RATE
Wyoming	60.5	Massachusetts	108.0	Nebraska	152.4	Michigan	201.8	Arkansas	313.4	Georgia	425.9
New Hampshire	61.1	Idaho	115.7	South Dakota	156.1	Arizona	207.1	Tennessee	315.8	D.C.	1544.3
Vermont	67.7	Indiana	117.4	Kansas	157.9	Nevada	217.2	California	339.4		
North Dakota	69.4	Kentucky	118.8	Oklahoma	160.4	New York	219.6	S. Carolina	344.2		
West Virginia	70.1	Pennsylvania	119.8	Louisiana	174.3	N. Carolina	226.8	Illinois	363.3		
Montana	75.8	Alabama	130.3	Washington	183.0	Virginia	228.6	Alaska	391.2		
Wisconsin	84.9	Colorado	133.5	Oregon	183.5	Florida	237.2				
Minnesota	87.1	Iowa	134.9	New Mexico	190.9	Maryland	240.6				
Hawaii	88.9	Connecticut	146.4	Ohio	192.7	Mississippi	245.3				
Utah	89.5					Missouri	252.8				
Maine	90.1					Delaware	297.9				
Rhode Island	95.7					Texas	299.3				
New Jersey	99.2										

*Source: Public Health Service — Reported Cases Only.

TABLE VII
GONORRHEA CASE RATES PER 100,000 POPULATION FOR CITIES
Fiscal Year 1968

0 - 99.9		100 - 199.9		200 - 299.9		300 - 399.9		400 - 499.9		500 - 699.9		700 - 999.9		1000 - 1789.6	
CITY	RATE	CITY	RATE	CITY	RATE	CITY	RATE	CITY	RATE	CITY	RATE	CITY	RATE	CITY	RATE
*Mineola, N.Y.	14.2	Canton, O.	106.1	Camden, N.J.	200.2	*Lansing, Mich.	313.3	*Oakland, Calif.	408.8	*Augusta, Ga.	500.6	Akron, O.	709.3	Norfolk, Va.	1002.3
*Riverhead, N.Y.	19.2	*Visalia, Calif.	108.5	Salt Lake City, Utah	200.2	*Louisville, Ky.	313.4	Saginaw, Mich.	418.9	*Chattanooga, Tenn.	508.8	Rockford, Ill.	759.9	Newark, N.J.	1086.9
*Pueblo, Colo.	19.4	*Binghamton, N.Y.	119.1	*Paterson, N.J.	201.5	*Fresno, Calif.	209.4	*Columbus, Ga.	330.0	Indianapolis, Ind.	437.1	Philadelphia, Pa.	527.5	Baltimore, Md.	764.5
*Kingston, N.Y.	21.0	*Riverside, Calif.	119.6	*Syracuse, N.Y.	213.5	*Winston Salem, N.C.	334.4	*Ft. Worth, Tex.	444.0	*Portland, Ore.	536.4	Stockton, Calif.	559.4	Richmond, Va.	778.8
*Duluth, Minn.	22.3	*Lorain, O.	122.4	*Phoenix, Ariz.	216.9	*Seattle, Wash.	345.8	*Los Angeles, Calif.	456.5	*Kansas City, Mo.	584.6	*Chicago, Ill.	900.6	*Charlotte, N.C.	796.0
*Towson, Md.	23.5	*Salinas, Calif.	123.3	*Copius Christi, Tex.	218.0	*Buffalo, N.Y.	223.8	*Marinez, Calif.	456.7	*Kansas City, Mo.	584.6	*St. Louis, Mo.	945.7	*San Francisco, Calif.	1315.4
*Mt. Clemens, Mich.	26.3	*Ft. Wayne, Ind.	125.6	*Orlando, Fla.	223.8	*Omaha, Neb.	352.4	*Peoria, Ill.	362.8	*Houston, Tex.	632.7	*Cleveland, O.	832.5	*Durham, N.C.	1768.1
*Springfield, Mo.	34.2	*Santa Ana, Calif.	127.1	*Miami, Fla.	232.1	*Lexington, Ky.	353.6	*Milwaukee, Wis.	354.1	*Trenton, N.J.	468.5	*Shreveport, La.	656.3	*Atlanta, Ga.	1789.6
*Rockville, Md.	38.7	*Lubbock, Tex.	130.8	*Knoxville, Tenn.	236.4	*West Palm Beach, Fla.	359.9	*Fayetteville, N.C.	361.4	*Newport News, Va.	482.4				
*Monroe, Mich.	43.0	*Topeka, Kans.	134.9	*Battle Creek, Mich.	242.8	*Ft. Worth, Tex.	444.0	*Peoria, Ill.	362.8	*Detroit, Mich.	492.7				
*Ventura, Calif.	56.7	*Charleston, W. Va.	136.5	*Greenboro, N.C.	243.2	*Birmingham, Ala.	243.5	*Tampa, Fla.	375.6						
*Covington, Ky.	56.8	*Waukegan, Ill.	138.8	*Birmingham, Ala.	243.5	*Toledo, O.	245.3	*New York, N.Y.	378.9						
*Cheverly, Md.	57.0	*Atlantic City, N.J.	140.8	*South Bend, Ind.	247.4	*St. Paul, Minn.	248.3	*Grand Rapids, Mich.	384.8						
*Annapolis, Md.	63.7	*Waterbury, Conn.	142.9	*Bridgeport, Conn.	249.0	*Albany, N.Y.	386.2								
*Evansville, Ind.	67.6	*Spokane, Wash.	143.8	*Vallejo, Calif.	249.3	*Mobile, Ala.	388.5								
*St. Petersburg, Fla.	77.3	*Tucson, Ariz.	145.7	*Youngstown, O.	258.5	*Denver, Colo.	389.1								
Baton Rouge, La.	87.6	*San Jose, Calif.	149.7	*Minneapolis, Minn.	260.6										
Utica, N.Y.	93.8	*San Antonio, Tex.	152.0	*Cincinnati, O.	261.0										
*Pittsburgh, Pa.	96.8	*San Bernardino, Calif.	152.7	*Macon, Ga.	261.9										
Yonkers, N.Y.	98.2	*Tulsa, Okla.	154.0	*Gulfport, Miss.	269.5										
		*Albuquerque, N.M.	155.5	*Des Moines, Iowa	271.0										
		*San Diego, Calif.	155.6	*Rochester, N.Y.	287.0										
		*San Benito, Tex.	158.2	*Flint, Mich.	291.9										
		*San Mateo, Calif.	171.0												
		*El Paso, Tex.	173.4												
		*Port Huron, Mich.	175.8												
		*Springfield, O.	180.4												
		*Raleigh, N.C.	181.2												
		*Lake Charles, La.	182.1												
		*Roanoke, Va.	195.2												
		*Jacksonville, Fla.	196.6												
		*Austin, Tex.	197.7												
		*Montgomery, Ala.	199.9												

*County Data

TABLE VIII
GONORRHEA
Case Rates Per 100,000 Population
Reported Cases Only
Fiscal Year 1968

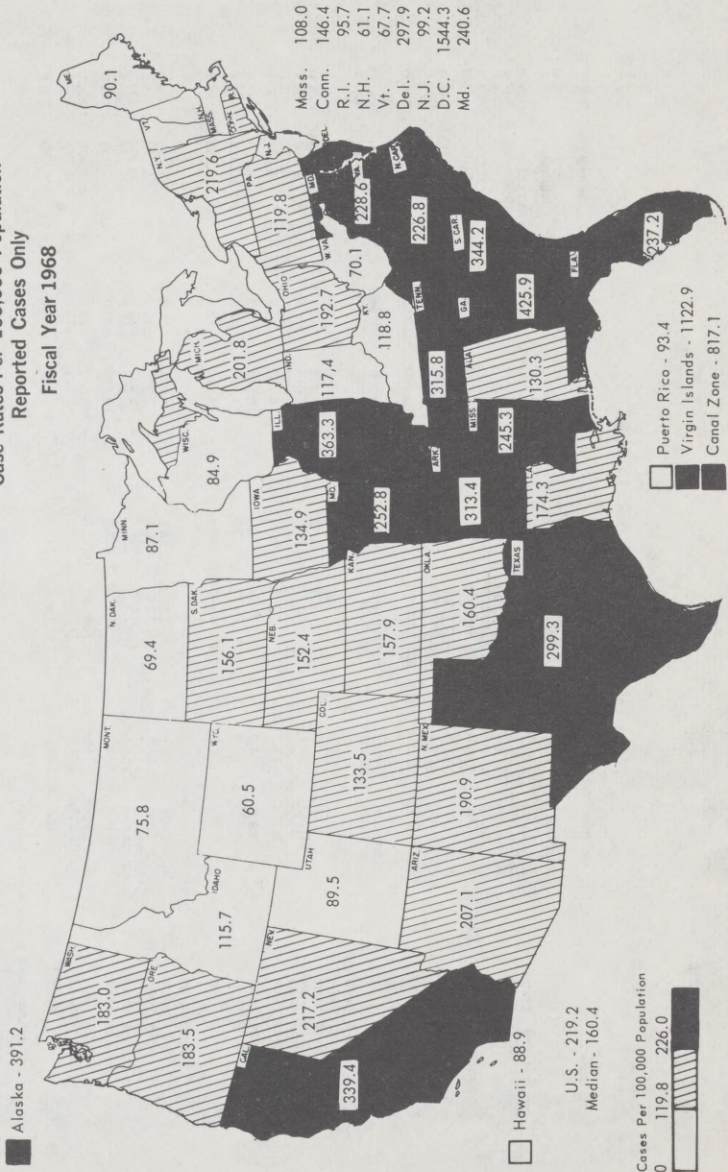


TABLE IX
VD INFECTION BY AGE GROUPS

	Calendar Year 1956				Calendar Year 1966				Calendar Year 1967			
	Population	Pct. of Total	Number of Cases	Rate per 100,000	Population	Pct. of Total	Number of Cases	Rate per 100,000	Population	Pct. of Total	Number of Cases	Rate per 100,000
P & S SYPHILIS												
0-9 Years	36,751,000	22.2	11	0	39,107,000	21.9	67	1	40,657,000	21.0	31	.1
10-14 Years	13,720,000	8.3	67	.5	16,985,000	9.5	139	.8	19,805,000	10.0	208	1.0
15-19 Years	10,855,000	6.6	1,163	10.7	12,998,000	7.3	2,577	19.8	17,434,000	9.0	3,265	18.7
20-24 Years	9,543,000	6.8	1,758	18.4	10,222,000	5.7	4,692	45.9	12,705,000	6.6	6,152	48.0
25-29 Years	11,181,000	6.8	1,263	11.3	10,549,000	5.9	3,385	32.1	11,152,000	5.8	4,181	35.7
0-24 Years	70,872,000	42.9	2,999	4.2	79,312,000	44.5	7,428	9.4	90,198,000	46.6	10,121	11.2
25 Years Up	94,470,000	57.1	3,396	3.6	98,888,000	55.5	7,717	8.8	104,836,000	53.4	10,856	10.4
Total	165,341,000	100.0	6,395	3.9	178,170,000	100.0	16,145	9.1	195,034,000	100.0	21,053	10.8
GONORRHEA												
0-9 Years	1,202	3.3	1,202	3.3	1,619	4.1	1,471	3.6	1,625	4.1	1,625	4.1
10-14 Years	4,398	17.5	3,261	19.2	5,361	19.2	2,775	14.3	3,170	15.9	3,170	15.9
15-19 Years	11,111	41.7	53,699	482.7	12,998	48.2	76,032	436.1	91,390	531.0	91,390	531.0
20-24 Years	74,663	781.8	83,711	1,109.1	83,711	82.2	126,339	954.4	148,877	1,088.9	148,877	1,088.9
25-29 Years	48,624	434.2	51,213	485.5	51,213	485.5	70,283	630.0	80,953	691.9	80,953	691.9
0-25 Years	123,454	174.0	146,352	184.5	146,352	184.5	206,617	229.1	245,062	269.7	245,062	269.7
25 Years Up	101,229	106.9	112,581	113.9	112,581	113.9	145,121	140.2	159,774	152.4	159,774	152.4
Total	224,683	135.7	258,933	145.3	258,933	145.3	351,738	181.6	404,836	206.9	404,836	206.9

*Source: Public Health Service — Reported Cases Only

TABLE X
15-19 YEAR AGE GROUP*
Case Rates For P&S Syphilis
Calendar Year 1967

0.0 - 1.9		2.0 - 4.9		5.0 - 9.9		10.0 - 19.9		20.0 - 39.9		40.0 - 220.4	
STATE	RATE	STATE	RATE	STATE	RATE	STATE	RATE	STATE	RATE	STATE	RATE
Maine	0.0	Colorado	2.3	Utah	5.2	South Dakota	11.1	New York	20.2	Texas	42.1
Oregon	0.6	Hawaii	2.9	Kansas	5.6	Ohio	11.2	Delaware	25.0	Louisiana	49.0
Wisconsin	1.1	Nebraska	3.2	Vermont	5.6	Oklahoma	11.2	Arizona	28.8	Georgia	57.3
Montana	1.5	West Virginia	3.4	Missouri	5.8	Virginia	15.3	New Mexico	29.3	Florida	77.6
North Dakota	1.7	New Hampshire	3.6	Idaho	5.9	New Jersey	15.5	Mississippi	34.0	Alabama	80.3
		Minnesota	3.8	Connecticut	6.0	Rhode Island	17.8	Michigan	34.4	South Carolina	87.2
		Washington	4.0	Indiana	6.9	Arkansas	18.2	North Carolina	35.8	D.C.	220.4
		Alaska	4.2	Wyoming	6.9	Tennessee	19.3	Maryland	37.2		
		Massachusetts	4.8	Pennsylvania	8.3	Illinois	19.6				
		Iowa	4.9	California	8.9						
				Nevada	3.1						
				Kentucky	3.7						

*Source: Public Health Service — Reported Cases Only

TABLE XI
15-19 YEAR AGE GROUP*
Case Rates for Gonorrhea
Calendar Year 1967

0 - 99.9		100 - 199.9		200 - 299.9		300 - 399.9		400 - 599.9		600 - 5285.2	
STATE	RATE	STATE	RATE	STATE	RATE	STATE	RATE	STATE	RATE	STATE	RATE
Hawaii	79.7	Wyoming	113.8	Maine	212.8	Pennsylvania	305.5	Nebraska	409.7	Maryland	601.9
		North Dakota	122.0	Utah	218.6	Oregon	342.7	Kansas	410.1	Louisiana	605.2
		Rhode Island	137.0	West Virginia	219.2	Indiana	344.1	Alabama	415.9	Mississippi	651.9
		Montana	140.0	Massachusetts	231.7	Colorado	356.4	Nevada	433.3	California	661.0
		Vermont	155.6	Connecticut	240.2	New Mexico	372.7	New York	450.4	South Carolina	683.4
		New Jersey	178.6	South Dakota	273.0	Washington	374.7	Alaska	483.3	North Carolina	705.4
		Idaho	185.3			Kentucky	376.9	Oklahoma	514.0	Texas	723.7
		New Hampshire	185.7			Iowa	392.6	Arizona	526.0	Illinois	729.9
		Wisconsin	197.0					Ohio	538.5	Missouri	736.3
		Minnesota	198.1					Michigan	541.3	Arkansas	740.3
								Virginia	590.1	Florida	774.6
										Delaware	952.3
										Tennessee	998.6
										Georgia	1126.5
										D. C.	5285.2

*Source: Public Health Service — Reported Cases Only

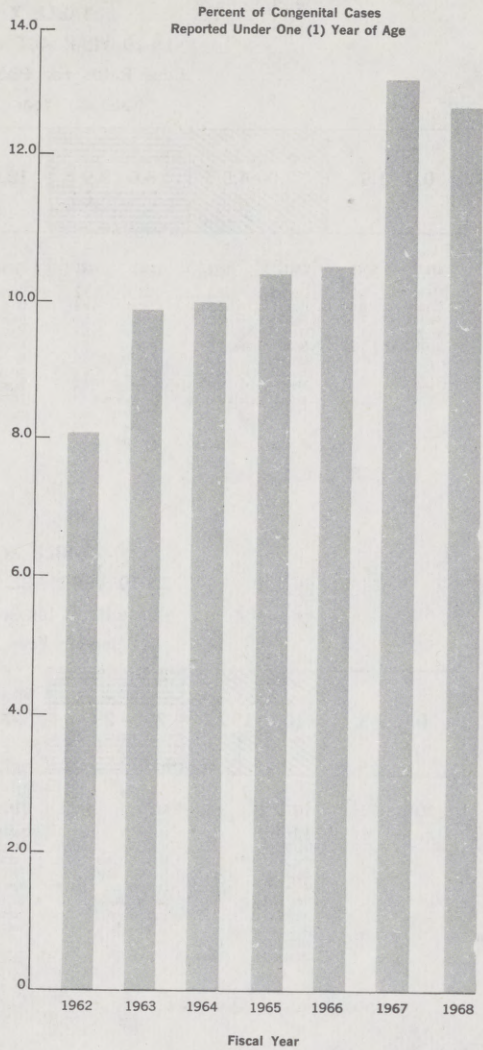
Table XII
CONGENITAL SYPHILIS
United States, Fiscal Years 1962-1968

Fiscal Year	Number of Cases Reported	
	Total	Under One (1) Year of Age
1962	4,085	330
1963	4,140	410
1964	3,737	374
1965	3,505	373
1966	3,464	370
1967	3,050	398
1968	2,596	327

Epidemiologically the increase in infectious syphilis in the age group 10-24 years of age during the years 1956 to 1965 set the stage for an increase in the incidence of congenital syphilis among infants under one year of age. In the period 1962 to 1968 the percentage of reported congenital syphilis under one year of age has increased, reaching its peak in 1967. Supplementing this information is the observation by public health authorities of an increased incidence of out-of-wedlock pregnancies in the same age group.

Of considerable concern are the findings that among the economically, socially and medically deprived in this country many young women do not seek or receive adequate prenatal care until they are in the final or terminal stages of their pregnancies. It has been recently reported that the United States has the highest incidence of congenital syphilis among the Western nations. There is also some concern that the index of suspicion leading to the diagnosis of congenital syphilis is low, and that the criteria for diagnosis are not adequately understood or followed.

These points of view express a need for increasing attention to the problems of congenital syphilis and call for vigorous and cooperative action by authorities responsible for VD control, maternal and child services and obstetrical care in the United States.



Summary Report

NATIONAL SURVEY OF VD INCIDENCE

Conducted by
AMERICAN SOCIAL HEALTH ASSOCIATION*

Period: April 1 - June 30, 1968

SPONSORS:

AMERICAN MEDICAL ASSOCIATION
AMERICAN OSTEOPATHIC ASSOCIATION
NATIONAL MEDICAL ASSOCIATION

*The survey was performed pursuant to Contract No. PH 21-2014 with the Public Health Service, U.S. Department of Health, Education and Welfare.

Purpose of the Survey

To determine the number of cases of infectious syphilis, other syphilis and gonorrhea treated by all medical and osteopathic physicians in private practice in the United States during the period April 1 through June 30, 1968 was the goal of the survey.

This information, together with the number of cases reported as treated by public health clinics and other public sources, provides a truer picture of the actual incidence of the venereal diseases in the United States than is presently available. It also provides more accurate information on actual incidence in each state and major city.

With the availability of this information on the incidence of infectious syphilis and gonorrhea, public health authorities—national, state and local—can plan programs designed to cope with the venereal disease problem according to its true dimensions.

Survey Method

All medical and osteopathic physicians in private practice in the United States were requested by letter, addressed to them individually, to reply to the questionnaire quoted below:

Letters were mailed in time to reach all physicians by July 1, 1968. A follow-up letter was mailed in mid-August to all physicians who had not responded to the initial mailing by that time.

For medical physicians, including both members and non-members of the American Medical Association and National Medical Association, the letters were signed by William L. Fleming, M.D., Chairman of the Venereal Disease Committee of the American Social Health Association, and F. J. L. Blasingame, M.D., then Executive Vice-President of the American Medical Association. A separate letter, signed by Lionel F. Swan, M.D., then President of the National Medical Association, was also sent to its membership urging cooperation in the survey.

For osteopathic physicians, the letters were signed by Dr. Fleming and by True B. Eveleth, D.O., then Executive Director of the American Osteopathic Association.

Mailings were made from lists maintained by the American Medical Association and the American Osteopathic Association for all physicians in private practice, including full-time medical school faculty. The "private physician" classification used for these mailings excluded physicians in federal service, interns, residents and fellows, full-time staff in hospital service, and

How many new (to you) cases of diagnosed syphilis and/or gonorrhea (excluding cases previously treated for these infections and persons treated "prophylactically") did you treat in your private practice during the three (3) month period, *APRIL 1 THROUGH JUNE 30, 1968?* (Do not include public cases treated by you in health clinics, hospital wards, or in military facilities.)

INFECTIOUS SYPHILIS NUMBER OF CASES TREATED

Primary syphilis (chancere present or healing) and/or secondary syphilis (generalized manifestations of skin, mucosae, etc., occurring in the first few years of the disease but *not* including late manifestations)

OTHER STAGES OF SYPHILIS NUMBER OF CASES TREATED

Positive serology (excluding known "false positives") only, late manifestations, or congenital manifestations

GONORRHEA NUMBER OF CASES TREATED

physicians in administrative medicine, research and retirement.

Number of Physicians Queried

The questionnaire was sent to 206,283 medical and osteopathic physicians in private practice in the United States and Puerto Rico.

Response

134,633 physicians, or 65.3% of those queried, responded.

Findings

43,720 physicians, or 32.5% of those responding, reported that they had treated one or more cases of infectious syphilis, other syphilis or gonorrhea during the period from April 1 through June 30, 1968.

- 4,370 physicians, or 3.2% of those responding, treated 8,849 cases of infectious syphilis.
- 10,934 physicians, or 8.1% of those responding, treated 22,022 cases of "other" syphilis.
- 39,392 physicians, or 29.3% of those responding, treated 185,548 cases of gonorrhea.

Percentage of Cases Reported to Cases Treated

Infectious Syphilis:

The total number of cases of infectious syphilis reported to public health authorities by all physicians in private practice during the three-month period of the survey was 1,655. The 134,633 physicians responding to the survey, representing 65.3% of all physicians in private practice, stated they had treated 8,849 cases during this same period. Assuming that the 34.7% of non-respondents treated cases at the same rate as the 65.3% of respondents, 206,283 physicians would have treated 13,744 cases of infectious syphilis during the quarter. The total number of cases reported to public health authorities by all physicians represents 12.0% of those cases projected as treated by the 206,283 physicians queried.

Other Syphilis:

The total number of cases of "other" syphilis reported to public health authorities by all private physicians during the three-month period was 11,277. The 134,633 or 65.3% responding had treated 22,022 cases. Again assuming that the 34.7% of non-respondents treated cases at the same rate as the 65.3% of respondents, 206,283 physicians would have treated 34,113 cases of "other" syphilis during the quarter. The total number

of cases reported by all physicians to public health authorities represents 33.1% of those cases projected as treated by the 206,283 physicians queried.

Gonorrhea:

The total number of cases of gonorrhea reported to public health authorities by all private physicians during the period was 31,378. The 134,633 or 65.3% responding had treated 185,548 cases. Again assuming that the 34.7% of non-respondents treated cases at the same rate as the 65.3% of respondents, 206,283 physicians would have treated 288,054 cases of gonorrhea during the quarter. The total number of cases reported by all physicians to public health authorities represents 10.9% of those cases projected as treated by the 206,283 physicians queried.

Projection of Findings to Fiscal Year 1968

Projecting the number of cases in each category estimated as treated by all private physicians during the quarter to the entire fiscal year, July 1, 1967 through June 30, 1968, and adding to this projection the number of cases in each category treated and reported by public sources for the same period, produces the following estimates of actual incidence by category for the fiscal year 1968:

	Infectious Syphilis	"Other" Syphilis	Gonorrhea
Number of cases treated and reported by public sources:	12,953	32,714	307,624
Number of cases treated and reported by private physicians:	7,229	45,299	123,756
Number of cases treated but not reported by private physicians (total estimated treated less total reported by them):	55,025	93,931	1,018,201
Estimated total number of cases treated during fiscal 1968 by all sources:	75,207	171,944	1,449,581

Comparison of 1968 and 1962 Surveys

A similar National Survey of VD Incidence was conducted by the American Social Health Association in 1962 for the same quarterly period, with the same sponsors as in 1968 and also financed by a contract with the Public Health Service. In 1962 computation of the average rate of reporting was based solely on applying the number of cases treated by the 71.7% of responding physicians to the number of cases reported to public health authorities by all physicians. It did not include a projection of the estimated number of cases treated by the 28.3% of non-respondents.

In order that a reasonable comparison could be made between the findings of the two surveys, the 1968 survey was figured both on the basis of an estimated rate of reporting for all private physicians, had they responded, and on the basis of responding physicians only, as in 1962. It was also possible to recalculate the overall results of the 1962 survey to obtain a national average of reporting for the quarter based on an estimated rate for all private physicians, had they responded.

Comparison of the findings, based on both the 1962 method of computation (excluding non-respondents) and the 1968 method (including a projection for non-respondents) shows improvement in private physician reporting as follows:

**Per Cent of Reporting Computed
by 1962 Method**

	1962	1968
For Infectious Syphilis	11.3	18.7
For "Other" Syphilis	37.5	51.2
For Gonorrhea	10.8	16.9

**Per Cent of Reporting Computed
by 1968 Method**

	8.1	12.0
For Infectious Syphilis	26.9	33.1
For "Other" Syphilis	7.7	10.9

Comparison of the total number of cases of infectious syphilis and gonorrhea estimated as treated during fiscal year 1962 with the number estimated as treated during fiscal 1968, calculated by adding the number of cases reported by public sources to the number of cases estimated as treated by all private physicians (including a projection for non-respondents) shows the following changes in total incidence in the two fiscal years:

	Infectious Syphilis	Gonorrhea
Fiscal 1962	106,442	1,071,125
Fiscal 1968	75,207	1,449,581
Net Change	-31,235	+ 378,456

The reduction in infectious syphilis supports the forecast of public health authorities that continued application of the case finding process—identification and treatment of all sex contacts of all persons with infectious syphilis—will progressively reduce its incidence.

The survey also supports the estimates of public health officials that the number of cases of gonorrhea in the United States has reached epidemic proportions. The survey estimate that one-and-one-half million gonorrhea cases were treated in 1968 also underlines the need for stepped up planning and major increases in funding for gonorrhea control programs.

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INFECTIOUS SYPHILIS — State

QUARTERLY PERIOD APRIL 1 THROUGH JUNE 30, 1968										FISCAL YEAR 1968			
	Pct. of Response	Cases Treated by Respondents	Cases Treated by All Physicians	Cases Reported by All Physicians	Per Cent Reported	Cases Treated and Reported by Private Physicians	Estimated Cases Treated by Public Sources	Estimated Cases Treated by Private Physicians	Total Cases Estimated Treated by All Sources				
TOTAL U.S.	65.3	8,849	13,744	1,655	12.0	7,229	12,953	55,025	75,207				
Alabama	58.6	182	311	49	15.8	199	482	1,060	1,741				
Alaska	61.5	4	7	0	—	1	1	27	29				
Arizona	63.8	92	144	17	11.8	88	177	658	923				
Arkansas	61.0	95	90	12	13.3	43	94	280	417				
California	61.0	1,250	1,400	192	13.0	1,058	841	5,388	7,181				
Colorado	68.2	127	140	21	15.0	106	91	384	585				
Connecticut	66.6	122	183	2	7.1	52	39	680	771				
Delaware	71.5	24	34	0	—	11	48	125	184				
District of Columbia	65.6	102	155	17	11.0	117	655	947	1,719				
Florida	64.4	420	652	165	25.3	253	1,273	1,707	3,558				
Georgia	61.6	222	360	45	12.5	277	628	1,939	2,844				
Hawaii	70.6	17	17	0	—	6	1	62	74				
Idaho	68.0	12	11	0	—	4	8	2	74				
Illinois	64.3	405	630	72	11.4	324	854	2,518	3,696				
Indiana	63.4	234	369	35	9.5	106	199	1,010	1,315				
Iowa	70.1	52	74	15	20.3	38	12	149	199				
Kansas	69.1	63	91	6	6.6	29	9	410	448				
Kentucky	61.4	83	135	11	8.1	60	105	681	846				
Louisiana	61.4	181	340	31	9.1	183	602	1,828	2,613				
Maine	68.2	10	10	1	10.0	6	2	0	10				
Maryland	66.5	109	164	29	17.7	141	381	656	1,178				
Massachusetts	67.0	108	161	17	10.6	64	133	540	737				
Michigan	64.9	458	706	82	11.6	502	569	3,826	4,897				
Minnesota	70.6	39	55	4	7.3	44	17	559	620				
Mississippi	59.9	135	225	21	9.3	74	265	722	1,061				
Missouri	64.5	193	299	13	4.3	64	118	1,424	1,606				
Montana	62.5	14	26	2	7.7	10	7	0	16				
Nebraska	70.6	57	81	5	6.2	28	7	424	459				
Nevada	54.8	22	40	5	12.5	13	25	91	129				
New Hampshire	63.5	13	20	0	—	4	0	76	80				
New Jersey	63.1	274	434	47	10.8	228	309	1,883	2,420				
New Mexico	59.5	49	82	9	11.0	45	122	364	531				
New York	70.0	1,010	1,451	9	17.9	1,103	1,222	5,059	7,384				
North Carolina	64.2	210	320	26	8.1	174	1,186	1,804	2,222				
North Dakota	73.8	15	20	4	20.0	6	0	24	30				
Ohio	66.4	455	685	39	5.7	237	319	3,921	4,477				
Oklahoma	65.3	77	118	11	9.3	32	55	312	399				
Oregon	75.1	56	75	7	9.3	18	17	176	211				
Pennsylvania	67.5	483	671	36	5.4	211	368	3,696	4,275				
Rhode Island	64.7	63	128	2	1.6	12	28	778	778				
South Carolina	66.8	113	166	4	2.4	30	30	780	1,326				
South Dakota	68.8	10	14	3	21.4	2	30	44	86				
Tennessee	63.0	114	181	35	19.3	131	228	548	907				
Texas	62.5	883	1,413	219	15.5	894	1,461	4,874	7,229				
Utah	65.6	46	70	6	8.6	8	2	85	95				
Vermont	66.3	6	9	0	—	3	0	33	36				
Virginia	68.0	146	215	25	11.6	104	188	793	1,085				
Washington	70.0	130	190	17	8.9	70	130	313	413				
West Virginia	62.3	70	112	5	4.5	13	19	276	308				
Wisconsin	72.2	69	96	7	7.3	14	8	178	200				
Wyoming	69.1	2	3	1	33.3	2	2	4	8				
TOTAL U.S.	65.3	8,849	13,744	1,655	12.0	7,229	12,953	55,025	75,207				
Puerto Rico	43.4	129	297	51	17.2	91	948	438	1,477				

INFECTIOUS SYPHILIS — City

QUARTERLY PERIOD APRIL 1 THROUGH JUNE 30, 1968

	Pct. of Response	Cases Treated by Respondents	Cases Treated by All Physicians	Cases Reported by All Physicians	Per Cent Reported	FISCAL YEAR 1968			
						Cases Treated and Reported: by Private Physicians	Cases Treated by Public Sources	Estimated Cases Treated by Private Physicians	Total Cases Treated Estimated by All Sources
Atlanta	65.6	48	73	3	4.1	19	203	444	666
Baltimore	67.3	62	92	15	16.3	81	416	416	738
Birmingham	57.7	31	54	11	20.4	35	197	137	369
Boston	65.8	57	87	5	5.7	27	10	10	48
Buffalo	62.2	32	51	2	3.9	4	23	196	228
Chicago	62.6	325	513	45	8.7	232	800	2,435	3,467
Cincinnati	66.7	49	73	2	2.7	17	37	613	667
Cleveland	66.1	231	349	17	4.9	144	203	2,795	3,142
Columbus	67.4	29	43	0	—	6	24	166	196
Dallas	64.9	107	165	22	13.3	83	524	541	1,148
Denver	66.3	43	65	2	3.1	15	7	469	481
Detroit	63.5	362	570	58	11.2	353	407	3,493	4,243
Ft. Worth	65.5	54	82	8	9.6	39	97	230	366
Houston	61.0	128	210	35	16.7	150	335	748	1,233
Indianapolis	65.2	8	12	21	—	68	170	—	238
Jacksonville	64.3	60	93	16	17.2	56	94	270	420
Kansas City (Mo.)	66.5	75	113	0	—	3	8	449	460
Los Angeles	66.4	496	747	58	7.8	225	265	2,659	3,149
Louisville	59.0	11	19	1	5.3	13	37	174	198
Memphis	67.5	23	52	6	11.5	24	37	185	246
Minneapolis	70.3	36	51	6	11.8	11	8	81	100
Mobile	70.1	13	19	0	—	10	8	66	84
Newark	51.5	24	47	5	10.6	19	53	160	232
New Orleans	63.4	57	90	13	14.4	58	134	345	537
New York City	55.7	46	83	8	9.6	28	115	264	337
Oakland	61.0	74	1,269	229	18.0	96	1,171	4,607	6,317
Philadelphia	61.5	13	18	1	5.6	13	169	4,679	5,016
Phoenix	65.6	243	365	11	3.0	97	211	3,136	3,444
Pittsburgh	62.8	46	73	9	12.3	37	65	264	366
San Antonio	65.6	59	90	11	12.2	46	134	331	511
San Diego	63	63	98	5	5.1	39	83	726	848
San Francisco	67.2	37	37	2	5.4	12	27	210	249
Seattle	64.9	123	190	49	25.8	131	158	377	508
St. Louis	62.7	12	15	10	8.7	10	167	346	378
Seattle	64.2	46	86	0	—	9	15	67	91
Washington	64.2	22	34	4	11.8	17	655	947	1,719
District of Columbia	55.6	102	155	17	11.0	117	655	947	1,719

"OTHER" SYPHILIS — State

	Pct. of Response	QUARTERLY PERIOD APRIL 1 THROUGH JUNE 30, 1968					FISCAL YEAR 1968		
		Cases Treated by Respondents	Cases Treated by All Physicians	Cases Reported by All Physicians	Per Cent Reported	Cases Treated by Private Physicians	Cases Treated and Reported by Public Sources	Estimated but Not Reported by Private Physicians	Total Cases Treated by All Sources
TOTAL U.S.	65.3	22,022	34,113	11,280	33.1	45,299	32,714	93,931	171,944
Alabama	58.6	329	561	28	5.0	110	169	2,369	39
Alaska	61.7	6	10	0	0.0	0	22	32	1,183
Arizona	63.3	342	17	88	16.4	332	32	1,165	1,654
Arkansas	61.0	156	256	62	24.2	372	127	12,307	21,279
California	67.1	2,911	4,338	1,259	29.0	5,027	3,945	13,839	22,927
Colorado	68.2	202	296	44	14.9	322	131	1,006	1,998
Connecticut	66.6	218	327	62	19.0	322	156	306	382
Delaware	71.5	91	127	42	33.1	166	320	751	2,039
Florida	65.6	156	138	93	39.1	482	806	1,871	3,456
Georgia	64.4	735	1,184	147	12.4	893	621	2,807	4,357
Hawaii	70.6	29	41	244	24.0	101	62	142	246
Idaho	68.0	17	25	3	12.0	8	9	59	76
Illinois	64.3	1,025	1,594	846	53.1	3,256	2,485	8,617	12,902
Indiana	63.4	494	779	245	31.5	839	253	1,824	2,916
Iowa	70.1	110	157	136	86.6	558	164	86	808
Kansas	61.1	27	43	136	44.4	778	256	1,165	2,100
Kentucky	61.4	282	453	134	29.6	404	116	2,900	4,379
Louisiana	63.3	449	842	87	10.3	333	1,146	2,900	4,379
Maine	68.2	41	60	87	—	313	22	—	335
Maryland	66.5	310	466	311	66.7	1,106	1,518	552	3,176
Massachusetts	67.0	268	400	326	81.5	1,646	561	374	2,581
Michigan	64.9	1,282	1,975	796	40.3	2,806	1,608	4,157	8,571
Minnesota	70.7	149	211	21	10.0	69	34	1,224	1,724
Mississippi	59.9	232	323	21	6.5	2,184	1,164	2,384	5,731
Missouri	64.5	896	1,389	664	47.8	2,184	1,164	2,384	5,731
Montana	62.2	54	87	3	3.4	30	14	852	896
Nebraska	70.6	80	113	40	35.4	242	111	442	795
Nevada	54.8	71	130	15	11.5	129	72	993	1,194
New Hampshire	63.5	27	43	16	37.2	60	2	101	163
New Jersey	61.1	648	1,027	411	40.0	1,604	1,344	2,406	5,354
New Mexico	59.5	18	15	2	13.3	749	286	6,940	8,175
New York	62.7	2,078	3,314	1,713	51.7	7,429	5,390	19,760	27,579
North Carolina	64.2	441	687	40	5.8	201	634	3,265	4,100
North Dakota	73.8	32	43	7	16.3	33	0	169	202
Ohio	56.4	1,449	2,182	672	30.8	2,308	1,273	5,186	8,767
Oklahoma	65.3	326	499	238	47.7	84	345	892	2,051
Oregon	75.1	203	270	29	10.7	108	49	901	1,058
Pennsylvania	67.5	1,235	1,716	672	33.8	2,700	1,067	4,842	8,609
Rhode Island	64.7	77	116	18	15.5	108	36	1,067	1,283
South Carolina	60.8	647	747	18	2.4	399	464	1,236	2,099
South Dakota	68.8	18	26	10	38.5	30	60	48	138
Tennessee	63.0	293	465	118	25.4	451	343	1,325	2,119
Texas	62.5	1,806	2,890	372	12.9	1,641	2,007	11,080	14,728
Utah	65.6	57	87	23	26.4	71	23	198	292
Vermont	68.0	32	48	19	36.7	36	0	180	216
Virginia	69.0	32	128	193	58.6	70	55	1,001	1,179
Washington	70.9	172	246	8	3.3	41	107	1,201	1,349
West Virginia	62.3	220	353	192	54.4	807	179	676	1,662
Wisconsin	72.2	298	413	263	63.7	1,263	59	720	2,042
Wyoming	69.1	17	25	17	68.0	55	6	26	87
TOTAL U.S.	65.3	22,022	34,113	11,280	33.1	45,299	32,714	93,931	171,944
Puerto Rico	43.4	168	387	15	3.9	95	1,205	2,341	3,641

"OTHER" SYPHILIS — City

QUARTERLY PERIOD APRIL 1 THROUGH JUNE 30, 1968

	Pct. of Response	FISCAL YEAR 1968			
		Cases Treated by Respondents	Cases Treated by All Physicians	Cases Reported by All Physicians	Per Cent Reported
Atlanta	65.6	301	459	53	11.5
Baltimore	67.3	182	270	115	42.6
Birmingham	67.7	132	205	123	56.9
Boston	65.8	135	205	123	60.0
Buffalo	67.2	59	88	36	40.9
Chicago	62.6	780	1,246	600	48.2
Cincinnati	66.7	174	261	39	14.9
Cleveland	66.1	402	608	153	25.2
Columbus	67.4	216	320	138	63.9
Dallas	66.5	140	177	38	26.5
Denver	66.3	144	217	12	5.5
Des Moines	65.5	895	1,411	507	35.9
El Paso	65.8	78	119	15	12.6
Fort Worth	61.0	269	441	89	20.2
Houston	65.2	34	52	78	—
Indianapolis	64.3	93	145	11	7.6
Jacksonville	66.5	207	311	10	4.8
Kansas City (Mo.)	66.4	1,068	1,605	823	49.9
Los Angeles	65.0	1,68	2,335	823	39.9
Long Beach	66.7	116	174	50	28.7
Memphis	70.3	174	248	160	64.5
Minneapolis	51.5	54	77	7	9.1
Mobile	63.4	66	128	6	4.7
Newark	61.0	120	189	63	33.3
New Orleans	65.7	132	205	123	56.9
New York City	61.0	1,833	3,005	1,527	50.8
Oakland	68.5	319	466	40	8.6
Philadelphia	65.6	519	779	216	27.7
Phoenix	62.8	275	438	40	9.1
Pittsburgh	65.6	239	364	95	26.1
San Antonio	64.1	162	253	49	19.4
San Diego	64.7	111	174	11	6.3
San Francisco	64.9	317	488	68	13.9
Seattle	62.7	362	577	246	42.6
St. Louis	67.6	95	141	1	0.7
Tulsa	64.2	88	137	58	42.3
District of Columbia	65.6	156	238	93	39.1
				Cases Treated and Reported by Private Physicians	
				Cases Treated and Reported by Public Sources	Estimated Cases Treated but Not Reported by Private Physicians
					Total Cases Estimated Treated by All Sources
Atlanta		203	268	1,562	2,033
Baltimore		441	873	873	1,314
Birmingham		615	368	510	1,393
Boston		132	235	191	558
Buffalo		2,405	2,163	2,585	7,153
Chicago		102	129	583	814
Cincinnati		564	391	1,674	2,629
Cleveland		128	159	1,374	1,661
Columbus		123	159	1,164	1,795
Dallas		123	89	2,113	2,325
Denver		1,549	1,127	2,766	5,442
Des Moines		49	82	340	471
El Paso		451	731	1,782	2,964
Fort Worth		275	170	—	445
Houston		45	102	597	744
Indianapolis		3,777	1,970	4,785	9,932
Jacksonville		215	185	335	735
Kansas City (Mo.)		188	134	467	789
Los Angeles		639	59	352	1,050
Long Beach		21	10	210	241
Memphis		18	44	365	427
Minneapolis		259	18	39	1,095
Mobile		18	43	1,378	1,480
Newark		6,724	4,737	6,312	17,973
New Orleans		129	170	1,371	1,670
New York City		940	691	2,454	4,085
Oakland		98	115	979	1,192
Philadelphia		322	217	912	1,451
Phoenix		249	184	1,084	1,517
Pittsburgh		245	131	1,026	1,056
San Antonio		380	380	1,518	2,143
San Diego		61	489	825	1,926
San Francisco		16	71	2,270	2,357
Seattle		209	88	285	582
St. Louis		482	806	751	2,039

GONORRHEA — State

QUARTERLY PERIOD APRIL 1 THROUGH JUNE 30, 1968

	Pct. of Response	Cases Treated by Respondents	Cases Treated by All Physicians	Cases Reported by All Physicians	Per Cent Reported	Cases Treated and Reported by All Physicians	Estimated Cases Treated by Private Physicians	Total Cases Estimated by All Sources
TOTAL U.S.	65.3	185,548	288,064	31,378	10.9	123,756	307,624	1,018,201
Alabama	58.6	3,174	5,416	43	0.8	931	3,674	28,809
Alaska	61.5	232	377	43	11.4	186	186	33,374
Arizona	63.8	1,540	2,414	148	6.1	571	2,795	12,766
Arkansas	61.0	2,847	4,667	1,404	30.1	5,425	715	12,598
California	67.1	24,575	36,623	4,795	13.1	18,038	45,695	119,988
Colorado	68.2	1,622	2,378	212	8.9	866	1,704	8,864
Connecticut	68.3	1,863	1,722	649	23.8	2,662	1,601	8,523
Delaware	71.5	1,863	1,323	111	8.4	983	951	5,754
District of Columbia	65.6	2,191	3,340	90	2.7	1,850	11,832	14,271
Florida	64.4	8,538	13,258	455	3.4	1,650	12,322	26,502
Georgia	61.6	6,642	10,782	677	6.3	2,388	16,300	42,785
Hawaii	70.6	518	734	105	14.3	460	148	5,517
Idaho	68.0	419	616	126	20.5	515	289	2,957
Illinois	67.5	7,975	12,403	1,740	14.0	7,629	31,697	46,864
Indiana	63.4	1,293	1,895	218	6.4	1,786	4,069	31,975
Iowa	70.1	1,293	1,895	303	37.5	2,149	3,965	8,002
Kansas	69.1	1,352	1,957	303	15.5	2,149	3,117	4,292
Kentucky	61.4	2,432	3,961	148	3.7	616	3,117	16,033
Louisiana	53.3	4,366	8,191	143	1.7	479	5,828	27,697
Maine	68.2	541	793	180	22.7	731	131	2,489
Maryland	65.5	2,951	4,438	330	7.4	1,479	7,199	18,507
Massachusetts	67.5	2,951	4,438	330	7.4	1,479	4,056	16,199
Michigan	64.9	8,259	12,716	443	3.4	7,655	10,018	47,773
Minnesota	70.6	1,842	2,609	372	13.2	1,886	4,802	29,636
Mississippi	59.9	4,148	6,925	162	2.3	886	9,400	28,418
Missouri	64.5	4,515	7,000	488	7.0	2,139	3,056	3,580
Montana	62.2	524	842	57	6.8	223	301	3,580
Nebraska	60.6	1,135	1,608	268	16.7	1,046	1,121	5,217
Nevada	54.5	622	1,190	56	4.7	213	736	7,384
New Hampshire	63.5	401	581	96	16.4	155	1	4,319
New Jersey	63.1	3,989	6,322	549	8.1	1,937	4,891	2,012
New Mexico	59.5	984	1,654	111	6.7	632	1,248	27,848
New York	62.7	14,017	22,499	3,771	16.8	13,720	26,474	58,801
North Carolina	73.8	234	317	124	39.1	435	678	1,113
North Dakota	65.3	277	11,562	198	17.2	8405	9,805	32,723
Ohio	65.3	2,771	3,362	152	4.5	357	0	678
Oklahoma	75.1	1,880	2,503	153	3.6	730	3,193	40,461
Oregon	67.5	8,360	12,385	1,279	10.3	4,796	17,395	19,548
Pennsylvania	67.5	3,561	5,857	1,277	21.8	4,903	9,112	17,395
Rhode Island	60.8	400	581	92	15.8	614	427	4,276
South Carolina	68.8	4,167	6,614	280	4.2	1,196	10,970	27,280
South Dakota	62.5	1,167	2,100	185	8.2	711	24,768	79,676
Tennessee	62.5	1,167	2,100	185	8.2	711	332	11,561
Texas	55.6	676	1,030	281	25.8	281	5,329	5,329
Utah	66.3	198	299	77	25.8	281	32	6,240
Vermont	68.0	4,934	7,256	1,201	16.6	4,698	5,220	33,921
Virginia	68.0	4,934	7,256	1,201	16.6	4,698	5,220	33,921
Washington	70.9	2,953	4,165	329	7.9	1,297	4,246	15,121
West Virginia	62.3	1,112	1,785	136	7.6	423	836	5,143
Wisconsin	72.7	1,758	2,435	355	14.6	1,411	2,140	8,253
Wyoming	69.1	206	298	31	10.4	114	74	982
TOTAL U.S.	65.3	185,548	288,064	31,378	10.9	123,756	307,624	1,018,201
Puerto Rico	43.4	1,054	2,429	10	0.4	54	2,427	13,446
								15,927

GONORRHEA — City

QUARTERLY PERIOD APRIL 1 THROUGH JUNE 30, 1968

	Pct. of Response	Cases Treated by Respondents	Cases Treated by All Physicians	Cases Reported by All Physicians	Per Cent Reported	Cases Treated and Reported: by Private Physicians	Estimated Cases Not Reported by Private Physicians	Total Cases Estimated by All Sources
Atlanta	65.6	2,689	4,099	176	4.3	625	13,910	25,706
Birmingham	67.2	1,757	2,626	139	5.3	654	11,686	18,745
Birmingham	57.7	890	1,542	-	1.2	150	12,350	13,986
Boston	65.8	1,486	2,258	176	7.8	678	8,014	11,459
Buffalo	67.2	610	908	113	12.4	600	8,239	9,254
Chicago	62.6	5,466	8,732	266	3.0	1,878	22,584	25,584
Cincinnati	66.7	1,149	1,723	109	6.3	340	8,031	9,641
Cleveland	66.1	1,905	2,822	109	3.8	3,395	9,341	16,699
Columbus	64.9	1,166	1,715	195	11.4	733	1,787	8,217
Dallas	64.9	1,730	2,666	121	4.5	729	7,433	28,633
Denver	66.3	917	1,383	80	5.8	382	6,204	8,124
Detroit	63.5	4,983	7,847	370	4.7	1,433	6,451	29,096
Ft. Worth	65.8	1,030	1,565	392	25.0	1,100	2,792	36,940
Houston	61.0	2,489	4,080	179	4.4	586	11,928	21,992
Indianapolis	65.2	400	613	149	24.4	241	1,826	5,153
Jacksonville	66.2	1,180	1,518	222	14.5	34	11,299	12,362
Kansas City (Mo.)	66.3	1,180	1,774	222	12.5	869	6,083	9,263
Louisville	66.4	11,977	18,038	2,423	13.4	9,325	17,944	60,265
Louisville	59.0	744	1,261	10	0.8	60	2,052	7,440
Memphis	66.7	1,508	2,261	112	5.0	512	6,299	9,728
Milwaukee	70.3	815	1,159	167	14.4	528	2,134	3,119
Minneapolis	66.7	967	1,379	119	8.6	481	5,941	7,209
Mobile	61.5	354	525	4	0.1	144	1,205	3,368
Newark	65.7	721	1,137	262	23.0	929	2,876	3,110
Newark	55.7	1,450	2,621	17	0.6	73	2,245	6,915
New York City	61.0	10,937	17,930	2,346	13.1	7,959	22,585	52,598
Oakland	68.5	2,158	3,150	354	11.2	3,297	9,919	14,412
Philadelphia	66.6	4,824	7,243	868	12.0	3,144	7,638	23,056
Phoenix	62.8	924	1,471	39	2.7	194	1,697	3,832
Pittsburgh	65.6	899	1,301	145	10.4	529	5,911	6,614
San Antonio	67.2	1,211	1,311	125	9.6	487	769	4,588
San Francisco	67.2	817	1,216	105	8.6	392	1,627	6,185
St. Louis	64.9	2,396	3,692	273	7.4	1,103	10,900	13,802
St. Louis	62.7	1,724	2,750	48	1.7	185	6,702	22,805
Seattle	67.6	1,609	2,380	152	6.4	572	3,010	7,684
Tulsa	64.2	696	1,084	10	0.9	57	815	6,276
District of Columbia	65.6	2,191	3,340	90	2.7	396	11,853	26,502

FISCAL YEAR 1968

PHYSICIANS TREATING VD IN THE U.S., APRIL-JUNE, 1968

Specialty	NUMBER OF PHYSICIANS TREATING			PER CENT OF RESPONDING PHYSICIANS TREATING								
	Number of Physicians Queried	Primary & Secondary Syphilis	Other Syphilis	Total Syphilis	Genorhea	Total VD	Primary & Secondary Syphilis	Other Syphilis	Total Syphilis	Genorhea	Total VD	
Total	206,283	134,633	4,370	10,934	13,663	39,392	43,720	3.2	8.1	10.1	29.3	32.5
General	10,048	5,283	2,400	10,934	13,663	39,392	43,720	5.4	12.1	15.4	52.6	55.5
Internal Medicine	12,633	8,283	4,086	10,934	13,663	39,392	43,720	1.6	5.1	6.8	10.7	10.7
Surgery	28,018	17,888	2,799	9,077	1,098	2,675	3,208	1.6	5.1	6.8	10.7	10.7
Internal Medicine	26,063	18,662	580	2,399	2,768	5,552	6,744	3.1	12.9	14.8	29.8	36.1
Urology	3,941	2,616	102	179	256	1,666	1,693	3.9	6.8	9.8	63.7	64.7
Dermatology	2,888	2,381	268	234	430	366	647	11.3	9.8	18.1	15.4	27.2
Pediatrics	10,230	7,479	72	68	130	525	599	1.0	0.9	1.7	7.0	8.0
Ophthalmology	4,277	4,277	23	170	187	85	253	0.5	0.4	0.4	2.0	5.9
Gastroenterology	429	317	4	25	29	65	85	3.5	7.9	9.7	38.7	23.7
Obstetrics-Gynecology	13,195	9,273	323	685	898	3,598	3,877	0.6	0.6	1.0	2.6	4.0
Anesthesiology	6,302	2,622	16	17	26	68	79	0.5	0.6	1.0	2.6	3.0
Psychiatry	10,471	6,886	36	201	226	162	346	0.5	2.9	3.3	2.4	5.8
Otolaryngology	4,108	2,473	16	65	77	58	118	0.6	2.6	3.1	2.3	4.0
Radiology	6,098	3,194	20	19	35	47	64	0.6	0.6	1.1	1.5	2.0
Pathology	2,333	1,226	15	18	25	35	46	1.2	1.5	2.0	3.1	3.8
Preventive Medicine	856	545	19	40	53	117	131	3.1	3.1	3.1	2.5	2.0
Medical Faculty	10,071	6,423	65	196	238	345	508	1.0	3.1	3.7	15.1	21.2
Other	659	432	8	32	41	78	96	1.8	7.1	9.1	17.3	21.2

Senator HUGHES. At this time we will receive a statement from the Senator from Alaska. Please proceed, Senator.

STATEMENT OF HON. TED STEVENS, A U.S. SENATOR FROM THE STATE OF ALASKA

Senator STEVENS. Since the enactment of the Vaccination Assistance Act in 1962 it is my firm belief that Alaska and the country have made enormous gains in the eradication of the childhood diseases of tetanus, diphtheria, whooping cough, polio, and measles.

However, with a projected Rubella epidemic only a short year or two away and young children not normally reached by school vaccination programs continuing to need protection against these dread diseases I believe it is vital that this immunization program be given the priority and assured adequate funding it will receive by a continuation of the Vaccination Assistance Act.

In the years since 1962 when this Act was initially passed the good it has done is clearly apparent from such statistics as these:

In my State of Alaska we had 648 cases of measles in 1966 and by late 1968 this was down to only two cases in the State. Also, we have had 38,000 children vaccinated for polio; 35,000 for diphtheria and tetanus; and 20,000 for measles since enactment of this legislation.

Nationwide the impact is even more impressive in its scope. We have reached 46 million children with polio vaccinations; 31 million for tetanus and diphtheria; and 33.5 million have been inoculated against measles.

As a result of such action, in concert with other vaccination programs, we continue to maintain polio, diphtheria, and tetanus at less than 200 cases per year across the country.

Since 1965 when the Vaccination Assistance Act was amended to include common measles the attack on this disease has brought impressive results, but with a significant challenge still facing us. In 1965 262,000 cases of measles were reported nationwide. By 1968 this had been reduced to 22,500 reported cases with an upswing to 24,000 anticipated in 1969.

So, much has been accomplished; but the situation is still in need of further remedy. This relatively high case rate of common measles, combined with the anticipated epidemic of Rubella in 1970 or 1971 for which vaccine is only recently commercially available and must now be distributed in order to prevent another tragedy such as occurred in the last Rubella epidemic in 1964—65, makes passage of this act even more critical.

In 1964—65 over 30,000 children were born blind, deaf or with heart defects, because their mothers had Rubella—German measles—during their first 3 months of pregnancy. I believe that the need to avoid this in the future speaks forcefully for the priority and adequate funding our legislation establishes for these vaccination programs in the Nation's health program.

Accordingly, I urge the committee to act positively on this legislation. It has proven itself many times over since 1962; and its continua-

tion is critical to protecting our children from these diseases which, with proper vaccination, need hold no threat to the lives and well-being of our youth.

Senator HUGHES. We thank you for your excellent testimony, Senator.

The hearing on Communicable Disease Control is now concluded. The record will be kept open for statements of those who could not appear and for other pertinent material submitted for the record.

(The material referred to follows:)

U.S. SENATE,
Washington, D.C., July 1, 1969.

HON. WILLIAM H. STEWART,
Surgeon General, Public Health Service, Department of Health, Education, and Welfare, Washington, D.C.

DEAR DR. STEWART: I was pleased to have the opportunity to be present during your testimony yesterday before the Senate Subcommittee on Health on the Vaccination Assistance Act, and other legislative proposals in our continuing efforts to eradicate infectious disease.

Unfortunately, I was obliged to leave the hearings before they were completed, and I was unable to pursue certain matters raised by your testimony, or to present a number of other questions I had intended to raise. In light of the important issues brought out by your testimony, Senator Yarborough and Senator Hughes were kind enough to allow me to submit the enclosed written questions for your comment and response. I understand that your replies will be made part of the record of the hearing.

I regret that my schedule did not permit me to raise these questions during the hearing itself. Let me say, however, I very much appreciate your cooperation and assistance in helping to elucidate the issues before the Subcommittee in connection with this vital legislation, and I look forward to your replies.

Sincerely,

EDWARD M. KENNEDY.

QUESTIONS SUBMITTED BY SENATOR KENNEDY AND THE ANSWERS SUBMITTED BY
EDWARD B. CROSS, M.D., ACTING SURGEON GENERAL, PUBLIC HEALTH SERVICE

Q1. Is it possible or practicable to immunize women of reproductive age against rubella? If so, why does the current program seek only to immunize children? Can this sort of "indirect" immunization campaign function quickly enough to provide the nationwide protection that is needed if we are to avoid the ravages of the anticipated rubella epidemic in 1970 or 1971?

A1. a. Is it possible or practicable to immunize women of reproductive age against rubella?

It is possible to immunize women of reproductive age against rubella, but the decision to use vaccine in these persons must be made on an individual basis. Women of childbearing age may be considered for vaccination only when the absence of pregnancy is assured for two months following immunization. This cautious approach to vaccinating post-pubertal females is indicated because the degree of risk to the unborn child from rubella vaccine virus administration in pregnancy has not been determined. I question advisability of emphasizing concern that vaccination program may be unjustly accused of causing congenital malformations as a major reason for not vaccinating women likely to become pregnant.

If vaccination of a woman of childbearing age is contemplated, the following steps are indicated:

(1) The woman should be tested for susceptibility to rubella. (Facilities for mass screening of adult women are not now readily available and would be expensive and quite difficult to develop in a short time.) Since about 90 percent of adult women will be immune to rubella, this serologic test will obviate the need for further consideration for vaccination and the immune woman can be assured vaccine is unnecessary.

(2) If susceptible, she should receive vaccine only if she understands that it is imperative for her to avoid becoming pregnant for two months.

(3) She should be informed of the frequent occurrence of joint pain and swelling when rubella vaccine is administered to adults. These symptoms are usually self limited and of relatively short duration. Thus, use of rubella vaccine in women of childbearing age is *not now practicable* for large scale programs.

A1. b. *If so, why does the current program seek only to immunize children?* Susceptible young children who congregate in groups are most important, *epidemiologically*, in the spread of rubella virus. Even if large scale programs to immunize women of reproductive age against rubella were practical, initial priority should include young school age children.

The accumulation of large numbers of young children who have missed infection with rubella is necessary for a higher than usual occurrence of rubella. When the virus is introduced into these susceptible groups, the virus can spread rapidly and widely. During periods of increased spread, the chance that susceptible adults will be infected is also increased.

As the number of susceptible persons is reduced by infection with rubella virus, the conditions which were favorable for spread are changed so the epidemic slows down and finally comes to an end. Vaccination of young children can reduce the reservoir of accumulated susceptibles, providing the most feasible method of preventing a future epidemic of rubella.

A1. c. *Can this sort of "indirect" immunization campaign function quickly enough to provide the nationwide protection that is needed if we are to avoid the ravages of the anticipated rubella epidemic in 1970 or 1971?*

Since the last widespread epidemic of rubella occurred in 1964-1965, the accumulation of susceptible school children will probably be sufficient for a higher than usual occurrence of rubella in 1970 or 1971. Well-planned programs of school immunization promptly initiated this year can have a significant impact in preventing large scale outbreaks.

In addition the Public Health Service is developing a program of intensive surveillance of rubella so that outbreaks can be recognized early and promptly terminated through prompt use of vaccine in areas where small clusters of cases begin to occur.

NOTE: The above described approach to rubella control by vaccination of children follows the recommendation of the Public Health Service Advisory Committee on Immunization Practices. This recommendation was developed in close collaboration with and has been endorsed by the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics.

Q2. *In your testimony, you mentioned that virtually all states are preparing State health plans under the Partnership for Health provisions, but you declined to assess the adequacy of the State plans. Can you give us any information with respect to the number of states that have included comprehensive immunization programs in their state plans at this time? It is my understanding that 75-85 states and communities received project grants under the Vaccination Assistance Act. How many of these areas now have operational immunization programs under their state plans? How many plan to develop such programs within the next six months? Would you please provide the Subcommittee with a list of all the states and your best estimate of the dates when each state will be able to take over and continue immunization programs in the state at the level of operation that existed under the Vaccination Assistance Act?*

A2 a. In your testimony, you mentioned that virtually all States are preparing State health plans under the Partnership for Health provisions, but you declined to assess the adequacy of the State plans. *Can you give us any information with respect to the number of States that have included comprehensive immunization programs in their State plans at this time?*

Differentiation between types of State plans is necessary. The State planning agency, established in response to Section 314(a) are in the process of developing plans that encompass all health activities—public and private in the States, and are still embryonic. In addition to this planning effort, State health departments submit a State plan for comprehensive health services for the use of 314(d) funds. These funds are provided to the States on a formula basis; with population and per capita income being the factors. A review of the State plans for using 314(d) funds shows that 37 mention immunization programs.

A2. b. It is my understanding that 75-85 States and communities received project grants under the Vaccination Assistance Act. *How many of these areas now have operational immunization programs under their State plans?*

In order to adequately answer this question an explanation of the review and approval process for project grants is necessary. Project grants made under the

authority of 314(e) must be in accord with such planning as has been done by the State Planning Agency, but do not need to be included in the State Plan for 314(d) funds. Grants made under the authority of the Vaccination Assistance Act were not required to have the review of the State Planning Agency. Seventy-two grants serving areas with 91% of the population were operational under the Vaccination Assistance Act. Sixty-eight grants serving areas also with 91% of the population are funded now under 314(e) and have been awarded with the approval of the State Planning Agency. These grants are for staff for comprehensive immunization programs, but will only purchase rubella vaccine. The costs for other vaccines must come from other sources.

A2. c. *How many plan to develop such programs within the next six months?*

d. *Would you please provide the Subcommittee with a list of all the States and your best estimate of the dates when each State will be able to take over and continue immunization programs in the State at the level of operation that existed under the Vaccination Assistance Act?*

Any such estimation by the Federal government would be of little value. Recognizing the realities of budget formulation and approval, there would be a lag of at least two years before most States could include such programs in their budgets. Also, if authorization ceilings for 314 grants were increased, this could change the estimate. It has been noted in several States that legislatures have provided funds for vaccines, but not for additional personnel to assure that programs are developed to reach all the children at risk.

Q3. *If, as you suggest, most states are still in the planning stages under the Partnership for Health provisions, shouldn't the Vaccination Assistance Act be continued at least until the Partnership programs are in full operation? In what practical—not theoretical—way would extension of the Vaccination Assistance Act at the present time interfere with the development of the approach you advocate under the Partnership for Health provisions?*

A3. a. *If, as you suggest, most States are still in the planning stages under the Partnership for Health provisions, shouldn't the Vaccination Assistance Act be continued at least until the Partnership programs are in full operation?*

There has been some misunderstanding with regard to the status of the development of the Partnership for Health program under Section 314. It is true that most States are in the organizational stages, or early planning efforts, of their comprehensive health planning, supported under Section 314(a). The areawide comprehensive health planning, supported under Section 314(b), is also in the developmental phase in most States, except for planning for hospital and medical facilities. The other parts of the Partnership for Health program, supported under Sections 314 (c), (d), and (e), however, are well developed and in full operation. This is particularly true of Sections 314 (d) and (e) under which the support of the State vaccination programs could be considered.

A3. b. *In what practical—not theoretical—way would extension of the Vaccination Assistance Act at the present time interfere with the development of the approach you advocate under the Partnership for Health provisions?*

With the enactment of P.L. 89-749 the Congress deliberately combined eight categorical formula grant programs under Section 314(d) and seven categorical project grant programs under Section 314(e), in order to provide greater flexibility and to be more responsive to health needs in different parts of the country. This Committee's report (Senate Report No. 724, 90th Congress, 1st Session) pointed out that "categorical grants tend to provide more aid in well-established program categories than in newly developing problem areas. This tendency has been particularly prejudicial to the purposes of project grants, where one of the major aims of Federal assistance is to help States and localities cope with new health problems or to meet changing circumstances." As rapidly as is feasible, we need to continue to simplify our grant programs and increase the flexibility in order to facilitate the utilization of Federal funds to support new priorities. Continuation of the Vaccination Assistance Act at this time would be an extension of a categorical project grant program and would thus as a practical matter lead to extensions and introductions of other categorical programs. The pragmatic test is whether the program can be as effectively run under Partnership for Health. We believe that it can be. Increased utilization and strengthening of the important Partnership for Health program would be most helpful.

Q4. *In your testimony, you suggested that it would not be desirable to initiate any new categorical grant programs in areas covered by the Partnership for Health provisions. Isn't S. 1622—and, in effect, S. 226—merely an extension of the Vaccination Assistance Act of 1962, a program which long preceded the*

Partnership for Health Act and which is hardly a "new" categorical grant program? Whatever the merits of working within the Partnership for Health provisions in the case of new health programs, why is it not desirable to continue well-established programs like the Vaccination Assistance Act until the Partnership programs become fully operational? Isn't this an appropriate procedure to follow in the case of "old" programs like the Vaccination Assistance Act, which have continuously proved their effectiveness and which antedate the Partnership provisions?

A4. a. In your testimony, you suggested that it would not be desirable to initiate any new categorical grant programs in areas covered by the Partnership for Health provisions. Isn't S. 1622—and, in effect, S. 2264—merely an extension of the Vaccination Assistance Act of 1962, a program which long preceded the Partnership for Health Act and which is hardly a "new" categorical grant program?

b. Whatever the merits of working within the Partnership for Health provisions in the case of new health programs, why is it not desirable to continue well-established programs like the Vaccination Assistance Act until the Partnership programs become fully operational?

c. Isn't this an appropriate procedure to follow in the case of "old" programs like the Vaccination Assistance Act, which have continuously proved their effectiveness and which antedate the Partnership provisions?

Inasmuch as we have flexible formula and project grant programs in Sections 314(d) and (e) through which we are able to assist the States and communities establish and maintain public health services, we do not consider it desirable to initiate new categorical grant programs or continue old ones longer than necessary in areas covered by the Partnership for Health provisions. It is true that S. 1622 constitutes an extension of the Vaccination Assistance Act of 1962. On the other hand, S. 2264 would provide a broader authorization, encompassing other communicable diseases for which health services may be, and are, supported currently under Sections 314(d) and (e).

The Partnership for Health philosophy includes the initial incorporation of categorical project grant programs in the non-categorical project grant program authorized under Section 314(e), which provides increased latitude in the use of funds to meet new priorities. When new health services have been adequately developed, they should be shifted to support under the formula grant to the State health and mental health agencies authorized by Section 314(d). It is through this mechanism that the decision-making responsibility is most effectively shared with the States in implementing the Partnership for Health program. Sections 314(d) and 314(e) provide ample authority for the support of these programs. Duplicating this authority by passage of S. 1622 would serve to weaken the continued development of the Partnership for Health program.

Q5. Aside from the special rubella immunization program you described, what preparations now exist under the Partnership for Health provisions to continue current immunization programs against other diseases? What plans do you have to assist the States in their diphtheria-whooping cough-tetanus immunization programs? What plans do you have to insure the continued low rate of polio in the United States? What plans do you have to help the states combat measles, especially those states which have not yet attained the "eradication level" against the disease? What plans do you have for immunization programs to eliminate mumps, for which I understand vaccines have recently become available? To eliminate chicken pox, for which vaccines are likely to be available soon?

A5. a. Aside from the special rubella immunization program you described, what preparations now exist under the Partnership for Health provisions to continue current immunization programs against other diseases?

Within the budget proposed for the Partnership for Health, there is no specified provision to continue current immunization programs against other diseases. However, projects for immunization programs at the State or community level may be submitted for consideration under Section 314(e).

A5. b. What plans do you have to assist the States in their diphtheria-whooping cough-tetanus immunization programs?

A5. c. What plans do you have to insure the continued low rate of polio in the United States?

A5. d. What plans do you have to help the States combat measles, especially those States which have not yet attained the "eradication level" against the disease?

We plan to continue the activities of the National Communicable Disease Center in surveillance and epidemic assistance of these diseases and in technical

assistance to the States in the organization of effective immunization programs.

A5. e. *What plans do you have for immunization programs to eliminate mumps, for which I understand vaccines have recently become available? To eliminate chicken pox, for which vaccines are likely to be available soon?*

The complications resulting from mumps infection can be severe, especially in post-pubertal males. These complications, however, are not as severe as those which result from rubella infection in pregnant females. The 1964 rubella epidemic resulted in approximately 50,000 infant deaths, stillbirths, or congenitally deformed infants. Another rubella epidemic is predicted in 1970-71. At this time, therefore, efforts to prevent a recurrence of the 1964 rubella epidemic must take priority over control of mumps. Additionally, studies are now being conducted on multi-virus vaccine, which includes mumps. It is likely that such a multi-virus vaccine will be available in the foreseeable future. Mumps control will be more practicable when a vaccine incorporating measles, rubella, and mumps is licensed.

Chicken pox vaccine is still in the research development stage. We are following its development closely.

Q6. *Testimony at the hearings by a representative of the Association of State and Territorial Health Officers suggested there is a strong possibility that their current communicable disease programs will be curtailed if the Vaccination Assistance Act is not extended. How realistic are these fears? How can you insure that these needed ongoing programs will not be cut back under your proposal? What is your estimate of the amount of Federal monies that will be allocated to immunization programs under the Partnership for Health provisions in fiscal year 1970?*

A6. a. Testimony at hearings by a representative of the Association of State and Territorial Health Officers suggested there is a strong possibility that their current communicable disease programs will be curtailed if the Vaccination Assistance Act is not extended. *How realistic are these fears?*

A6. b. *How can you insure that these needed ongoing programs will not be cut back under your proposal?*

The curtailment of present communicable disease programs will vary by State depending on the amount of resources available and the State priorities for all health programs. From available information, we cannot state at what level the States intend to continue support of their present programs, nor the various sources and amounts of funds they will be able to utilize, in fiscal year 1970. We have no way of insuring that States will not cut back on the support of various health programs while expanding other health programs. The Partnership for Health program is based upon the assumption that the States should be provided flexibility in their use of the Federal funds. The Congress and the Administration have held that the State health agencies, with the guidance of the comprehensive health planning agencies, are in the best position to determine the relative health needs in each State. It is reasonable to expect that the support of various health programs will fluctuate within each State in relation to the need in that State for the program as well as to the amount of funds from various sources which are available to support health services. We are confident that the State health departments will continue to support those programs which are considered to be the most needed in their States. In addition, any health projects which have been developed to meet demonstrated special needs and which have been approved by the State health planning agency will continue to be eligible to compete for Section 314(e) funds as they have in the past.

A6. c. *What is your estimate of the amount of Federal monies that will be allocated to immunization programs under the Partnership for Health provisions in fiscal year 1970?*

In the fiscal year 1970 budget, \$16 million was included in 314(e) for the support of rubella immunization programs. To this can be added \$9.6 million from the fiscal year 1969 supplemental appropriation for rubella which was signed by the President July 22, 1969.

We do not have information related to the amounts of 314(d) funds that will be used by the States for immunization programs.

Q7. *What studies has the Public Health Service conducted of State and local needs and disease with respect to immunization programs? How many State and local governments concur with your proposals? How many disagree?*

A7. a. *What studies has the Public Health Service conducted of State and local needs and disease with respect to immunization programs?*

(1) The epidemiology of rubella, measles, poliomyelitis, and other diseases has been and continuously is being intensively studied to determine as accurately as

possible the cyclicity of occurrence, patterns of spread, frequency of occurrence, by age, sex, and socioeconomic status and seasonal variation in incidence.

(2) Surveys of immunity to rubella in various populations have been made to further define and confirm these epidemiologic patterns. For example, a stratified random serologic survey of more than 2,000 families in Hillsborough County (Tampa), Florida was carried out to determine immune status of the population against various immunizable diseases. Precise information on immunity against rubella in all segments of the population was recently obtained. A similar survey was conducted there in 1963 (one year prior to the rubella epidemic) and valuable comparisons could be made on the changes noted in the patterns of immunity.

(3) The National Communicable Disease Center collaborates with the Bureau of the Census each year to survey the entire country for information on vaccine usage. Data are collected, analyzed, and published annually on immune status of the population by age, sex, socioeconomic status, geographic location, etc., on vaccination against polio, measles, diphtheria, tetanus, pertussis, and smallpox. Rubella vaccine is to be included in future surveys.

(4) Establishment of a registry for Congenital Rubella Syndrome, to better define the incidence, severity, and public health impact of this entity and to document the effectiveness of rubella vaccines in reducing the occurrence of future years is in development.

This continued surveillance of disease and immunization status provides assistance in determining the need for immunization programs with the degree of specification required for planning and evaluation.

A7. b. *How many State and local governments concur with your proposals?*

A7. c. *How many disagree?*

No survey of opinion was conducted, but we have no reason to believe that a majority would not support the proposals.

Q8. *Can you provide any information on the amounts of measles vaccine and other vaccines that have been made available in the various States under the Vaccination Assistance Act for distribution through the offices of private physicians, as opposed to distribution through public health agencies or through mass community immunization programs? If the Vaccination Assistance Act is extended, would you favor a provision requiring that no more than a specified percentage of the vaccine made available under the Act could be distributed to private physicians? What action do you plan to take in this respect for immunization programs carried out under the Partnership for Health provisions?*

AS. a. *Can you provide any information on the amounts of measles vaccine and other vaccines that have been made available in the various States under the Vaccination Assistance Act for distribution through the offices of private physicians, as opposed to distribution through public health agencies or through mass community immunization programs?*

The Immunization Branch, National Communicable Disease Center, receives reports from grantees on the administration of measles vaccine and other vaccines made available under the Vaccination Assistance Act for distribution through the offices of private physicians and through the public health agencies and mass community immunization programs. During calendar year 1967, the percent of Vaccination Assistance Act vaccine administered through private physicians averaged the following: 14.7% measles, 17.9% polio, 10.3% diphtheria, 10.3% pertussis, and 10.6% tetanus. On a project by project basis, the percentage of Vaccination Assistance Act vaccine administered through private physicians varied widely—from 0.0% to 90.8% for measles; from 0.0% to 84.8% for polio; and, from 0.0% to 100% for diphtheria, pertussis, and tetanus. This variation was largely due to the differences in State and local public health resources organized to administer immunizations to the economically deprived.

Although the following table does not include all grantees, it is illustrative of the variation of the percent of Vaccination Assistance Act measles vaccine administered in 1967.

PERCENT OF VACCINATION ASSISTANCE ACT MEASLES VACCINE ADMINISTERED THROUGH CLINICS AND PRIVATE PHYSICIANS FOR SELECTED STATES, 1967

Selected States and cities	Clinic	Private physician	Selected States and cities	Clinic	Private physician
Minnesota (excluding Minneapolis, Rochester, St. Paul).....	9.2	90.8	Iowa.....	75.0	25.0
Minneapolis.....	42.3	57.7	New York City.....	83.2	16.8
New Hampshire.....	54.7	45.3	West Virginia.....	97.1	2.9
Colorado.....	55.2	44.8	Texas.....	98.2	1.8
Missouri.....	58.7	41.3	Oklahoma.....	98.4	1.6
Ohio.....	66.7	33.3	Alabama.....	100.0	0
Pennsylvania.....	67.6	32.4	Rhode Island.....	100.0	0

A8. b. *If the Vaccination Assistance Act is extended, would you favor a provision requiring that no more than a specified percentage of the vaccine made available under the Act could be distributed to private physicians?*

If the Vaccination Assistance Act were extended, we would not favor a provision that would specify a percentage limit on vaccine that could be provided to private physicians because: (1) An inflexible formula allocation of vaccine to private physicians presents considerable barriers to effective program operation and disease control measures in many areas; (2) It will place an additional burden on grantees to maintain complex records for audit; and (3) It will penalize those States, such as Iowa, Idaho, and others that have limited organized public health resources and are highly dependent on private physicians to administer immunizations to the economically deprived.

A8. c. *What action do you plan to take in this respect for immunization programs carried out under the Partnership for Health provisions?*

Current guidelines for awarding rubella grants under the Partnership for Health specify that grantees maintain certification to ensure that Federally supplied rubella vaccine is used only for prepubertal children and that no charge is made for vaccine administered privately or in public clinics. We expect that the experience for rubella as regards distribution to private physicians will be similar to that of measles because of the existing system developed for this purpose.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,

PUBLIC HEALTH SERVICE,

Washington, D.C., July 17, 1969.

HON. RALPH W. YARBOROUGH,
Chairman, Subcommittee on Health,
Senate Committee on Labor and Welfare,
U.S. Senate, Washington, D.C.

DEAR SENATOR YARBOROUGH: By reason of the fact that I appeared as principal witness for the Department of Health, Education, and Welfare before your subcommittee on June 30, 1969, Secretary Finch has asked me to respond to your letter dated July 7 requesting responses for the record to some additional questions. I am pleased to supply this information for your use as your committee considers S. 2264.

The questions and our responses follow:

1. *How many cases of measles were reported in 1968? What has been the experience of the measles eradication program so far in 1969 compared to the same period in 1968?*

Answer. Reported cases of measles:

Total cases reported in 1968.....	22,617
Cases reported through June 17, 1968.....	16,483
Cases reported through June 17, 1969.....	16,645

2. *Of the funds requested under the Partnership for Health for the rubella immunization program (\$9.6 million in a 1969 supplemental and \$16 million in 1970), has there been any provision made for continuing the measles eradication program?*

Answer. No specific provision has been made for measles eradication as a part of the rubella immunization program. However, under the Partnership for Health, States may choose to use funds allocated under 314(d) formula grants

for carrying forward measles programs. In addition, any State or locality may apply for a project grant under section 314(e), but any such applications would have to compete with other health services development projects.

3. *Should Congress act favorably on S. 2264, would you favor inclusion of an RH vaccine program?*

Answer. No. It would be inappropriate to include an RH vaccine program because in that instance we are not dealing with a communicable disease. The communicable disease control proposal can be justified as an extension of the Federal responsibility for controlling the interstate spread of infectious diseases. A more appropriate course of action would be to have the Department make a report on how the RH vaccine can best be applied in public health practice, drawing upon the resources of the Children's Bureau as well as Health Services and Mental Health Administration.

4. *Under the proposed transfer of \$18 million from project grants to formula grants, is it possible that a State or States with the greater health problems would end up receiving proportionately less funds than States which do not have as great a health problem?*

Answer. While such a result may be possible, it is certainly not anticipated. With respect to the formula grants, the State is able to define its most critical health problems and apply the formula grant funds to those problems. The project grant mechanism is available to deal with health needs which are of "... specialized regional or national significance." In the event that a State's resources, including formula grants, were insufficient to cover total needs, a project grant could be applied for which would be designed either to deal with a portion of the problem on a less than State-wide basis, or to supplement funds supporting State-wide programs directed toward any problem of "regional significance." In dealing with a health problem, there are usually some activities which are carried out on a State-wide basis and other activities which are only appropriate for local programs. When a State has adequate local health resources in all jurisdictions and where State laws permit, funds can be transferred to those local agencies by the State. There are times when a State health department may need to provide services directly at the local level. The flexibility required to deal with the many varied State-local situations is provided by the present mix of formula and project grant mechanisms under Section 314 of the PHS Act. By direction of the Surgeon General, grant regulations are being revised to increase the flexibility of providing project grant funds under Section 314(e) which will assure the same sort of response to varied National-State situations. It is anticipated that these funds will go to States in proportion to their health problems, as identified in their project grant applications.

Please let me know if we can be of further assistance to you and your committee.

Sincerely yours,

RICHARD A. PRINDLE, M.D.
(For the Surgeon General)

PREPARED STATEMENT OF ERNEST B. HOWARD, M.D., EXECUTIVE VICE PRESIDENT,
AMERICAN MEDICAL ASSOCIATION

The following statement is submitted on behalf of the American Medical Association with respect to S. 1622, Vaccination Assistance Act of 1969, and S. 2264, Communicable Disease Control Amendments of 1969, which are now before your Committee for consideration.

As we understand S. 1622, it amends Section 317 of the Public Health Service Act, concerned with grants for immunization programs, by extending the present Vaccination Assistance Act for five years, until 1974, and adds rubella as a specific disease to be included in the immunization program on the same basis as poliomyelitis, diphtheria, whooping cough, tetanus, and measles.

A different approach to the same problem is taken by S. 2264 by adding a new subsection to Section 361 of the Public Health Service Act concerning the control of communicable diseases. Under this proposal, the Secretary of HEW is authorized to make grants to states and political subdivisions, to assist them in carrying on a communicable disease control program against rubella, measles, poliomyelitis, diphtheria, tetanus, whooping cough and other communicable diseases. Also specifically called for, adding to present programs, are new efforts against tuberculosis and venereal disease.

As this Committee knows, in 1962 the American Medical Association actively urged the Congress to enact the original Vaccination Assistance Act so as to assist states and communities to carry out intensive vaccination programs for young children. The Association actively supported the continuation of the Vaccination Assistance Act when it was extended by the Congress in 1965. The Act expired on June 30, 1968, and its authorization for appropriations ended on June 30, 1969.

Medicine, on the national, state, county and community levels, has consistently worked to bring to its patients the benefit of advances in medical research and development. The physicians of America and the Public Health Service have long been partners in the fight against disease and in the campaign to eradicate contagion wherever it is found.

In supporting the principles and purposes of the legislation now pending before your Committee, we do so in recognition that there still exists population pockets, particularly children, who are not utilizing or do not have available to them vaccines for the prevention of poliomyelitis, diphtheria, whooping cough, tetanus, measles and rubella. The bills before you authorize grants to the states, and their political subdivisions, to enable them to continue a concentrated campaign to provide immunization against these communicable diseases. We believe that substantial progress was made by the Vaccination Assistance Act in reducing the incidence of the named diseases, and we strongly recommend continuation of the programs of this Act.

With specific reference to S. 2264, we are concerned with the inclusion of tuberculosis and venereal disease as diseases subject to the proposed program. When the Deputy Surgeon General of the U.S. Public Health Service testified on behalf of the Administration before your Committee on S. 3008, which became Public Law 89-749, the Comprehensive Health Planning and Public Health Service Amendments of 1966, he recommended the elimination of separate categorical formula grants to the states, including tuberculosis and venereal disease control, calling instead for block grants so that the states could set their own priorities and place emphasis where it is most needed. Such grants are now provided under Section 314(d) of P.L. 89-749. As well, additional funds are available through grants under Section 314(e) of the same Act.

It seems clear to us, in reviewing the Administration testimony in 1966, that Public Law 89-749, as later amended by the Partnership for Health Act (Public Law 90-174), was intended to provide the vehicle of federal support to the states in their efforts against these two diseases. Sections 314(d) and 314(e) were intended to provide broad discretionary assistance to the states, with project funds to be used for special situations warranting a more concentrated form of federal assistance. The American Medical Association believes that the need continues to support the nation's efforts to control tuberculosis and venereal disease. We believe, however, that the legislative framework already exists under P.L. 89-749 for this purpose.

In conclusion, let me reiterate our support of legislation which would reestablish and expand the now expired Vaccination Assistance Act. This program has been instrumental in the elimination and control of communicable diseases and has made a substantial improvement in the overall health of school children.

I would appreciate your arranging for this statement to be included in the record of hearings on S. 1622 and S. 2264.

TEXAS TUBERCULOSIS AND RESPIRATORY DISEASE ASSOCIATION,
Lubbock Tex., April 26, 1969.

Hon. RALPH YARBOROUGH,
Senate Office Building,
Washington, D.C.

DEAR SENATOR YARBOROUGH: As Chairman of the Legislative and TB Control Committee of the Texas Tuberculosis and Respiratory Disease Association, I am most interested in urging your support of legislation and appropriations which would help in the detection and control of tuberculosis in Texas. The problem is especially acute along the border where international travel is so extensive. The magnitude and international nature of the project is such as to involve federal funding, in my opinion, if the effort to reduce tuberculosis is to achieve the success which current medical knowledge can produce.

Your support in this critical health project will be deeply appreciated.

Sincerely,

S. M. KENNEDY,
Chairman, Legislative Committee and President-Elect.

TEXAS STATE DEPARTMENT OF HEALTH,
Austin, Tex., February 17, 1969.

HON. RALPH W. YARBOROUGH,
Special Committee on Aging,
U.S. Senate, Washington, D.C.

DEAR SENATOR YARBOROUGH: Enclosed you will find a brief description of the initial activities of the TransCentury Corporation. It has been prepared by Mr. Duarte who is director of this study group in El Paso.

I would like to present some information for your own study regarding tuberculosis in the United States. When we talk of tuberculosis control activities we are recognizing the problem which faces the country and are then willing to commit personnel and funds to achieve the goals set. Prior to my arrival in El Paso there was no full time physician assigned to tuberculosis control and the total expenditure on the part of the local city-county government for tuberculosis control was around \$30,000.00 a year. As a result of a special project grant from the Federal Government to the Texas State Department of Health, and because of the United States Public Health Service Program which was in effect at the National Communicable Disease Center, two things occurred. State and Federal monies were directed to the El Paso community, and I, as a Public Health Officer, was assigned to this area. Today the total budget for tuberculosis control in this community is nearly \$150,000.00 with an equal amount recently being added as a result of a contract agreement between the State Department of Health and Thomason General Hospital whereby the indigent tuberculosis patient may now be treated locally instead of having to be hospitalized some 500 miles away in a State facility. The need for this approach especially for the closely-knit Mexican-American family is clear.

With this increased commitment we have been able to increase our staff which has led to a significant improvement in our case finding techniques, and in the delivery of services to the community. However, several things have occurred which tend to darken this picture. Because of a change in the Federal Regulations markedly restricting those circumstances under which a Public Health Officer may fulfil his military obligation, the supply of qualified physicians from the National Communicable Disease Center has been cut off. When I entered the program over 50 physicians were assigned to Health Departments throughout the country in tuberculosis control activities. This past July, I believe only three officers were accepted to the program. This loss of course, has not only affected tuberculosis but many other community-oriented health programs. Practically speaking the ability to replace these vacated positions is in great doubt, most will remain vacant at the local level. Secondly, we are losing this program's ability to train physicians in a disease which is not given too much attention in medical school and to expose and possibly interest these physicians in the field of public health.

As a result of the comprehensive health planning approach federal money is no longer available specifically for tuberculosis. It is up to the individual community to request and distribute their money as they see the need. In Texas the rate of tuberculosis has been steadily increasing over the past few years while in the United States it has been decreasing. The reason is simple—greater effort has been spent resulting in the identification of more cases. Had the State not chosen this course, it too could have shown a steady decline in cases during this same period. This successful program has only been made possible through the past concept of health partnership between the Federal Government and the Texas State Department of Health. The problem that the State now faces is that as the five-year tuberculosis project grant funds expire as has already occurred in San Antonio and Houston and as it will eventually happen in El Paso and Brownsville, the State cannot, nor be expected to match this loss of funds from the Federal Government. When we realize what a serious problem tuberculosis poses for Texas and especially for communities along the Texas-Mexican Border, any reduction in existing efforts directed at tuberculosis control, a consequence of decreased availability of funds, can only have disastrous effects on the citizens of these communities. This problem must be faced and resolved before significant and undue suffering develops in our already poor and struggling Mexican American citizens.

The problem is that too many people, including physicians, consider tuberculosis no longer a problem. They compare it to how it was in the past and since an improvement is noticed, not only do they become less concerned but they soon begin to pull personnel and money out of existing programs and shift their efforts

to so-called other areas of priority. The fallacy with this approach has been demonstrated time and again; for once the disease becomes a blatant problem again the tide will turn with more money and personnel being spent. This is not to mention the unnecessary suffering and hardship which results from this kind of approach. Would it not make more sense to spend more money, utilize more personnel at a time when we seem to be winning the battle for people's health. For if this is done, we could truly be victorious over this scourge of men's bodies and minds.

You may be interested to know that recently at the request of the government of the United States and the government of Mexico, the Pan American Sanitary Bureau which has an office in El Paso invited Dr. Santos Neves as a short-term consultant to evaluate the problems of tuberculosis in the border community of El Paso-Juarez. The report has been completed and submitted to the respective governments for final approval. The findings are of significant interest and have implications for the entire United States-Mexico Border.

If I can be of any assistance to you in the future, please do not hesitate to call upon me.

Sincerely yours,

MELVIN FOX, M.D.,
Medical Director.

Enclosure.

FEBRUARY 17, 1969.

To: Dr. Melvin Fox, Medical Director, Region I-B, Division of Tuberculosis Control, Texas State Department of Health.

From: Pete T. Duarte, Team Leader, TransCentury-HEW Health Project.

Subject: TransCentury team activities to date.

The TransCentury team has been working in El Paso since the beginning of the year. They have met with local health officials, the social agencies, consumer groups and community leaders. Their approach has been to present themselves as a team of individuals who are here to work for the benefit of all segments of the community and to try as best as possible to keep everyone informed about the team's activities. The rationale behind this approach is: (1) to establish contact with a cross section of the community from the beginning in order to avoid confusion, controversy and to circumvent misunderstanding about the TransCentury-HEW Health Project; (2) to familiarize themselves with what exists; (3) to find out who the personalities are and what their attitudes are; and (4) to seek means for mutual cooperation. At present they are in the process of establishing overall objectives based on their preliminary findings. These objectives will be general and flexible enough so that they can be changed if the need arises.

The following is a list of agencies and grassroots organizations contacted, categorized as: (1) established health community; (2) consumer community; and (3) other established organizations and agencies. These categories were established by and for the internal usage of the team.

CONTACTS

Established Health Community:

R. E. Thomason General Hospital
City-County Health Department
El Paso Mental Health Project
T.B. Control, State of Texas (Region I-B)
El Paso Visiting Nurses Association
P.H.S. Quarantine Division, Mexican Border Area
El Paso County Medical Society
Private Medical Practitioners
Others:

Department of H.E.W., Region VII
Department of H.E.W., National Institute of Mental Health
Texas State Department of Health
American Friends Service Committee, Houston
Community Mental Health Project, Houston

Consumer Community:

Southside Improvement Association
Ochoa Parents Association
Tepeyac Federal Credit Union
Camino a las Viviendas

Other Established Institutions and Organizations:

General Assistance
 State Welfare Department
 County Welfare Department
 Vocational Rehabilitation
 Texas Educational Agency
 County Extension Agent
 United Fund
 Council on Aging
 Social Security Office
 Sunshine Day Nursery
 Boy's Club
 Our Lady's Neighborhood Center
 Operation S.E.R.
 Sacred Heart Church
 Project MACHOS
 Amigos de MACHOS
 MACHOS Block Organizations
 University of Texas at El Paso
 Project BRAVO:

Alameda Center
 Southside Community Center
 Tigua Center
 Casa Blanca
 Executive Board of Project BRAVO
 Minority Mobilization Project
 VISTA Volunteers

HEW Juvenile Delinquency Project

Project JACS

Lawyers

Politicians

City Planning Commission

Southwest Council of La Raza

City Parks and Recreation

Lutheran Border Ministry

THE OHIO STATE UNIVERSITY HOSPITALS,
 Columbus, Ohio, June 27, 1969.

Re S. 2264.

Senator RALPH YARBOROUGH,
 Senate Office Building,
 Washington, D.C.

DEAR SENATOR: This is a note to indicate my interest in the above bill, which would provide continuation of project grants for tuberculosis study and control.

We appreciate the fact that you have introduced this bill and are supporting it. We believe it is important that it pass the Congress. Tuberculosis control has not yet reached the stage where this type of support is not a vital need.

Sincerely yours,

R. H. BROWNING, M.D.,
 Professor of Medicine (Pulmonary Diseases).

WEST VIRGINIA TUBERCULOSIS AND
 RESPIRATORY DISEASE ASSOCIATION, INC.,
 Charleston, W. Va., June 24, 1969.

Hon. JENNINGS RANDOLPH,
 U.S. Congress, Senate Office Building,
 Washington, D.C.

DEAR SENATOR RANDOLPH: I understand that hearings will be soon in order for the Bill, which has been introduced by Senator Ralph Yarborough, S. 2264 concerning Communicable Disease Grants.

The Board of Directors of the West Virginia Tuberculosis and Respiratory Disease Association and myself would appreciate your consideration in giving your support to this Bill, S. 2264 Communicable Disease Grants. The West Vir-

ginia Tuberculosis and Respiratory Disease Association is exceedingly interested in the passage of this Bill because it will continue grants for case-detection techniques which is greatly needed to determine unknown cases of tuberculosis and either treat or isolate this infection. Tuberculosis, as you know, is a communicable disease and it is communicated from a person who has the disease to a person who is well and healthy. This is drastic.

If we are to continue our progress towards the eradication of tuberculosis, it is most important that unknown cases of this infectious disease be known and either treat or isolate this infection. The passage of Bill S. 2264 Communicable Disease Grants will make this possible and will continue the work which has been done in the past. To not receive the needed financial support would greatly jeopardize the work which has already been done.

With our sincere appreciation and many thanks for your kind consideration in supporting the above Bill and with best personal regards, I am

Sincerely,

THOMAS A. DEVENY, JR.,
Executive Director.

ARKANSAS BOARD OF HEALTH,
Little Rock, June 24, 1969.

HON. J. W. FULBRIGHT,
*U.S. Senator, U.S. Senate Building,
Washington, D.C.*

DEAR SENATOR FULBRIGHT: It is our understanding that Senator Yarborough of Texas has introduced an amendment to Public Health Service Act 361 (Senate Bill 2264). This bill concerns project assistance to states for the control of communicable diseases.

We feel that this legislation is vital to the State of Arkansas because funds for the control of communicable diseases are presently distributed (under Public Law 89-749) on the basis of population rather than the basis of the extent of the problem and the financial need.

For the betterment of Arkansas, we earnestly solicit your support for passage of this legislation.

Yours truly,

J. T. HERRON, M.D.,
State Health Officer.

HEALTH DEPARTMENT, OFFICE OF THE DIRECTOR,
Kansas City, Mo., June 30, 1969.

HON. STUART H. SYMINGTON,
*U.S. Senate,
Washington, D.C.*

DEAR SENATOR SYMINGTON: This letter is to inform you of my support for Senate Bill 2264 introduced by Senator Yarborough. This bill, which provides for the direct funding by the Department of Health, Education and Welfare for the control of communicable disease, is mandatory in order to maintain the present level of control in tuberculosis and other communicable diseases, and would also provide us with the hope of being able to increase the control of these communicable diseases in the near future.

Due to the importance of this matter in regard to the health of your constituents, I strongly urge your support and your influence in the Senate to expedite the approval of this bill.

Yours very truly,

EDWIN O. WICKS, M.D., Dr. P.H.,
Health Director.

Senator HUGHES. The chairman wishes to thank all who appeared and contributed to these hearings. The committee will give careful consideration to all testimony and other material submitted for our use in the executive sessions ahead of us.

Thank you, again, for your cooperation.

(Whereupon, at 1 p.m., the committee adjourned, subject to the call of the Chair.)

